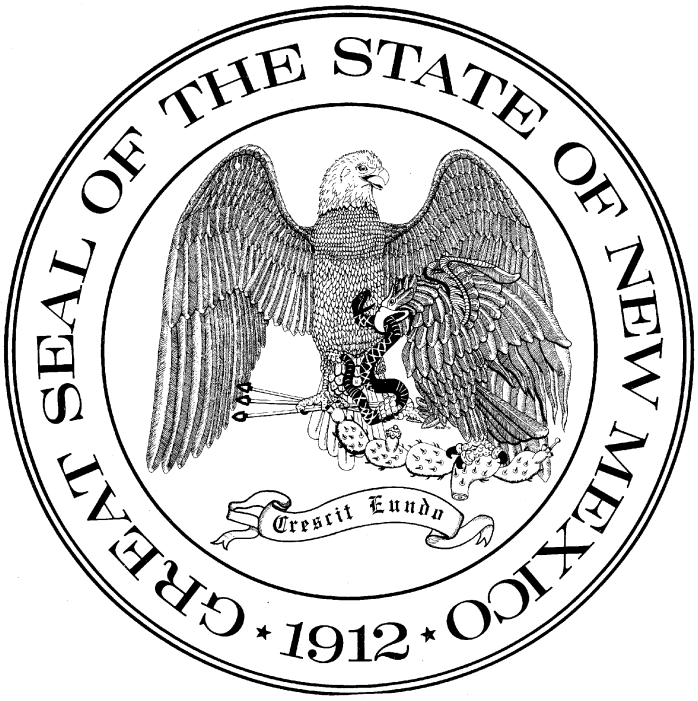
HUMAN SERVICES DEPARTMENT

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002



Report to

the LEGISLATIVE FINANCE COMMITTEE

LEGISLATIVE FINANCE COMMITTEE

Representative Luciano "Lucky" Varela, Chairman
Senator Ben D Altamirano, Vice-Chairman
Senator Sue F. Beffort
Senator Pete Campos
Representative Max Coll
Senator Linda Lopez
Senator Patrick H. Lyons
Senator Cisco McSorley
Representative Joe Mohorovic
Senator Leonard Lee Rawson
Representative Henry "Kiki" Saavedra
Representative Nick L. Salazar
Senator John Arthur Smith
Representative Sandra L. Townsend
Representative Jeannette Wallace
Representative Donald L. Whitaker

DIRECTOR

David Abbey

DEPUTY DIRECTOR

Dannette K. Burch, CPA

PERFORMANCE AUDIT MANAGER

Manu Patel, CPA

AUDIT TEAM

G. Christine Chavez, CPA
LaVonne Cornett, CPA
Susan Fleischmann, CPA
Lorenzo Garcia, CPA
Alicia Ortiz
J. Scott Roybal
Aurora B. Sandoval, CISA

AUDIT STAFF FROM THE STATE AUDITOR'S OFFICE

Chan Kim, CPA
Charles Schroeder
Carol Sturdivant

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

Table of Contents **Page No.**

State of New Mexico
LEGISLATIVE FINANCE COMMITTEE

325 Don Gaspar • Suite 101, Santa Fe, New Mexico 87501
(505) 986-4550 Fax: (505) 986-4545

DAVID ABBEY
DIRECTOR

March 22, 2002

Ms. Robin Otten, Deputy Secretary
Human Services Department
Santa Fe, New Mexico 87504

Dear Ms. Otten:

On behalf of the Legislative Finance Committee (Committee), we are pleased to transmit this report of the Medicaid managed care (Salud!) Encounter Data Program. We believe this report addresses the issues the Committee asked us to review and hope the Human Services Department (department) will benefit from our efforts. We also believe the report addresses the program objectives of the National State Auditors Association Joint Audit Project of encounter data.

The audit team interviewed key personnel, examined documents and analyzed the department's encounter Data. The report was discussed with Human Services Department staff at an exit conference held on February 18, 2002. At the April 2002 meeting, the Committee will focus on the department's tactical plan to timely implement and execute the recommendations of the audit. The report will be combined with reports from the states of New York, Tennessee and Pennsylvania and presented at the June 2002 annual meeting of the National State Auditors Association.

Thank you very much for your cooperation and assistance.

Sincerely,

David Abbey
Director

DA/njw

Executive Summary

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

EXECUTIVE SUMMARY

Pursuant to a request from the Legislative Finance Committee (Committee), the performance auditors conducted an audit of the Human Services Department's (department) Medicaid Managed Care (Salud!) encounter data program. The audit period was from the inception of Salud! (July 1, 1997) through June 30, 2001. The audit was a joint project with three other states of the National State Auditors Association (NSAA). The purpose of this review was to:

- Determine the adequacy and progress of the department's strategic plan for implementation and use of an encounter data program;
- Review and evaluate the capability of the department to ensure the reliability of encounter data;
- Assess the reliability of the encounter data; and
- Review and evaluate the adequacy and effectiveness of the department's use of encounter data.

Although encounter data is vital to the overall administration of a managed care program, it is important to understand that it is not the only means by which a managed care program is monitored. Encounter data is excellent for determining and analyzing quantities of services performed; however, it cannot fully determine the quality of such services. Hence, by itself it is not sufficient for overall Medicaid management. Direct monitoring of the quality of services must be performed by other means.

Under the fee-for-service (FFS) program, providers submit claims for health care services provided to Medicaid recipients directly to the department. Information from billing documentation is processed and used to analyze cost and services trends and statistics. Under the current managed care environment, the managed care organizations (MCOs) are required to submit equivalent encounter data. Without reliable (complete, accurate and timely) encounter data the department cannot adequately manage the Salud! program or individually monitor the MCOs.

Although there are indications of progress in implementation of the encounter data program since the inception of Salud!, such progress has been slow. For the time period audited, a strategic plan with identified milestones and time-lines for implementation and use of encounter data had not been established. The department's monitoring, encounter data validation, accounting for overpayment reimbursements, and file maintenance were lacking in various areas. The deficiencies of the encounter data hinder the department's ability to evaluate and monitor MCO

performance and overall health care. With regard to its use for cost effectiveness demonstration and rate setting, the data is not reliable.

The department's management recognizes the importance of encounter data as well as the current problems regarding completeness and accuracy of the data. It is also cognizant of its shortcomings with regard to monitoring and validation. Management appears committed to continue to improve data accuracy and completeness in order to render it reliable for its intended purposes. An encounter data validation review performed by a consultant in November 1999 identified significant problems with data reliability and cautioned the department about releasing encounter data information publicly. Also, in 1999, Health Care Financing Administration (HCFA) concluded that the department did not have reliable encounter data and stated that Salud! could not be adequately monitored without useful encounter data.

The audit team recognizes that Medicaid managed care is relatively new to New Mexico and that major program conversions are never accomplished without obstacles and complications. Also, many of the difficulties that New Mexico has experienced with its encounter data program implementation are common to all states that transition from a fee-for-service program to a Medicaid managed care environment. Therefore, the findings, observations and recommendations in this report are offered and intended to help the department to achieve the goal of effectively implementing, maintaining and using a reliable encounter data program. This audit includes the following findings:

General Monitoring and Validation of Encounter Data

- As of June 30, 2001, the department did not have a strategic plan which clearly and comprehensively describes the implementation and use of Medicaid encounter data. The current state of the data hinders full health care evaluation, MCO monitoring, capitation rate development and cost effectiveness demonstration.

- As of June 30, 2001, the department did not have a comprehensive internal data validation review process. The primary validation activity currently used by the department is data analysis, via computer edits, that test for basic data entry related errors and omissions. A comprehensive data validation program would, at a minimum, include not only system edits but also analytical and medical chart reviews.

- The recent establishment of a workgroup comprised of department and MCO staff to address various encounter data related issues and problems is an indicator of the department's desire to improve the reliability of the data. However, the goals of the workgroup are broad and specific deliverables or time-lines towards the achievement of goals are not identified.

- The MCO contracts are general with regard to data accuracy and completeness and do not require self-assessments of encounter data. Data problems known by the MCO but not by the department could be identified by self assessment reports. The contracts also do not require that the MCOs submit health care cost information as elements of the encounter data. Rate setting and cost containment analysis cannot be performed without such information.

- As of June 30, 2001, the department did not have a detailed sanction plan or guidelines specific to encounter data monitoring. The process of developing an adequate encounter data program may have been further advanced, had the department exercised its power to impose sanctions more frequently.

- As of June 30, 2001, the department had not reviewed, approved or adequately monitored MCO provider education plans as required by the contracts. It also had not communicated guidelines or criteria for identifying what should be included in provider training plans to the MCOs.

- As of June 30, 2001, the department had not maintained an adequate accounting of encounter data systems edit error rejects and re-submissions. Hence, it could not determine the absolute completeness of the data for each MCO. The department contends that overall rejects have progressively declined since the inception of Salud!. An analysis performed by the auditors clearly supports this contention.

- The encounter data MCO comparison report, which displays aggregate recipient and services data, has not been used effectively by the department for health services utilization management. This report can be an excellent tool for encounter data validation analysis and health care monitoring. It can, however, be improved to make it an even more effective instrument to monitor the MCOs.

Analysis For Timeliness, Accuracy and Completeness of Encounter Data

- Of 96 MCO comparison report services reviewed, there were 52 instances (54 percent) in FY00 where one or more MCOs appeared to have served fewer recipients and/or provided significantly fewer encounters when compared to the other MCO(s) and/or its proportionate share of Medicaid recipients. MCO inquiries about these variances revealed a variety of encounter data reporting problems, including nonsubmission of data, coding inconsistencies, and MCO disagreements with information reflected in the MCO comparison reports.

- A review of transportation encounters for the fiscal year ending June 30, 2000 revealed that of a total 110,236 encounters, there were 17,763 (16 percent) for which there was no

other accompanying medical service reported within 24 hours before or after the reported encounter. An analysis of the procedure codes used by the MCOs to report transportation encounters identifies reporting inconsistencies between the MCOs.

- A review of lab and radiology encounters for the fiscal year ending June 30, 2000 revealed a disproportionate distribution of lab and radiology encounters between MCOs when compared to their proportionate share of recipients.

- Submission to the department of claims denied by the MCOs is not required. The department would be better able to monitor the health care of a Medicaid recipient if his or her complete encounter history, including claims that were denied by the MCO, were known. It would also be better able to monitor claim denial activity of the MCOs in aggregate as well as by specific service or service category.

- The combined average encounter data submission times for all services by the three MCOs for the fiscal period ending June 30, 2000 and June 30, 2001 was 124 and 134 days, respectively. The current contracts require that encounter data be submitted to HSD within 90 days of the date of service or discharge.

- A review of Salud! clients in FY00 revealed that of an estimated 206,473 recipients, only 7,669 (3.71 percent) had no reported encounters. This appears to reflect positively on general access to care. However, FY00 average monthly cost of $225 for recipients with no reported encounters is higher than the overall average cost of $205 for all Salud! clients. This may suggest that those recipients with no reported encounters are in higher risk groups and, therefore, would likely have greater medical needs than the average Salud! population.

Other Observations

- Since the inception of Salud!, quarterly health care utilization reports submitted by the MCOs in accordance with contractual requirements have shown inaccuracies. The data in the reports show variances in services from one quarter to the next. In some cases information relating to particular services appears unrealistic.

- In the fiscal year ending June 30, 2000, the department overpaid FFS providers $302,071 for medical services that were covered under managed care. Most of the claims were related to services provided to newborns that were born into managed care. It is likely that a similar analysis performed on each year since the inception of managed care would yield similar results.

- From the inception of Salud! to June 30, 2001, the department overpaid the MCOs an estimated $5.8 million because dual Medicaid/Medicare eligibles have not been timely identified and removed from the Salud! roster. Approximately $5 million has been forfeited by the department because it did not attempt to collect within 12 months as required in the MCO contracts. Overall collections from the MCOs for dual eligible capitation payments have been minimal. Exact amounts are undeterminable due to inadequacies of the department's system of accounting for dual eligibles and other collections.

Recommendations

- Establish a strategic plan for implementation and use of encounter data;
- Continue to exercise caution when using encounter data;
- Establish a comprehensive internal data validation process to include strengthening system edits;
- Require the encounter data workgroup to address long-term and short-term trends and issues;
- Strengthen the MCO contracts to improve data reporting;
- Increase the use of sanctions when MCOs fail to report timely, accurate and comprehensive encounter data;
- Strengthen oversight of MCO provider education plans;
- Improve and strengthen the MCO encounter data comparison reports;
- Provide the necessary guidance to the MCOs to ensure consistent coding and reporting of encounters throughout all services;
- Require claim denials as part of regular MCO encounter data submissions;
- Continue to work with the MCOs to determine the reasons for variances between counties and why recipients with no reported encounters appear to be in higher risk cohorts;
- Establish a quarterly health care utilization report review program that will ensure regular quality analysis;

- Identify all ineligible fee for service claims paid and request reimbursement from providers; and

- Develop and maintain a dual eligible detection, collection and accounting system.

Department Responses

Overall the New Mexico Human Services Department (HSD) agrees with majority of the findings and recommendations in the report. The audit period, from the beginning of Salud! to June 30, 2001, was a period of significant change for the state Medicaid program. HSD agrees with the report that the difficulties that New Mexico has experienced with its encounter data program implementation are common to all states that transition from a fee-for-service program to managed care. In reading the report and considering the recommendations, it is extremely important to be aware that encounter data is an excellent tool for determining and analyzing quantities of services performed; it cannot be used solely to monitor and safeguard the quality of and access to those services. HSD utilizes a number of other methods to measure the quality of care and to ensure access. In addition, especially in light of the state's current fiscal situation, the reader must be aware that there are costs associated with obtaining, assessing, submitting and analyzing encounter data for the Salud! managed care organizations (MCOs) and the state. In this regard, a few of the LFC's recommendations, if implemented, would raise Medicaid costs even more.

With those caveats, HSD welcomes the Legislative Finance Committee (LFC) staffs' observations and recommendations in the report and appreciates that the recommendations are intended to help HSD. In return, HSD pledges to consider each finding and incorporate the recommendations, when possible, to achieve an improved encounter data program. In fact, the department has already taken steps to address many of the findings. These actions as well as other observations about the report are discussed at the end of each section of the report.

REVIEW INFORMATION

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

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. New Mexico has over 320,000 Medicaid recipients and expenditures of more than $1.4 billion for FY01.

Section 27-2-12 NMSA 1978 designates the New Mexico Human Services Department (HSD) as the state agency responsible for administering the program. Laws 1994, Chapter 62 (Section 27-2-12.6 NMSA 1978) mandated HSD to provide for a statewide managed care system that would be cost-efficient and would deliver preventative, primary and acute care for Medicaid clients. In October 1996, HSD submitted a section 1915(b) waiver request to the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (DHHS). The waiver was approved for a two-year period that included fiscal years ending June 30, 1998 and 1999. A subsequent waiver renewal request was granted by HCFA on October 19, 2000 for a two-year period ending October 22, 2002.

In 1999, the New Mexico Legislature passed House Joint Memorial (HJM) 18 which, in part, required the Legislative Finance Committee (LFC) to conduct a fiscal and performance audit of the department's managed care program. The LFC Performance Audit Unit presented three separate reports to the LFC in November 1999, May 2000 and October 2000. The November 1999 report addressed Native American concerns. The May 2000 report addressed cost effectiveness and managed care monitoring issues, including a cursory review of the department's encounter data program. In the October 2000 report, the cost effectiveness update was presented, and issues on behavioral health and access to care were reported.

In a fee-for-service (FFS) environment, providers submit claims directly to the department for services provided to a Medicaid recipient. Information from billing documentation is processed and used to analyze cost and service trends and statistics. In a managed care environment, such claims data does not exist. Hence, one condition of HCFA's waiver approval of the Section 1915.b waiver was that submission of encounter data be required of all participating managed care organizations (MCOs).

Encounter data is the record of documented procedures or services rendered to a patient on a given date. The effective collection and use of reliable encounter data are vital to the management of a health care program. The data can be used by managed care administrators to conduct a variety of assessment and quality improvement activities. Encounter data can identify patterns of service utilization by individual recipients and specific groups of recipients that receive similar services. Aggregated encounter data can be used to calculate broad utilization patterns and clinical performance measures. Ten principal uses of encounter data are:

- Monitor and safeguard quality of care;
- Monitor access to care;
- Analyze utilization patterns;
- Develop capitation payment rates;
- Calculate risk adjustment;
- Assess an MCO's contractual performance;
- Respond to information requests;
- Meet federal reporting requirements;
- Estimate cost savings from managed care; and
- Detection and deterrence of fraud.

In 1999, the department contracted with the Island Peer Review Organization (IPRO) to perform an encounter data validation review. In its November 1999, report IPRO identified problems with the accuracy and completeness of the department's encounter data. IPRO recommended that the department use caution when releasing encounter data based information to the public. A 1999 HCFA department review report also concluded that the department did not have reliable encounter data. The report stated that the state cannot adequately monitor the Salud! program without useful encounter data.

NATIONAL STATE AUDITORS ASSOCIATION (NSAA) JOINT AUDIT

Each year, the National State Auditors Association (NSAA) selects a single audit topic of national scope and importance, and invites member states to participate in a joint audit effort. The LFC performance audit unit agreed to participate in the year 2001 NSAA joint audit of Medicaid encounter data. The other participating states are New York, Pennsylvania and Tennessee. The State of New York Controller's Office is the lead on this project. The basic objectives of the states are virtually the same. Telephone conference progress meetings were held monthly. An audit mid-point meeting was held in Albany, New York in August 2001. This report represents the results of New Mexico's contribution to the 2001 NSAA joint audit of Medicaid encounter data. The final joint report will be presented to the NSAA Audit Performance Committee and shared with all of the participating states.

OBJECTIVE, SCOPE AND AUDIT PERIOD

This audit was conducted in accordance with applicable Government Auditing Standards. Its purpose was to provide an independent and objective evaluation and progress of the department's managed care encounter data program. Specific objectives were to:

- Determine the adequacy and progress of the department's strategic plan for implementation and use of an encounter data program;

- Review and evaluate the capability of the department to ensure the reliability of encounter data;

- Assess the reliability of the encounter data; and

- Review and evaluate the adequacy and effectiveness of the department's use of encounter data.

The overall period audited was from the inception of Salud! (July 1, 1997) through June 30, 2001. However, because of data completeness issues due to timing of data submissions, some tests were performed on data from the fiscal year ending June 30, 2000.

PROCEDURES

Our procedures included:

- A review of federal and state statutes, regulations, policies and procedures;

- A review of the managed care contracts, requests for proposal and managed care systems manual;

- Review of encounter data programs of other states;

- Review of HCFA's *Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data*;

- Meetings and discussions with HSD and MCO officials;

- Meetings and discussions with various audit and medical professionals;

- Meetings and discussions with auditors of other states that are participating in encounter data audits of their respective Medicaid agency; and

- Analysis of various computer generated encounter data reports and queries.

AUDIT LIMITATIONS DUE TO CONFIDENTIALITY CONCERNS

During the course of the audit the department raised strong objections to auditors having access to Medicaid recipient identification and health data. Hence, auditors were precluded from comparing Salud! encounter data to patient medical files for accuracy, completeness and consistency of reporting by MCOs. Such tests would have enabled auditors to identify specific encounter data reporting problems at the provider level. Discussions with providers about such

problems would have been beneficial to not only the auditors, but also to the providers, the MCOs and the department. Notwithstanding these limitations, sufficient other analysis was performed to support the conclusions expressed in this report. Recognition should be given to its Management Information Systems Bureau and, in particular, its former bureau chief for working diligently with the auditors in analyzing various aspects of the encounter database. The impact of the limitations posed by the confidentiality issues was significantly curtailed as a result of such cooperation.

EXIT CONFERENCE

The contents of this report were discussed with Deputy Secretary Robin Otten, Director Robert Maruca, Deputy Director Cathi Valdes, Deputy Director Roger Gillespie, Bureau Chief Martin Rosenblatt, Bureau Chief Mary Kay Pera and Dr. Charles Boatright on Monday, February 18, 2002 at 4:00 p.m. Representing the LFC at this exit conference was Audit Manager Manu Patel, Senior Performance Auditor Lorenzo Garcia and Auditor Charles Schroeder.

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, Legislative Finance Committee and National State Auditors Association. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

Manu Patel
Performance Audit Manager

FINDINGS, RECOMMENDATIONS, AND DEPARTMENT RESPONSES

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

I. General Monitoring and Validation of Encounter Data

A. Strategic Plan for Implementation and Use of Encounter Data Program. As of June 30, 2001 the department did not have a written strategic plan for the implementation and use of an encounter data program. It had not established implementation and progress objectives with milestones or time-lines for their achievement. As a result, progress of implementation has been very slow. The data, in its present state, cannot be used for its intended purposes. The department continues to strive to improve accuracy, completeness and timeliness of data, but still does not know when the data will be adequate for use as intended. The department's intended uses of encounter data are:

- Evaluation of health care quality;
- Evaluation of MCO performance;
- Development of capitation rates and reimbursement rates; and
- Cost containment and cost effectiveness demonstration.

Management's hesitance to use encounter data to evaluate health care and MCO performance is largely due to its dissatisfaction with the completeness and accuracy of the data. Accordingly, since the inception of Salud! and throughout the encounter data gathering process, the department has identified numerous occurrences of data incompleteness and inaccuracy. Its use of encounter data thus far has primarily been limited to researching and reviewing various issues via ad hoc queries. Such research and reviews have usually been triggered by either internal or external inquiries about specific services or concerns, such as dental services, childhood immunization and fraud investigation related issues.

With regard to the use of encounter data for developing capitation rates and cost containment, the department has not considered when or how this will be done. The main reason for such minimal effort thus far, according to management, has been limitations in capabilities of the information systems. Management has stated that a new information system will make it much easier to implement programs and processes for encounter data for rate setting and cost effectiveness calculations.

Recommendations

We recommend the following:

- Establish a strategic plan for implementation and use of encounter data that clearly describes major milestones and timeliness for their achievement. At a minimum the plan should include the following components: Vision, mission, goals, objectives, resources, monitoring and evaluation, responsibilities, time-lines and progress. It should also specifically address issues of completeness and accuracy of encounter data. The department should review and revise the document on a periodic basis;

- Designate a committee comprised of HSD Medical Assistance Division staff and MCO representatives to monitor progress of the plan; and

- Continue to exercise caution when using encounter data. If distributed publicly, include necessary disclaimers and/or qualifiers in order to prevent the external users from drawing misleading or inaccurate conclusions.

Department Responses

During the period of the audit review, the department worked with the Salud! MCOs to improve the reliability and timely submission of encounter data. With the advent of the current contract period, which began July 1, 2002, the department began a thorough and systematic review of all reports, including the status of the encounter data. In response, HSD developed and implemented an encounter data plan. This plan happens also to address many of the LFC's findings and recommendations. The plan is being expanded upon to include all components specified in the LFC's recommendations. (See section entitled, "Workgroup" for additional details.)

B. Encounter Data Validation Program. As of June 30, 2001, the department did not have a comprehensive internal data validation review process. The primary validation activity currently used by the department is data analysis, via computer edits, that test for basic data entry related errors and omissions. Edits are further discussed in the finding below entitled "System Edits".

Another validation activity performed by the department is general physical and subjective review of encounter data MCO comparison reports for apparent inconsistencies among MCOs. Although the MCO comparison report can be an effective tool for broad general validation purposes, in its present form, its effectiveness for specific or comprehensive data is limited. Uses and limitations of the MCO comparison report are further discussed in the findings entitled "MCO Comparison Reports" and "Analyses of MCO Comparison Reports". Of further significance is the fact that this review has been largely reliant on the knowledge and expertise of the former MISB chief who retired effective July 2001.

In its *Guide to States to Assist in the Collection and Analysis of Medicaid Managed Care Data*, HCFA states that no data source should be considered accurate unless data quality assessments have been conducted. Such assessments include system edits, analytical reviews and medical chart reviews. They would involve more computer-generated analysis and logic tests such as the identification of inconsistent trends and omissions of specific services. Based on the results of these analysis, overall inaccuracies or incompleteness of submitted data could be estimated.

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

Recommendations

We recommend that the department implement a comprehensive encounter data validation program that includes:

- Review and monitoring activity that regularly compares samples of encounter data to MCO and provider records;

- Comparative analysis of encounter data to prior Salud! actuarially projected fee-for-service data.

Department Responses

As the LFC Audit of Medicaid Managed Care Program (SALUD!) Managed Care Encounter Data points out, at the time of the audit, the Department did not have a comprehensive internal data validation review process; however, most of the necessary and recommended components were in fact in place. Validating encounter data is an evolving process not just for the states, but also for the federal government. The first draft protocol for Validating Encounter Data in External Quality Review of Medicaid managed Care Organizations and Prepaid Health Plans was issued by the Centers for Medicare and Medicaid Services (CMS) only last October (2001), just four months after the period audited by the LFC.

The edits employed by the SALUD! MCOs are somewhat less than the edits used by the Department in the Medicaid Management Information System (now replaced and improved by Omnicaid). After the first encounter data validation project completed by Island Peer Review Organization in 1999, the Department took steps to assess the MCOs' information systems. This was done by mandating an annual HEDIS Compliance Audit™ performed by a certified HEDIS auditor. This is the first of three core activities recommended in the CMS protocols. The second and third activities recommended in the CMS protocols are: analysis of MCO electronic encounter data for accuracy and completeness, including analysis of data reasonableness and review of medical records for additional confirmation of findings. These two activities were performed by Island Peer Review Organization in 1999. The recommendations were put in place and are still being incorporated into the Department's process. One example of this is the revised contract wording in the July 2001 MCOs' contracts with the Department. The standards for encounter data submission are far more prescriptive than in the first contracts.

Development of accurate and complete encounter data is an iterative process. The CMS draft protocols for improving the completeness and accuracy of encounter data recommends a phased-in approach primarily, because "it is often not possible for MCOs... to overcome all limitations in their IS and data policies in one year."

The encounter data MCO comparison reports were designed in advance of the first submission of data and without the knowledge and expertise found thorough working with encounter data. Certain of these reports, are validated by audited and reported HEDIS data. These comparison reports will continue to be refined and used as another tool to measure MCO performance.

Review and monitoring activities on a regular basis can and should occur once clear and common definitions have been established. This is the mission of the encounter data workgroup discussed in Section C, and should be completed by mid-2002. A baseline encounter data validation will be performed by the Island Peer Review Organization in late 2002 and regularly from that point forward. These audits are expensive and should occur after the recommendations have been put in place and have had time to take effect.

Because there are differences in encounter data logic by plan, these tests must be performed at a micro level by the individual MCO and again on a macro level by the Department. The Salud! contracts are with three different MCOs with their own policies and procedures. Policy interpretation and application plays a critical role in this process and to recommend computer driven analytical review (logic tests) of encounter data, looking for (example given) transportation encounters that are not accompanied by another medical procedure on the same service date, is a gross simplification of the problem.

The Department questions the purpose of comparative analyses to projections arrived from actuarially projected fee-for-service data. First, these projections are based on utilization of physician services under non-capitated fee arrangements. The behavior of medical care delivery is different under fee for service than it is under a managed care system. While it may be useful for rate setting, it validates nothing at the code level or at the encounter level (medical record). For a true comparison to take place both the fee-for-service claim and an identical encounter claim would have to be validated. Resources of the Department will be better spent following the protocols proposed by CMS and by following the recommendations of the independent encounter data specialists, once regular audits are established and on going.

In conclusion, the goal of reliable encounter data is the same for both the LFC and the Department. Certain tasks must be accomplished in order for this to happen and have been in process since 1999. This audit identifies those areas that are still less than ideal, but not being ignored.

- Computer driven analytical review (logic tests) of encounter data, such as specific missing medical procedures that, on the basis of the patient's condition, should be performed and reported. For example, transportation encounters that are not accompanied by another medical procedure on the same service date. MCOs could be asked to explain the reasons for such inconsistencies. This sort of test is not only valid as a data validation test, but could also be used as a tool for quality of care review; and

C. Workgroup. On October 2001, the department formed a workgroup to assess the current status of the encounter data and to develop and implement a strategic plan for addressing any deficiencies identified. We commend the department staff for the establishment of this workgroup. It is clearly an indication of its recognition of the limitations of its encounter data program as well as its desire to improve upon the accuracy and completeness of the data.

The workgroup is comprised of department staff and representatives of all three MCOs. The department intends for the encounter data workgroup to meet on a monthly basis for the duration of the contract period (June 30, 2003). Its establishment was primarily a result of the analysis of the encounter data comparison reports by LFC audit staff, the department and the MCOs. The goals of the workgroup have been identified as: ensuring the completeness, accuracy and timeliness of encounter data; making use of encounter data to monitor MCO performance and utilizing encounter data in rate setting. Audit staff discussed the goals and activities of the workgroup with department staff. We also reviewed various documents provided by the department. The following are some general observations

- The encounter data workgroup does not have a mission statement;
- The encounter data workgroup work plan time-lines provided to LFC staff is primarily a listing of procedures related to the submission and processing of encounter data. It does not specifically address issues of completeness and accuracy of encounter data, nor does it identify specific deliverables; and
- The goals of the work group are broad statements that may not be completed within its stated duration.

Recommendations

We recommend the following:

- The encounter data workgroup should establish a clear and well-defined mission statement that will identify both long-term and short-term goals and objectives as well as specific time-lines and deliverables;
- The encounter data workgroup should be ongoing and proactive so that it can adequately address long-term as well as short-term trends and issues;
- If the workgroup is to continue to act only for the duration of this contract period (FY01 through FY03), modify the workgroup goals to be a realistic representation of what the workgroup can accomplish within this time period; and

- The department should modify the workgroup goals so that they are specific, measurable, attainable, realistic and timely.

Department Responses

The new managed care contract period, effective July 1, 2002, presented HSD with an opportunity to improve many aspects of the Salud! program, including reporting requirements, such as encounter data. In this regard, the encounter data workgroup, which was convened in October of 2001, focused specifically on Salud! Report # 1, Encounter data. A comprehensive review of the current encounter data program was completed and a formalized approach was developed and implemented to manage the encounter data program. This plan is being expanded upon to include a mission statement and short and long term goals and objectives, monitoring and evaluation, responsibilities and timelines. In addition, revisions are being made to the report parameters and service descriptions and to the section on encounter data in HSD's Salud! Systems Manual. The workgroup, comprised of HSD Medical Assistance Division staff and MCO representatives, will continue to meet regularly on a monthly basis to oversee the encounter data program, monitor its progress, and to address all issues related to encounter data.

D. MCO Contracts. The MCO contracts are general with regard to data accuracy and completeness. They are also lacking in other aspects related to encounter data.

- Accuracy and completeness is briefly described in the contracts as the system edit error rate threshold of no more than 5 percent of the data that is submitted. Because the error threshold cannot be applied to nonsubmitted data the limitation of the definition of accuracy and completeness is misleading. In fact, accuracy and completeness can be addressed by other means, including assurances of 100 percent data submissions from the original providers, and coding consistencies between MCOs.

- Although the responsibility of the department is clear with regard to monitoring and accounting for accuracy and completeness of encounter data, the contracts are not specific about how this requirement will be achieved.

- The contracts require the MCOs to submit various fiscal and health data reports, but do not require MCO self-assessments of data accuracy and completeness. Data problems known to the MCO but not to the department could be identified by requiring this kind of report.

- The contracts do not require that the MCOs submit health care cost information as part of the encounter data. Rate setting and cost containment analyses cannot be performed without such information.

Recommendations

We recommend the following:

- The department should issue guidance memorandums that expand and elaborate on its definition of accuracy and completeness and its role in monitoring and accounting for encounter data submissions and re-submissions of rejected data;

- The department should also require MCOs to submit self-assessment reports for accuracy and completeness of encounter data; and
- The department should require that cost information be included with all encounter data.

Department Responses

HSD/MAD agrees with the recommendations.

MAD has completed a good deal of work with the MCOs on encounter data and will continue to issue guidance memorandums to expand and elaborate on its definition of accuracy and completeness including the monitoring of encounter submissions and the re-submission of rejected claims. We will incorporate appropriate changes into the next MCO contracts. It is important to understand all the services that have been delivered to Medicaid beneficiaries even if some of those services are not covered or paid for by Medicaid. Additionally, we must ensure that encounters that are rejected because they are duplicates are not re-submitted so we do not inflate the actual number of encounters.

HSD/MAD will work with the MCOs to further develop self-assessment reports that will be submitted and reviewed on a periodic basis.

HSD/MAD agrees that cost information is critical to evaluate the appropriateness of the rates set with each of the MCOs. Under Omnicaid, MCOs are required to submit payment information as part of their Encounter Date Report. This process will be initiated with the next quarterly submission. HSD/MAD will continue to work with the MCOs to refine cost data, as necessary, until it meets our requirements. It is important to note that this information, like specific rates by cohort, is proprietary and must be kept confidential.

E. Use of Sanctions. As of June 30, 2001, the department did not have a detailed sanction plan or guidelines specific to encounter data monitoring. The nonexistence of such a plan can result in irregular, inconsistent and unfair application of sanctions.

The establishment of a sanction plan and/or guidelines would help to ensure fair and consistent execution of encounter data related sanctions by clearly matching degrees of infractions to degrees of remedies. This would be particularly useful to an incoming manager who would be involved in making sanction related decisions.

Sanctions for continuous noncompliance with HSD encounter data requirements have been used minimally since the inception of Salud!. Use of encounter data related sanctions has been limited to failure of the MCO to meet the 95 percent accuracy threshold based on data input system edits. Sanctions have not been used against MCOs for other reasons, even though the department has been aware of major omissions of encounter data.

- There has been only one monetary sanction levied to an MCO and one sanction threatened to each of the other two MCOs, but not levied. The reason for the levy was because the MCO did not provide complete and accurate behavioral health encounter data from 1997, 1998 and 1999 and did not meet the maximum 5 percent error threshold requirements. This sanction was allowed to languish among a series of appeals by the MCO. The original amount was for $144,215. The department and the MCO agreed to a corrective action plan. The MCO, however, did not meet the minimum requirements of the plan. The MCO submitted files to try to rectify the situation, but four of nine re-submitted files failed to meet minimum requirements within specified time frames. Nonetheless, the sanction was lowered to $72,107.

- A monetary sanction was threatened to the other two MCOs on July 15, 1999 for failure to provide timely, accurate and comprehensive encounter data from 1997 to1998. The encounter data submitted was incomplete and showed rejection rates as high as 99.23 percent and 83.84 percent for one MCO and 51.8 percent and 54.33 percent for the other. Corrective action plans were executed and the matters were resolved to the department's satisfaction.

Sanctions can be an effective tool for the enforcement of contract requirements and ensuring the collection of complete, accurate and timely encounter data. The reduction in sanction amounts can send a conflicting message to the MCOs, particularly in situations where the MCO clearly did not adhere to the corrective action plan, as was evident in one case described above. Accordingly, MCOs can continue to provide inaccurate, incomplete or untimely data with little or no consequences.

The department clearly has authority to impose sanctions against the MCOs for encounter data noncompliance. The Health Care Finance Administration (HCFA) also recommends the use of sanctions. Refer to the following:

- The Medicaid managed care services agreement (contract) states that submission of late, inaccurate or otherwise incomplete reports constitutes a failure to report. The contract also

outlines the time frame for an MCO to submit encounters to HSD. A monetary or non-monetary penalty may be assessed for noncompliance. The medical assistance policy manual also states that HSD is required to impose sanctions against providers for violation of the provisions outlined in the manual.

- The Health Care Finance Administration (HCFA) recommends in their *Guide for States to Assist in the Collection and Analysis of Medicaid Managed Care Data*, that if states choose to include positive and/or negative incentives in the contracts, they should be realistic, incremental and measurable. This approach allows the MCOs the opportunity to fairly comply and facilitates the state's ability to identify the problem and apply a set of progressively more rigorous sanctions.

A "Status of Encounter Data" report produced by the department has identified various weaknesses relating to accuracy and completeness of encounter data. The department has stated that such weaknesses have been acknowledged by the MCOs. As stated in the findings of this report, the department continues to have difficulty obtaining accurate encounter data. The process of developing an adequate encounter data program may have been further advanced, had the department exercised its power to impose sanctions more frequently.

Recommendations

We recommend the following:

- The department should develop a detailed sanction plan or guidelines specific to monitoring of encounter data. Such a plan would help to insure fair and consistent execution of encounter data related sanctions by clearly matching degrees of infractions to degrees of remedies; and

- HSD should impose sanctions for all significant infractions, not just for data that may not meet the 95 percent accuracy threshold that is based on the established computer data input edits. Sanctions can be imposed for failure of MCO sub-providers to submit complete and accurate encounter data.

Department Responses

While HSD/MAD agrees that sanctions are important and must be used fairly and consistently, we feel that the development of a detailed sanction plan in addition to the three pages of sanction steps in the current MCO contracts would create an administrative and management burden that would lessen departmental flexibility when looking at the submission of encounter data on a case-by-case basis. HSD/MAD will look at developing and publishing additional guidelines that more clearly spell out MCO requirements while allowing us to use sanctions consistently for all significant infractions as well as on-going uncorrected less significant issues.

F. Provider Education Plans Not Reviewed, Approved or Monitored. As of June 30, 2001, the department had not reviewed, approved or adequately monitored MCO provider education plans as required by the contracts. It had not communicated clearly to the MCOs the guidelines or criteria for identifying what should be included in provider training plans. Such a checklist of criteria would help to ensure completeness, consistency and comprehensiveness of the plans. In a memorandum dated November 30, 2001 to the audit staff, the department states that it was never intended that HSD would review and approve lesson plans. The Department did not realize that the provision for review and approval was incorporated into the prior contracts, via a July 1999 amendment.

Auditors were provided no information about past review and approval of provider education plans. The materials that were provided consisted of information that was recently requested from the MCOs by the department following the audit staff's request for past MCO provider education plans.

The department has not provided the MCOs with criteria relating to MCO education plan content. Such criteria would ensure the inclusion and consistency between MCOs of vital processes and procedures, including encounter data related issues. It would also provide a basis by which the department can approve and monitor the MCO provider education plans and related materials.

Although the department has mentioned its recognition of the need to enhance its monitoring of MCO provider education, it has not shown how it intends to do so. Such issues were, however, discussed during the department's policy review in the spring and summer of 2000. Those discussions were focused on the necessity for additional oversight in the current contract period due to the challenges that the MCOs face in disseminating information and achieving compliance from their providers.

The MCO contracts and Medical Assistance Division (MAD) policy both address the provider training and education issues:

- A July 1, 1999 amendment to the MCO contracts states that the contractor shall develop and implement annually a training plan to educate providers and their staff on selected managed care or contractor processes and procedures. The plan shall be submitted to HSD for review and approval on or before July of each year. That same language was carried forward to the MCO contracts dated July 1, 2001 through June 30, 2003.

- The MAD policy manual dated July 1, 2001 states that the MCOs need to provide an annual provider educational training schedule to HSD. Further, the manual states that the MCO must provide evidence to HSD of ongoing statewide provider educational activities.

Recommendations

We recommend that the department:

- Establish criteria with regard to MCO education plan content to ensure the inclusion and consistency between MCOs of vital processes and procedures, including encounter data related issues;

- Establish an education plan review, approval and monitoring program to ensure adequacy and consistency of the execution of the plans by the MCOs; and

- Establish and maintain a complete file of each MCO provider education plan and all related documentation and correspondence.

Department Responses

In anticipation of the new contract period, which began July 1, 2001, HSD undertook a readiness review in the spring and summer of 2001 of the MCOs to establish their readiness for implementing provisions of the new contract. Part of the review included an assessment of the MCOs' provider manuals and training schedule. Per the LFC's recommendations, HSD will incorporate its review criteria into a more formalized review process of provider education. HSD agrees that such standardization will ensure consistency among the MCOs of vital processes and procedures, including encounter data-related issues.

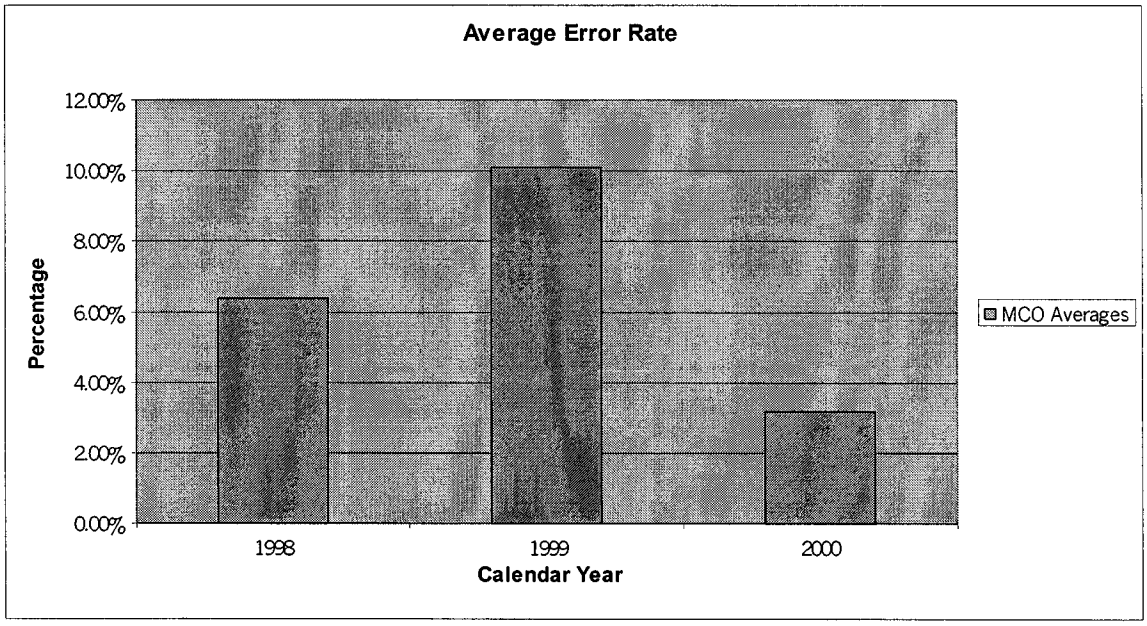
G. System Edits. The department did not maintain an adequate accounting of resubmitted systems edit rejects of encounter data. The current Medicaid management information system (MMIS) performs the edit function and sends rejected data back to the MCOs for correction and resubmission. However, it does not generate cumulative encounter edit rejection and resubmission reports.

The systems edit process identifies critical and noncritical errors. Critical errors are rejected while noncritical errors are not. The MCO is required to correct and resubmit rejected errors only if the error rate for the batch exceeds 5 percent. The Salud! systems manual states that MCOs are not required to resubmit data if the accuracy falls within the error threshold of 5 percent. MCOs are merely encouraged to do so. Because there is no record of such rejected data that has or has not been resubmitted, the department cannot determine the absolute completeness of the data for each MCO. While one MCO may resubmit such data, another MCO may not. Incompleteness of data, even in small percentages, can have a significant impact on dollar amounts. This point was clearly made in a recent audit of the encounter data program of the state of Oregon. The department needs to consider this as it moves towards using encounter data for rate-setting and cost effectiveness calculations.

Rejected data that exceed 5 percent of the batch total must be corrected and resubmitted within 30 days of the rejected data report date. The department, however, does not monitor compliance with the 30-day requirement. Data is rejected for a variety of reasons. A recent exception report of one MCO identifies the following types of edit exceptions:

Edit Exceptions	Number	Percent
Place of Service Not Found (Non Critical Error)	10,048	63%
Duplicate Encounter Found (Critical Error)	3,765	24%
Other Diagnosis not Found on Diagnosis File (Non Critical Error)	932	6%
Various O7ther Reasons (Critical and Non Critical)	1,177	7%
Total	**15,922**	**100%**

The department states that it has made significant progress with regard to the computer edits of data entry errors and omissions because increasingly fewer exceptions are being identified. An analysis was performed of the estimated encounter data submission error rates for the three MCOs for calendar years 1998, 1999, and 2000 which shows that the average error rate has improved. This point is illustrated in the following graph:



Recommendations

We recommend that the department:

- Implement an effective system to account and report all aspects of encounter data submissions, rejects and resubmissions;
- Require MCOs to submit and resubmit 100 percent of all encounter data;
- Monitor the resubmission of rejected data for compliance with the 30-day requirement; and
- Use sanctions, as necessary, to ensure compliance with all aspects of encounter data submission and resubmission requirements.

Department Responses

HSD/MAD agrees with the findings and the recommendations with the exception of the re-submission of 100 of rejected encounters. We feel that all rejected encounters need to be reported to an reviewed by the department, but those that are valid rejections, such as duplicate claims, should not be resubmitted. That would create an unnecessary administrative burden for both the MCOs and the department. HSD/MAD will work with the MCOs to outline which rejected encounters should be re-submitted.

H. MCO Comparison Reports (General). The MCO comparison report, which shows aggregate recipient and encounter data for 116 services (Exhibit A) has not been used sufficiently or effectively by the department for health services utilization management. Although the report can be an excellent tool for analysis and monitoring of aggregate encounter data by services and populations, the department has not used it for this purpose. The report (Exhibit A) displays basic aggregate encounter data information such as number of eligible recipients, number of eligible recipients receiving services and frequency of services. The information is reported cumulatively by year and by the current quarter. There are 116 services that are grouped into five categories. Refer to the schedule below:

Service Category	Number Services
Behavioral health services	25
Acute and chronic conditions	37
Primary and specialist care	9
Children's health services	27
Women's health services	18
Total	**116**

Although the report, in its present form, is good for broad general trend utilization, it has some significant limitations:

- The 116 services shown on the report may not be sufficiently comprehensive to adequately monitor the entire spectrum of health services;
- The report lacks sufficient detail such as reasons for hospital admittance and by types of therapy (family, individual, group, etc.);
- There are some services such as professional consultation (medical professionals consulting with one another) that are of minimal reportable value;
- Some services, such as organ transplants, could be grouped in to one (major organ transplants) category;
- The report in its present form is not reader friendly and very difficult to analyze. Refer to Exhibit A;
- There are separate reports for each year; however, comparison of information from one year to the next is extremely difficult;
- Because cost information is not included, it cannot be used for any sort of financial analysis; and
- The report does not show statistics geographically and by provider accessibility.

Recommendations

The department should enhance the report by:

- Considering the increase of number of services to ensure that all vital health concerns are being monitored;
- Providing more detail as necessary for each service to ensure adequate detailed analysis;
- Eliminating services that have minimal reporting value;
- Grouping closely related services;
- Including graphs and charts that will make the report more user friendly;

- Including cost related data; and

- Including geographic and provider accessibility data.

Department Response

No response provided by the department for this finding.

II. Analysis For Timeliness, Accuracy and Completeness

A. Analysis of MCO Comparison Reports. The department did not know the reasons for many of the inconsistencies and/or inaccuracies of utilization data contained in the MCO comparison reports. Auditors reviewed 96 of the 116 services for inconsistencies and/or inaccuracies between MCOs and between periods. Twenty services with minimal (100 or less) encounters and/or recipients serviced were not reviewed.

Of the 96 services that were reviewed, auditors identified 52 negative test failures (54 percent) in FY00. A negative test failure occurs when one or more MCO has serviced less recipients and/or provided significantly less encounters (50 percent for behavioral health services and 33 percent for all other services) when compared to the other MCO(s) and/or its proportionate share of Medicaid recipients. Auditors also identified 27 instances (28 percent) in which the MCOs failed the test positively. A positive failure is a situation in which the MCO shows that it has serviced more than its proportionate share of recipients. See Exhibit B and the following schedule:

	Number	Percent
MCOs did not fail test	17	18%
Negative test failures	52	54%
Positive test failures	27	28%
Total tested	**96**	**100%**

The department and the MCOs were asked to provide explanations for the 52 negative test failures. The following schedule represents an aggregate analysis of these responses:

Response Description	Number	Percent
No Response	18	19%
Incomplete or Unclear Explanation	24	25%
Coding Related Problems	32	33%
Other Data Related Problems	13	14%
MCO Disagrees with Data	9	9%
Total Responses	**96***	**100%**

*Test failure for many of the services applied to more than one MCO. In addition, responses applicable to some services in which there was a test failure contained more than one reason. Hence, the number of responses (96) is greater than the total number of services (52) where there was a test failure.

Examples of test failures and MCO responses:

1. Service: Medication Management (Category: Behavioral Health). Presbyterian had 51 percent of the recipients eligible for this service but reported no encounters in FY00. Lovelace had 24 percent recipients eligible and only 11 percent of the encounters. Cimarron, however, had 25 percent eligible recipients and 89 percent of the total encounters. In addition, Lovelace reported an 84 percent decrease in encounters provided from FY99 to FY00 (1,499 to 234). See Exhibits A1.2, B1.1 and C1.1.

Presbyterian Response:
Presbyterian's response stated that the codes used by Salud! are "home grown" and inconsistent with national standards.

Lovelace Response:
Lovelace states that the proper codes are not captured by Salud! encounter data for this service and, therefore, are not representative of all actual encounters.

2. Service: Urinary Incontinence Supply (Category: Acute and Chronic Conditions). In FY00, Cimarron showed a 91 percent decrease in recipients serviced from FY99 to FY00 (263 to 23). Presbyterian provided no services in FY00. See Exhibits A.1.6, B.1.5 and C.1.2.

Cimarron Response:
Cimarron questioned the accuracy of the Salud! encounter data. Aside from the eligibility numbers, these service codes reflect various diaper quantities per case. Cimarron believes that the decrease can be attributed to the use of other codes being used to reflect the quantities.

Presbyterian Response:
Presbyterian responded that the Salud encounter data includes "home grown" codes, which are not recognized nationally by the health care industry.

3. Service: Clients receiving care from Federally Qualified Health Centers (FQHC) (Category: Primary and Specialist Care). In FY00, Lovelace had a proportionate recipient share of 24 percent for this service but reported servicing only 6 percent of total recipients. Cimarron reported a recipient share of 25 percent and 94 percent of recipients served. Presbyterian reported no services in FY00. There were significant decreases in the frequency of services (encounters) by Lovelace and Cimarron from FY99 to FY00. See Exhibits A.1.9, B.1.6 and C.1.3.

Lovelace Response:
Lovelace believes that the difference is a function of the different manners in which the MCOs classify providers. Lovelace did not address why there was a significant decrease in the frequency of services provided from FY99 to FY00.

Presbyterian Response:
Presbyterian did not explain why it did not report any services in FY00.

Cimarron Response:
Cimarron did not explain why it did not report any services in FY00.

4. Service: Diphtheria, Tetanus, Pertussis (DTP) Vaccine, ages 0-5 (Category: Children's Health Services). In FY00, Presbyterian reported 50 percent of the enrollees eligible for this service but served only 42 percent. Cimarron reported 26 percent of the eligible enrollees and served only 17 percent. Lovelace reported 24 percent of the eligible enrollees and served 41 percent. This is a 24 percent difference between Lovelace and Cimarron, who each had a similar share of the recipients. There were also significant decreases in recipients serviced by Presbyterian and Cimarron from FY99 to FY00. See Exhibits A.1.10, B.1.7 and C.1.4.

Cimarron Response:
Cimarron states that the recommended current procedural terminology (CPT) code for the vaccine was not used. It did not explain the reasons for the significant decreases.

Presbyterian Response:
Presbyterian was not certain about the reason for the differences but suggested several possibilities, including coding problems, movement by recipients between health plans, and vaccinations may be provided at other sites such as clinics or schools. Presbyterian did not explain the reasons for the significant decreases.

5. Service: Pap test, ages 41 and over (Category: Women's Health Services). All MCOs showed a significant decrease in recipients serviced for the FY00. The decrease for the MCOs from FY99 to FY00 was as follows: Presbyterian, 81 percent (626 to 119), Lovelace, 64 percent (371 to 133) and Cimarron 76 percent (306 to 73). Refer to exhibits A.1.13, B.1.10 and C.1.5.

Presbyterian Response:
Presbyterian stated that the Salud! data does not include several applicable procedure and revenue codes. Its own analysis showed increases in cervical cancer screening from FY99 to FY00.

Cimarron Response:
Cimarron stated that the Salud! codes used to identify pap utilization were incomplete. Cimarron's data is not definitive for this service and performing further review.

Lovelace Response:
Lovelace believes the decrease in recipients serviced for FY00 are attributable to its increased use of codes for pap tests that are becoming more common in health care. Such codes are not used by Salud!'s encounter data in this analysis.

Recommendations

We recommend that the department continue to work with the MCOs to :

- Identify the reasons for the inaccuracies, incompleteness and inconsistencies reflected in the MCO comparison report; and

- Provide the necessary training and guidance to the MCOs to ensure accuracy, completeness and consistency of reporting in the future.

Department Responses

In anticipation of the new contract period, which began July 1, 2001, HSD undertook a readiness review in the spring and summer of 2001 of the MCOs to establish their readiness for implementing provisions of the new contract. Part of the review included an assessment of the MCOs' provider manuals and training schedule. Per the LFC's recommendations, HSD will incorporate its review criteria into a more formalized review process of provider education. HSD agrees that such standardization will ensure consistency among the MCOs of vital processes and procedures, including encounter data-related issues.

B. Transportation Encounters. A review of transportation encounters for the fiscal year ending June 30, 2000 revealed that of a total 110,236 encounters there were 17,763 (16 percent) for which there was no other accompanying medical service reported within 24 hours before or after the reported encounter. Because it is reasonable to assume that every trip for a medical service should result in a medical encounter of one kind or another, this percentage of apparent encounter

data omission is extremely high. Although it is not reasonable to extrapolate this percentage (16 percent) to the entire population of encounter data submissions, it is certainly a strong indicator of problems relating to completeness of data.

Auditors were not provided sufficient definitive or conclusive explanations for this high rate of apparent data omissions. Department management and the MCOs agree that this situation is serious and warrants further inquiry. The recently formed encounter data workgroup specifically addressed the matter in one of its meetings.

Further analysis of these 17,763 transportation encounters by MCO and procedure types reveals reporting inconsistencies by the MCOs for specific services. For example, Presbyterian reports 96 percent of its total encounters as procedures 1 through 4. Cimarron and Lovelace report no encounters for these procedures. Cimarron and Lovelace report 98 percent of their total encounters as procedures 5, 6 and 7. Presbyterian reports no encounters for these procedures. Refer to the following schedule:

	Procedure Description	Cimarron	Lovelace	Presbyterian	Total
1	Non Emergency - Over 100 Miles			2,610	2,610
2	Medicare Non Emergency - Intra-City Taxi			2,361	2,361
3	Medicare Only Non Emergency - Other			250	250
4	Ambulance Emergency - Special Services			60	60
5	Non Emergency to Provider	3,199	2,340		5,539
6	Non Emergency to Home	3,086	2,223		5,309
7	Non Emergency Transportation for Medical Attendant	738	518		1,256
8	24 Other Transportation Services	101	69	208	378
	TOTAL	**7,124**	**5,150**	**5,489**	**17,763**

Recommendations

We recommend that the department:

- Thoroughly investigate the reason(s) why so many medical encounters associated with transportation encounters are not being reported; and

- Provide the necessary guidance to the MCOs to ensure uniform and consistent coding of encounters.

Department Responses

HSD investigated this matter and learned that data was being lost, especially transportation to behavioral health services, with the multiple administrative layers between the provider of services and the MCO. These administrative layers in the behavioral health program have been eliminated in the new contract period, effective July 1, 2001. HSD and the MCOs believe this will improve the reporting of encounter data, such as transportation data.

C. Lab and X-Ray Encounters. A review of lab and radiology encounters for the fiscal year ending June 30, 2000 revealed a disproportionate distribution of lab and radiology encounters among MCOs when compared to the distribution of eligibles assigned to the MCOs. For example, although Cimarron had 24 percent of total eligibles, it provided only 6 percent of all lab and radiology encounters. Lovelace, however, had 23 percent of eligibles, yet provided 58 percent of all lab and radiology encounters.

MCO	Total Lab and Radiology	Percent	Average Member Months	% Salud Clients
Lovelace	5,820	57.63%	46,486	22.51%
Cimarron	619	6.13%	109,912	24.25%
Presbyterian	3,660	36.24%	50,075	53.23%
Total	**10,099**	**100.00%**	**206,473**	**100.00%**

Additional analysis of lab and radiology encounters showed that there were only 49 of 10,099 (one half percent) such encounters for which there was no other accompanying medical service reported within 60 days before or after the reported encounter. The MCOs provided reasonable explanations for most of the apparently missing corresponding encounters.

MCO	Total Lab and Radiology Encounters	Lab & Radiology Encounters With No Other Service	Percent
Lovelace	5,820	33	0.57%
Cimarron	619	0	0.00%
Presbyterian	3,660	16	0.44%
Total	**10,099**	**49**	**0.49%**

Recommendations

We recommend that the department:

- Provide guidance about proper and consistent coding of lab and radiology claims to the MCOs; and

- Monitor data submissions regularly to ensure correct and consistent encounter data, including lab and radiology related data.

Department Response

HSD agrees with the findings and recommendations.

D. Denied Claims Not Required. The department does not require MCOs to submit denied claims as part of the encounter data elements. The Salud! systems manual specifically states that encounters do not include denied claims for services rendered. The exclusion of denied claims can significantly affect the overall completeness of the encounter data. The department would be better able to monitor the health care of a Medicaid recipient if his or her complete encounter history, including claims that were denied by the MCO, were known. The department would also be better able to monitor claim denial activity of the MCOs in aggregate as well as by specific service or service category. Detailed comparative denial activity analysis by MCO, geographic area, provider and recipient age and sex could also be performed.

Recommendations

We recommend that the department:

- Require adequately coded claim denials as part of regular MCO encounter data submissions; and

- Monitor MCO claim denial activity by specific service or service category, geographic area, provider, and recipient age and sex.

Department Responses

HSD/MAD agrees that denied claims need to be part of the encounter data reported to for departmental review. Denied encounters, for services not covered by Medicaid, are still services received by Medicaid Beneficiaries and have a potential impact on the overall health of those individuals. Additionally, there is a potential impact on HSD/MAD decision making concerning future covered services.

HSD/MAD will require MCOs to submit information on all denied claims by:

Reason for Denial;
Service Category requested;
Geographic Area;
Provider;
Age; and
Sex

E. Timeliness of MCO Encounter Data Submissions. The combined average submission times for all services by the three MCOs for the fiscal years ending June 30, 2000 and June 30, 2001 were 124 and 134 days, respectively. The former contracts (prior to July 1, 2001) did not require the MCOs to submit data within a certain time-frame from date of service. However, the current contracts (effective July 1, 2001) specifically stipulate that encounter data be submitted to HSD within 90 days of the date of service or discharge. Hence, although there are no technical violations of contract terms, the average submission days for FY00 and FY01 appear rather high when compared to the current contract requirements. Of additional significance is the fact that only one MCO showed slight overall improvement (112 average days to 108 average days) from FY00 to FY01.

In addition, submission times by category of service are much greater for some services. For example, in FY01 the average combined MCO days of data submission for behavioral health services is 179. The three MCOs combined show an increase in average days (124 to134). The following schedules show the average submission days of the three MCOs for five categories of service individually and combined for FY01 and FY00:

Average Days for FY01				
Service Category	**Lovelace**	**Cimarron**	**Presbyterian**	**All MCOs**
In-patient hospital	211	146	141	**161**
Professional services	172	119	119	**130**
Drug services	91	87	177	**141**
Dental services	142	96	112	**115**
Behavior health	184	183	173	**179**
All services	**142**	**108**	**144**	**134**

Audit of Medicaid Managed Care Program (SALUD!)
Managed Care Encounter Data
March 18, 2002

	Average Days for FY00			
Service Category	**Lovelace**	**Cimarron**	**Presbyterian**	**All MCOs**
In-patient hospital	134	144	120	**129**
Professional services	117	128	117	**120**
Drug services	126	90	103	**105**
Dental services	129	100	281	**207**
Behavior health	208	171	157	**193**
All services	**124**	**112**	**131**	**124**

Of further significance is the fact that in FY01 64 percent of all data submissions exceeded 90 days and 15 percent exceeded 180 days. The following schedule shows the MCO percentages of total encounter data submissions that exceed 90 days and 180 days.

	FY00		FY01	
MCO	**Percent Over 90 Days**	**Percent Over 180 Days**	**Percent Over 90 Days**	**Percent Over 180 Days**
Lovelace	71%	12%	74%	23%
Cimarron	62%	8%	59%	5%
Presbyterian	67%	18%	63%	16%
All MCOs	**67%**	**14%**	**64%**	**15%**

A comparison with other states participating in this project shows that New Mexico timeliness of data submission is substantially inferior with regard to percent over 90 days. With regard to submissions over 180 days, New Mexico appears to be in line with the other states.

State	**Percent Over 90 Days**	**Percent Over 180 Days**
Iowa	16.5%	8.0%
New Mexico	64.0%	15.0%
New York	42.0%	20.0%
Pennsylvania	27.6%	12.9%
Tennessee	Very Few	Very Few

Timeliness of encounter data submission is very important to analyze medical activity. Without current encounter data, the department must rely primarily on older data for purposes of MCO monitoring and quality of care analysis.

Recommendation

Require MCOs to comply with the requirements of the MCO contracts that relate to timeliness of submissions. If deemed necessary, apply sanctions as prescribed in the MCO contracts.

Department Responses

HSD agrees that timeliness of encounter data submission is important. That is why the department established encounter data reporting timeframes in the current contract period, effective July 1, 2001. HSD agrees with the recommendations.

F. Managed Care Clients with no Reported Encounters. A review of Salud! clients in FY00 revealed that of an estimated 206,473 recipients only 7,669 (3.7 percent) had no reported encounters. Although this is not an indicator that the MCOs are submitting complete and accurate encounter data, it appears to reflect positively on general access to care. It is important to note that the 3.7 percent represents an aggregate of all MCOs and all counties in the state. Further analysis shows percentages in excess of 14 percent in some counties and 1 percent or less in others.

In addition, the estimated average cost of $225 for those recipients who have no reported encounters is higher than the estimated average overall cost of $205 for all Salud! clients. This suggests that, on average, those recipients who have had no reported encounters are in slightly higher risk groups and, therefore, could likely have greater medical needs than the average Salud! population. Refer to exhibits D and to the following schedules.

MCO	Average Monthly Membership	Salud Clients With No Encounters	Percent of Total Salud Clients
Lovelace	46,486	1,649	3.5%
Presbyterian	109,912	4,089	3.7%
Cimarron	50,075	1,931	3.9%
Total	**206,473**	**7,669**	**3.7%**

Salud! Clients With No Encounters				
Age Group	Female	Male	Total	Percent
1 to 5	395	413	808	11%
6 to 20	2,415	3,020	5,435	71%
21 to 44	314	432	746	9%
45 to 59	128	235	363	5%
60 to 75	118	149	267	3%
75+	23	27	50	1%
Total	**3,393**	**4,276**	**7,669**	**100%**

Recommendation

We recommend that the department work with the MCOs to determine the reasons for the variances among counties and for the reasons why recipients with no reported encounters appear to be in higher average risk cohorts.

Department Responses

HSD agrees with the recommendation that this matter should be further investigated. However, it is important to note that there is really no research that shows that seeing a practitioner once a year is worthwhile for asymptomatic individuals. In addition, the Salud! contract is risk-based and, in setting the capitation rates, the department assumed that some clients would not visit a practitioner. To assume otherwise will increase the costs of the program.

III. Other Observations

A. Quarterly Reports Review. Since the inception of Salud!, quarterly health care utilization reports submitted by the MCOs in accordance with contractual requirements have shown major inaccuracies. The data in the reports show significant variances in services from one quarter to the next. In some cases, information relating to particular services appears highly unrealistic.

HSD reviews and analyzes all quarterly reports submitted by the MCOs and compares them to previous quarters. When variances are identified or data is suspect, HSD obtains explanations from the MCOs and requests corrective action where appropriate. The department staff person responsible for reviewing these reports has indicated that because of these constant and continuous inaccuracies, the reports are unreliable for adequate monitoring of MCO quality and access of health care. They also cannot be used to compare health care activity between MCOs.

However, the reports have been useful in bringing data inconsistencies to the attention of the MCOs.

Documentation provided to the auditors included HSD requests for clarification, resubmission or explanation of data for quarters 2, 3 and 4 of calendar year 2000. There was no discrepancy-related MCO correspondence of quarterly exception report reviews provided, prior to the second quarter of 2000 or for calendar year 2001. Of additional significance is that MAD's filing system for maintaining and reviewing the quarterly health care utilization reports is very disorganized. Related MCO correspondence is not kept in a central location, but maintained by various HSD staff members. Hence, the tracking of correspondence and issue resolution is extremely difficult. Department staff was unable to provide an estimate of the times, information and/or explanations related to data inconsistencies that have been requested from the MCOs. Some examples of such discrepancies are as follows:

- One MCO showed a 163 percent increase (19 to 50) in pregnant females for the 12 to 16 year age group from the first to the second quarter in calendar year 2000.

- There was a very low incidence of complaints for one MCO. Average quarterly complaints in calendar year 2000 were 43 for this MCO compared to approximately 365 for the other two.

- One MCO submitted reports that included prescriptions for oral contraceptives that were submitted for males under 12 years of age.

- One MCO reported 2,941 claims for vision services in the second quarter and only 26 in the third quarter of calendar year 2000.

- One MCO reported a 94 percent increase in grievances and a 109 percent increase in provider complaints from one quarter to the next.

Audit staff reviewed various responses by the MCOs related to department requests for clarification, resubmission or explanation of data. Reasons given by the MCOs for data variances follow:

- MCO data entry and other clerical errors related to report preparation.

- MCO acknowledged having reported incorrect categorization of services for in-network and out-of-network hospitals.

- Authorization request amounts for vision services and for nonemergency transportation for an entire quarter were not initially reported.

- Complete data was stored on two computer drives; however, data was reported from only one computer drive.

- An MCO sub-provider summed data from several quarters when initially reporting.

- MCO acknowledged inconsistencies but could not explain the reasons for variances.

The MCO contracts define the reports as HSD managerial, financial, utilization and quality reports. They also state that submission of late, inaccurate or otherwise incomplete reports constitute a failure to report. The contracts further state that HSD retains the right to apply progressively strict sanctions against the MCO, including an assessment of a monetary penalty against the MCO, for failure to perform in any contract areas.

The department is required to monitor the effectiveness of the MCOs quality assurance program. In order to effectively monitor utilization reports, it must monitor all relevant information and reports to identify trends in quality of care, access to care and service delivery. MAD policy 8.305.14.13 states that utilization and quality management reports demonstrate compliance with HSD's service delivery and quality standards. Regular monitoring of these reports is crucial. Such reports include, but may not be limited to: a monthly report that describes critical incidents, regular reporting of encounter data, and regular reporting of utilization management activity. Critical incidents are those that contribute to a trend that impacts negatively on areas such as access to, and quality of care, or service delivery.

Recommendations

We recommend that the department:

- Establish a well-defined and documented quarterly health care utilization report review program that will ensure regular quality analysis;

- Implement and maintain a quarterly health care utilization report central filing system that will adequately track all review materials and related correspondence, including requests for clarification, resubmission or explanation of data;

- Consider the use of sanctions as a tool to ensure accurate and consistent reporting by the MCOs; and

- Consider the use of encounter data as a source to compare the quarterly utilization reports.

Department Responses

As the Department discussed with the LFC, the requirements for the MCO quarterly reports have changed numerous times over the last several years due to changing requirements from the federal government and changing state objectives, often beyond the control of the Department. Each change has required changes in report definitions and MCO systems and time for new data to

stabilize. This is not an excuse, merely reality, and regardless, the Department has always strived to assure that the MCOs report accurate data, as evidenced by the large number of clarifications and requests sent by the Department to the MCOs, and which the LFC reviewed.

The LFC has included comments and opinions from one of several staff members responsible for reviewing the quarterly reports which are not the view of the Department. The Department's filing system for quarterly reports was not disorganized, but resided with each individual reviewer to ensure the reviewer had easy access to the reports they actually dealt with. At the suggestion of the LFC, a central filing system has been created, in part to aid auditors. The Department follows up on all discrepancies identified in or between quarterly reports and will continue to utilize sanctions to assure accurate data reporting. As the LFC was told in detail, the Department has a wide variety of methods for monitoring the effectiveness of the MCOs quality assurance programs, of which the quarterly reports only one small part, and a part which the Department regularly monitors. Critical incidents are also monitored on a regular basis, both through the quarterly reports and through numerous other methods.

The Department has further defined our already existing MCO quarterly report review system. The system includes regular analysis of the quarterly MCO reports and prompt feedback, questions, and where appropriate, corrective action to the MCOs. Quarterly report review is divided among the Quality Assurance and Contract Administration Bureaus.

The Department has established a central file in the Quality Assurance and Contract Administration Bureaus for all materials related to quarterly reports handled by each Bureau.

The Department will continue to utilize sanctions, to ensure accurate and consistent reporting by the MCOs, as we have in the past.

MAD will continue and increase our use of encounter data as a source to compare trends in quarterly reports. As was explained to the LFC, the quarterly reports report prior approvals for services, not utilization of services and cannot be directly compared to encounter data, which shows actual utilization of services.

B. Analysis of Managed Care Clients with Fee-For-Service Claims. In fiscal year ending June 30, 2000 the department inappropriately paid $302,071 to fee-for-service (FFS) providers for medical services that were covered under managed care. Most claims were related to services provided to newborns that were born into managed care. The following schedule identifies the specific types of services, the number of claims and the amounts paid.

Claim Type	Claims	Amount Paid
Dental claim	1	48
Federal qualified health center	56	4,792
Home health	3	1,306
Inpatient hospital	60	138,018
Lab and X-Ray	1	8
Medical supply	6	2,178
Outpatient hospital	206	18,167
Pharmacy	768	8,284
Professional service	1,994	123,421
Rural health clinic	4	25
Transportation	69	5,824
Total	**3,168**	**302,071**

Although this analysis was performed only on claims for the fiscal year ending June 30, 2000, a similar analysis performed on each year since the inception of managed care would likely yield similar results. The aggregate number of claims and amounts could easily exceed 10,000 (3,168 times 3+ years) and $1,000,000 ($302,071 times 3+ years), respectively.

Recommendations

We recommend that the department:

- Identify all FFS claims paid since the inception of managed care by utilizing the same query that was used in this analysis for FY00;
- Request reimbursement from the providers;
- Implement regular and on-going edits similar to the ad-hoc query that was used to identify those claims described above so that future ineligible FFS claims can be detected and rejected prior to payment;
- Perform the necessary inquiries of MCOs and providers to determine the reasons for such ineligible claim submissions; and
- Educate and train those providers that submit ineligible FFS claims.

Department Responses

HSD agrees with the LFC's findings and recommendations. In fact, with Medicaid's new information system, which will make it easier to monitor the FFS program for payment of claims for Salud! clients, HSD has implemented a process to track payment of claims in FFS for Salud! clients and recoup such payments.

C. Update of Medicare/Medicaid Dual Eligibles. From the inception of Salud! to June 30, 2001, the department has overpaid the MCOs an estimated $5.8 million because dual Medicaid/Medicare eligibles have not been timely identified and removed from the Salud! roster. Approximately $5 million has been forfeited by the department because it did not attempt to collect within 12 months as required in the MCO contracts. Overall collections from the MCOs for dual eligible capitation payments have been minimal. Exact amounts are undeterminable due to inadequacies of the department's system of accounting for dual eligibles and other collections.

Recipients of both Medicare and Medicaid (dual eligibles) are exempt from participation in Salud! In accordance with the terms of the managed care contracts, the MCOs are required to reimburse the department for all dual eligible related capitation payments. The previous contracts, which were effective from the inception of Salud! until June 30, 2001, required the department to request reimbursement within 12 months of the related capitation payment. The current contracts (effective July 1, 2001) allow the department 24 months to request reimbursement. The MCOs are not liable for reimbursement requests made subsequent to the applicable 12 month or 24 month limits.

A departmental process that matches all Salud! enrollees to a Medicare eligible electronic listing will eliminate dual eligibles from the Salud! roster as of the match date. It will not, however, research and identify the number of months prior to the match date that those recipients were included in the Salud! roster.

The Medicare eligibility listing is often received several months subsequent to the date the recipients became eligible for Medicare. Because of this untimely recognition of Medicare eligibility, a significant number of enrollees continue to be included on both the Salud! roster and the Medicare tape for several months before being detected.

On May 25, 2000, the audit unit reported to the Legislative Finance Committee that the department had not timely identified and removed all dual eligibles from the Salud! roster. Because of such untimely action it had forfeited its contractual right to collect reimbursement for significant amounts of capitation payments made to the MCOs.

According to the May 25, 2000 report, auditors had identified 7,818 enrollee member months of dual eligibles for which the MCOs had erroneously received capitation payments. The estimated dollar amount was $3.6 million. The report also stated that, because the department failed to request reimbursement from the MCOs within 12 months of the capitation payments as required

in the MCO contracts, it had forfeited its right to collect for approximately 5,716 member months for an estimated dollar amount of $2.6 million.

As of June 30, 2001, the number of member months of dual eligibles for which the MCOs had erroneously received capitation payments had grown to 13,098 and an estimated dollar amount of $5,815,672. The estimated collectible for all dual eligibles from inception to June 30 was 1,291 member months and $573,438. The estimated uncollectible was 11,807 member months and $5,242,234. An estimated additional 6,091 (11,807 current forfeits minus 5,716 previous forfeits) member months for a total of $2,615,147 ($5,242,234 -$2,627,087) has been forfeited from April 2000 to June 2001:

Identified Dual Eligibles From Inception to April 30, 2000			
	Total	More than 12 Months	Less than 12 Months
Months	7,818	5,716	2,102
Amount	$3,625,810	$2,627,087	$998,723

Identified Dual Eligibles From Inception to June 30, 2001			
	Total	More than 12 Months	Less than 12 Months
Months	13,098	11,807	1,291
Amount	$5,815,672	$5,242,234	$573,438

Although the department does have a program for requesting reimbursement from the MCOs for various reasons, including dual eligibles, total collections have been minimal. Because of inadequacies of the department's system of accounting for collections, the collected amounts attributable to a particular reason cannot be easily determined.

The following schedule shows amounts collected from inception of Salud! through June 30, 2001:

Fiscal Year	*Amount Recouped
1998	$ 0
1999	$ 0
2000	$137,739
2001	$324,778
Total	$462,517

*These amounts include recoupments for various reasons, including dual eligibles. Due to inadequacies of the department's system of accounting for collections, the portion of the amounts recouped attributable to dual eligibles could not be easily determined.

In effect, our review of the department's procedures for identifying dual eligible related capitation payments and subsequent collection of same revealed a system that cannot timely and accurately account for related capitation payment identification and collection activity.

- The department was unable to reconcile the number and dollar amounts of dual eligible capitation payments to the reimbursement requests since the inception of Salud;
- The department was unable to reconcile the total reimbursement requests to the amounts actually collected;
- Information about collection activities that was provided to the auditors for review was not sufficiently complete for adequate analysis;
- Information about collection activities that was provided to the auditors for review contained significant volumes of data from other (nondual eligible related) types of collection activities; and
- Collection data report forms that were provided to the auditors for review were inconsistent from one collection period to another and from one MCO to another.

Recommendations

The department should develop and maintain a dual eligible detection, collection and accounting system that will, at a minimum, perform the following on a regular basis:

- Match the Medicare data tape received from the Social Security Administration to the Medicaid enrollment roster to identify persons that appear on both sets of data;
- Delete those persons that appear on both sets of data from the Medicaid enrollment roster;

- Run the query used to research and identify past dual eligibles member months;

- Compare those identified member months to the encounter data that has been submitted by the MCOs to determine if the MCO(s) have performed any medical services for these same persons during the member months in question;

- Immediately upon their identification, request reimbursement for those persons who have had no services performed (based on encounter data information) by the MCOs during the member month periods in question;

- Require the MCO to submit documented proof for those persons that did receive medical services even though such information was not found in the encounter data information;

- Request explanations about the encounter data inaccuracies from the MCOs in those cases where encounter data did not identify encounters, yet the MCO is able to demonstrate that services were actually provided; and

- Prepare dual eligible identification, collection and accounting reports that can be clearly and easily supported by subsidiary reports and detailed source data.

Department Responses

HSD agrees with the findings and recommendations and is using the recommendations to implement a process for managing dual eligibles and recouping payments.

EXHIBITS

EXHIBIT A

ENCOUNTER DATA MCO COMPARISON REPORTS

The MCO Comparison Reports in this exhibit are produced by the Medical Assistance Division (MAD) of the New Mexico Human Services Department (department). Auditors performed an analysis the MCO Comparison Report for fiscal years 1998, 1999 and 2000, and identified 52 of 116 total services in which the reported data appeared illogical when compared between MCOs and/or between fiscal years. MCOs and the department were asked to explain the reasons for such apparent variances. Five of these 52 services and the related MCO responses are specifically discussed in the report. This exhibit contains the Fiscal Year 2000 MCO Comparison Reports for the 52 services that appeared illogical. The five services discussed in the report are shaded for easy identification and cross reference.

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Behavioral Health Services								
1. Inpatient Adult Psych								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	101	301	15	60	18	62	134	423
% Eligibles Rcvg/Total Elig	0.48%	0.92%	0.15%	0.39%	0.17%	0.38%	0.33%	0.69
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.55%	1.52%	0.18%	0.73%	0.20%	0.66%	0.38%	1.13
# Inpatient Days (frequency)	716	2,498	112	444	271	783	1,099	3,725
Freq Per Elig Rcvg (ALOS)	7.08	8.29	7.46	7.4	15.05	12.62	8.2	8.8
# Elig Readmitted wi/14 Days	6	15	0	1	0	2	6	18
% Elig Readmit/Tot Elig Rcvg	0.05%	0.04%	0.00%	0.01%	0.00%	0.03%	0.04%	0.04
2. Adult Psychotherapy/Counsl								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	1,308	2,493	504	910	615	1,019	2,424	4,336
% Eligibles Rcvg/Total Elig	6.25%	7.63%	5.11%	5.96%	5.90%	6.29%	5.94%	7.07
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	7.24%	12.60%	6.16%	11.13%	6.86%	10.98%	6.88%	11.65
# of Sessions (frequency)	3,896	17,956	1,347	5,094	1,914	6,706	7,157	29,756
Frequency Per Eligible Rcvg	2.97	7.2	2.67	5.59	3.11	6.58	2.95	6.86
3. Psychosocial Rehab Service								
Crisis Intervention								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	0	0	0	0	0	0	0	0
% Eligibles Rcvg/Total Elig	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
# of Services (frequency)	0	0	0	0	0	0	0	0
Frequency Per Eligible Rcvg	0	0	0	0	0	0	0	0
Psychosocial Intervention								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	191	318	71	100	114	172	375	574
% Eligibles Rcvg/Total Elig	0.91%	0.97%	0.72%	0.66%	1.09%	1.06%	0.92%	0.94
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	1.05%	1.60%	0.86%	1.22%	1.27%	1.85%	1.06%	1.54
# of Sessions (frequency)	47,791	161,537	14,901	33,875	30,002	106,631	92,694	302,043
Frequency Per Eligible Rcvg	250.21	507.97	209.87	338.75	263.17	619.94	247.18	526.2
Therapeutic Intervention								

EXHIBIT A.1.1

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	0	0	0	0	0	0	0	0
% Eligibles Rcvg/Total Elig	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
# of Sessions (frequency)	0	0	0	0	0	0	0	0
Frequency Per Eligible Rcvg	0	0	0	0	0	0	0	0
Medication Management								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	0	0	39	60	124	203	163	263
% Eligibles Rcvg/Total Elig	0.00%	0.00%	0.40%	0.39%	1.19%	1.25%	0.40%	0.43
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.00%	0.00%	0.47%	0.73%	1.38%	2.18%	0.46%	0.7
# of Sessions (frequency)	0	0	107	234	441	1,879	548	2,113
Frequency Per Eligible Rcvg	0	0	2.74	3.9	3.55	9.25	3.36	8.03
5. Adult CM-Chronic Mental Ill								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	528	941	201	295	275	464	1,003	1,658
% Eligibles Rcvg/Total Elig	2.52%	2.88%	2.04%	1.93%	2.64%	2.86%	2.46%	2.7
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	2.92%	4.75%	2.45%	3.61%	3.06%	5.00%	2.85%	4.45
# of Services (frequency)	15,608	62,012	3,577	9,781	6,575	25,344	25,760	97,137
Frequency Per Eligible Rcvg	29.56	65.9	17.79	33.15	23.9	54.62	25.68	58.58
7. Inpt Servs for Adults w/SA								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	14	67	2	10	7	29	23	106
% Eligibles Rcvg/Total Elig	0.07%	0.21%	0.02%	0.07%	0.07%	0.18%	0.06%	0.17
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.07%	0.33%	0.02%	0.12%	0.07%	0.31%	0.06%	0.28
# of Days (frequency)	61	363	12	67	53	160	126	590
Freq Per Elig Rcvg (ALOS)	4.35	5.41	6	6.7	7.57	5.51	5.47	5.56
# Elig Readmitted wi/14 Days	1	1	0	0	0	0	1	1
% Elig Readmit/Tot Elig Rcvg	0.07%	0.01%	0.00%	0.00%	0.00%	0.00%	0.04%	0
9. Adult Enhanced Services								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	17	33	3	5	11	22	31	60
% Eligibles Rcvg/Total Elig	0.08%	0.10%	0.03%	0.03%	0.11%	0.14%	0.08%	0.1

EXHIBIT A.1.2

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elg Rcvg/Avg Elg Mons in Pd	0.09%	0.16%	0.03%	0.06%	0.12%	0.23%	0.08%	0.16
# of Services (frequency)	810	3,669	152	409	312	816	1,274	4,894
Frequency Per Eligible Rcvg	47.64	111.18	50.66	81.8	28.36	37.09	41.09	81.56
10. Inpatient Child Psych								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	92	317	18	79	29	116	139	508
% Eligibles Rcvg/Total Elig	0.10%	0.25%	0.04%	0.13%	0.06%	0.19%	0.08%	0.21
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.10%	0.34%	0.04%	0.20%	0.07%	0.28%	0.08%	0.29
# Inpatient Days (frequency)	1,223	4,222	194	842	523	2,820	1,940	7,884
Freq Per Elig Rcvg (ALOS)	13.29	13.31	10.77	10.65	18.03	24.31	13.95	15.51
# Elig Readmitted wi/14 Days	4	12	4	7	0	3	8	22
% Elig Readmit/Tot Elig Rcvg	0.04%	0.03%	0.22%	0.08%	0.00%	0.02%	0.05%	0.04
12. Part Hospitalization-Child								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	17	72	4	14	15	73	36	159
% Eligibles Rcvg/Total Elig	0.02%	0.06%	0.01%	0.02%	0.03%	0.12%	0.02%	0.07
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.01%	0.07%	0.01%	0.03%	0.03%	0.17%	0.02%	0.09
# of Services (frequency)	0	0	0	0	0	0	0	0
Frequency Per Eligible Rcvg	0	0	0	0	0	0	0	0
13. Day Treatment								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	84	222	52	118	21	54	157	394
% Eligibles Rcvg/Total Elig	0.09%	0.17%	0.12%	0.20%	0.05%	0.09%	0.09%	0.17
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.09%	0.24%	0.13%	0.30%	0.05%	0.13%	0.09%	0.23
# of Services (frequency)	11,120	39,531	1,445	4,804	3,005	9,966	15,570	54,301
Frequency Per Eligible Rcvg	132.38	178.06	27.78	40.71	143.09	184.55	99.17	137.81
14. Residential Treatment Center								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	234	637	61	188	77	198	370	995
% Eligibles Rcvg/Total Elig	0.24%	0.50%	0.14%	0.32%	0.17%	0.32%	0.20%	0.42
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.27%	0.69%	0.15%	0.48%	0.18%	0.48%	0.22%	0.58
# of Days (frequency) (LOS)	8,824	38,354	1,003	5,781	2,553	8,849	12,380	52,984

EXHIBIT A.1.3

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Freq Per Elig Rcvg (ALOS)	37.7	60.21	16.44	30.75	33.15	44.69	33.45	53.25
# Elig Readmitted wi/14 Days	70	246	15	79	11	29	95	350
% Elig Readmit/Tot Elig Rcvg	0.29%	0.38%	0.24%	0.42%	0.14%	0.14%	0.25%	0.35
15. Treatment Foster Care								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	225	479	91	159	70	140	385	776
% Eligibles Rcvg/Total Elig	0.24%	0.37%	0.20%	0.27%	0.16%	0.23%	0.21%	0.33
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.26%	0.52%	0.22%	0.40%	0.17%	0.33%	0.23%	0.45
# of Days (frequency) (LOS)	10,897	53,323	1,403	2,628	3,092	9,279	15,392	65,230
Freq Per Elig Rcvg (ALOS)	48.43	111.32	15.41	16.52	44.17	66.27	39.97	84.05
16. Child Behavior Management								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	29	149	19	61	41	83	88	288
% Eligibles Rcvg/Total Elig	0.03%	0.12%	0.04%	0.10%	0.09%	0.13%	0.05%	0.12
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.03%	0.16%	0.04%	0.15%	0.10%	0.20%	0.05%	0.16
# of Services (frequency)	6,067	27,596	473	2,256	2,803	10,665	9,343	40,517
Frequency Per Eligible Rcvg	209.2	185.2	24.89	36.98	68.36	128.49	106.17	140.68
19. Inpt Servs for Child w/SA								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	5	23	1	13	4	26	10	62
% Eligibles Rcvg/Total Elig	0.01%	0.02%	0.00%	0.02%	0.01%	0.04%	0.01%	0.03
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.00%	0.02%	0.00%	0.03%	0.00%	0.06%	0.00%	0.03
# of Days (frequency)	46	185	4	211	61	600	111	996
Freq Per Elig Rcvg (ALOS)	9.2	8.04	4	16.23	15.25	23.07	11.1	16.06
# Elig Readmitted wi/14 Days	0	0	0	0	0	0	0	0
% Elig Readmit/Tot Elig Rcvg	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
21. Child Enhanced Services								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	127	416	53	145	35	122	215	682
% Eligibles Rcvg/Total Elig	0.13%	0.32%	0.12%	0.24%	0.08%	0.20%	0.12%	0.29
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elg Rcvg/Avg Elg Mons in Pd	0.14%	0.45%	0.13%	0.37%	0.08%	0.29%	0.12%	0.39
# of Services (frequency)	3,351	16,639	1,344	6,083	515	3,509	5,210	26,231
Frequency Per Eligible Rcvg	26.38	39.99	25.35	41.95	14.71	28.76	24.23	38.46

EXHIBIT A.1.4

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Acute and Chronic Conditions								
3. AIDS Pat Rcvg Proteas Inhib								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	23	34	18	25	37	51	78	106
% Eligibles Rcvg/Total Elig	0.02%	0.02%	0.03%	0.03%	0.07%	0.07%	0.03%	0.04
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.02%	0.03%	0.04%	0.05%	0.07%	0.10%	0.04%	0.05
6. Dialysis Use								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	38	74	10	12	18	32	62	114
% Eligibles Rcvg/Total Elig	0.03%	0.05%	0.02%	0.02%	0.03%	0.04%	0.03%	0.04
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.04%	0.07%	0.02%	0.03%	0.04%	0.06%	0.03%	0.05
# Dialysis Treatments (freq)	137	584	23	57	62	230	222	871
Freq Per Elig Rcvg	3.6	7.89	2.3	4.75	3.44	7.18	3.58	7.64
19. Triage								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	33	109	1	1	38	127	72	237
% Eligibles Rcvg/Total Elig	0.03%	0.07%	0.00%	0.00%	0.07%	0.16%	0.03%	0.08
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.03%	0.10%	0.00%	0.00%	0.08%	0.25%	0.04%	0.11
# of Visits (freq)	33	110	1	1	41	137	75	248
Freq Per Elig Rcvg	1	1	1	1	1.07	1.07	1.04	1.04
# Visits Per 1000 Members	0.28	0.69	0.02	0.01	0.74	1.76	0.33	0.83
21. Observation Visits								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	724	2,950	138	559	351	1,532	1,212	5,017
% Eligibles Rcvg/Total Elig	0.62%	1.84%	0.25%	0.75%	0.63%	1.97%	0.54%	1.68
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.69%	2.66%	0.29%	1.19%	0.70%	3.03%	0.60%	2.41
# of Visits (freq)	938	4,178	162	639	414	2,004	1,514	6,821
Freq Per Elig Rcvg	1.29	1.41	1.17	1.14	1.17	1.3	1.24	1.35
# Visits Per 1000 Members	8.06	26.12	2.95	8.6	7.49	25.79	6.73	22.84
26. DME Purchase								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	290	516	51	103	84	196	425	808
% Eligibles Rcvg/Total Elig	0.25%	0.32%	0.09%	0.14%	0.15%	0.25%	0.19%	0.27

EXHIBIT A.1.5

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.28%	0.47%	0.11%	0.22%	0.17%	0.39%	0.21%	0.39
32. Home Health								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	333	1,027	51	215	130	533	512	1,759
% Eligibles Rcvg/Total Elig	0.29%	0.64%	0.09%	0.29%	0.24%	0.69%	0.23%	0.59
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.32%	0.93%	0.11%	0.46%	0.26%	1.06%	0.25%	0.84
# of Visits (freq)	1,190	5,072	63	308	247	3,332	1,500	8,712
Freq Per Elig Rcvg	3.57	4.93	1.23	1.43	1.9	6.25	2.92	4.95
33. Urinary Incontinence Supply								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	0	0	90	125	1	23	91	148
% Eligibles Rcvg/Total Elig	0.00%	0.00%	0.16%	0.17%	0.00%	0.03%	0.04%	0.05
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.00%	0.00%	0.19%	0.27%	0.00%	0.05%	0.05%	0.07
34. PT/OT/Speech								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	1,091	3,111	259	834	423	1,410	1,771	5,317
% Eligibles Rcvg/Total Elig	0.94%	1.95%	0.47%	1.12%	0.76%	1.81%	0.79%	1.78
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	1.05%	2.81%	0.54%	1.77%	0.85%	2.79%	0.88%	2.55
36. Inpatient Rehab								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	3	24	0	0	3	4	6	28
% Eligibles Rcvg/Total Elig	0.00%	0.02%	0.00%	0.00%	0.01%	0.01%	0.00%	0.01
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.00%	0.02%	0.00%	0.00%	0.01%	0.01%	0.00%	0.01
# of Days Stay (freq)	49	323	0	0	12	27	61	350
Freq Per Elig Rcvg (ALOS)	16.33	13.45	0	0	4	6.75	10.16	12.5
37. 30 Day Nursing Home Stays								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	22	37	0	1	16	48	38	86
% Eligibles Rcvg/Total Elig	0.02%	0.02%	0.00%	0.00%	0.03%	0.06%	0.02%	0.03
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elg Rcvg/Av Elg Mons in Pd	0.02%	0.03%	0.00%	0.00%	0.03%	0.10%	0.02%	0.04

EXHIBIT A.1.6

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Days Stay (freq)	117	318	0	14	413	1,457	530	1,789
Freq Per Elig Rcvg (ALOS)	5.31	8.59	0	14	25.81	30.35	13.94	20.8

EXHIBIT A.1.7

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Primary and Specialist Care								
1. CI Rcvg PC 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	36,391	89,396	7,449	21,367	18,364	36,044	62,105	143,907
% Eligibles Rcvg/Total Elig	38.05%	69.82%	16.50%	35.98%	40.86%	58.28%	33.68%	60.28
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elig Rcvg/Elig Mnths in Pd	42.23%	98.11%	18.63%	55.02%	44.96%	87.40%	37.19%	84.06
# of PCP Vists (frequency)	109,884	692,431	18,463	72,926	62,074	235,599	190,421	1,000,956
Freq Per Elig Rcvg (ALOS)	3.01	7.74	2.47	3.41	3.38	6.53	3.06	6.95
2. CI Rcvg PC 21+								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	10,148	22,660	2,541	5,808	5,257	9,591	17,893	37,042
% Eligibles Rcvg/Total Elig	48.51%	69.40%	25.75%	38.05%	50.48%	59.17%	43.82%	60.39
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elig Rcvg/Elig Mnths in Pd	56.22%	114.61%	31.06%	71.09%	58.68%	103.42%	50.85%	99.53
# of PCP Visits (frequency)	48,099	354,567	7,858	27,053	24,156	86,741	80,113	468,361
Frequency Per Eligible Rcvg	4.73	15.64	3.09	4.65	4.59	9.04	4.47	12.64
5. CI Rcvg Spcialist Care 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	9,741	17,593	3,136	6,318	5,617	15,988	18,467	39,689
% Eligibles Rcvg/Total Elig	10.18%	13.74%	6.95%	10.64%	12.50%	25.85%	10.02%	16.63
# of Eligible Mnths in Period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Elig Rcvg/Elig Mnths in Pd	11.30%	19.30%	7.84%	16.27%	13.75%	38.77%	11.05%	23.18
# of Visits (frequency)	28,564	59,131	6,686	13,741	13,675	54,186	48,925	127,058
Frequency Per Eligible Rcvg	2.93	3.36	2.13	2.17	2.43	3.38	2.64	3.2
6. CI Rcvg Spcialist Care 21+								
# of Eligibles	20,918	32,653	9,869	15,265	10,415	16,208	40,837	61,342
# of Eligibles Rcvg	5,097	7,780	1,751	3,148	3,088	6,909	9,915	17,643
% Eligibles Rcvg/Total Elig	24.37%	23.83%	17.74%	20.62%	29.65%	42.63%	24.28%	28.76
# of Eligible Mnths in Period	54,144	237,256	24,542	98,038	26,874	111,286	105,560	446,580
% Elig Rcvg/Elig Mnths in Pd	28.24%	39.34%	21.40%	38.53%	34.47%	74.49%	28.17%	47.4
# of Visits (frequency)	20,729	39,225	5,179	10,506	11,719	45,966	37,627	95,697
Frequency Per Eligible Rcvg	4.06	5.04	2.95	3.33	3.79	6.65	3.79	5.42
8. CI Rcvg Care from IHS								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	1,193	3,217	40	401	190	1,912	1,423	5,516
% Eligibles Rcvg/Total Elig	1.02%	2.01%	0.07%	0.54%	0.34%	2.46%	0.63%	1.85

EXHIBIT A.1.8

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elig Rcvg/Elig Mnths in Pd	1.14%	2.90%	0.08%	0.85%	0.38%	3.78%	0.70%	2.64
# of Visits (frequency)	4,329	13,041	56	656	413	5,192	4,798	18,889
Frequency Per Eligible Rcvg	3.62	4.05	1.4	1.63	2.17	2.71	3.37	3.42
9. CI Rcvg Care from FQHC								
# of Eligibles	116,441	159,948	54,959	74,307	55,300	77,706	224,990	298,613
# of Eligibles Rcvg	0	0	45	121	630	1,939	675	2,060
% Eligibles Rcvg/Total Elig	0.00%	0.00%	0.08%	0.16%	1.14%	2.50%	0.30%	0.69
# of Eligible Mnths in Period	312,630	1,330,587	144,450	563,990	149,401	606,121	606,481	2,500,698
% Elig Rcvg/Elig Mnths in Pd	0.00%	0.00%	0.09%	0.25%	1.26%	3.83%	0.33%	0.98
# of Visits (frequency)	0	0	155	525	1,246	3,458	1,401	3,983
Frequency Per Eligible Rcvg	0	0	3.44	4.33	1.97	1.78	2.07	1.93

EXHIBIT A.1.9

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Children's Health Services								
9. Non EPSDT PCP Visits, 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	26,682	70,393	4,050	14,035	14,360	28,235	45,042	110,818
% of Total Eligs Receiving	27.90%	54.98%	8.97%	23.64%	31.95%	45.65%	24.43%	46.42
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	30.97%	77.26%	10.13%	36.15%	35.16%	68.47%	26.98%	64.74
# visits (Frequency)	49,981	235,140	11,168	50,817	31,124	123,386	92,273	409,343
Frequency Per Elig Receiving	1.87	3.34	2.76	3.62	2.17	4.37	2.05	3.69
10. EPSDT Refs, Diag/Treat,0-2								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	3	1,164	18	264	112	1,265	133	2,690
% of Total Eligs Receiving	0.00%	0.91%	0.04%	0.44%	0.25%	2.05%	0.07%	1.13
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	0.00%	1.28%	0.05%	0.68%	0.27%	3.07%	0.08%	1.57
15. DTP Vaccine, Ages 0-5								
# of Eligibles	35,509	50,749	17,428	24,061	18,840	26,481	71,169	96,635
# of Eligibles Rcvg	304	1,817	432	1,754	146	712	882	4,279
% of Total Eligs Receiving	0.86%	3.58%	2.48%	7.29%	0.77%	2.69%	1.24%	4.43
# of Elig Months in period	94,252	400,747	45,376	176,926	50,337	196,604	189,965	774,277
% Eligs Receiv'g Annualized	0.97%	5.44%	2.86%	11.90%	0.87%	4.35%	1.39%	6.63
18. Tetanus Tox,Sgl Agt, 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	21	161	8	39	6	30	35	230
% of Total Eligs Receiving	0.02%	0.13%	0.02%	0.07%	0.01%	0.05%	0.02%	0.1
# of Elig Months in period od	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	0.02%	0.18%	0.02%	0.10%	0.01%	0.07%	0.02%	0.13
22. HIB Vac,Single Agnt, 6-20								
# of Eligibles	60,914	82,061	28,071	37,365	26,452	37,412	114,708	151,032
# of Eligibles Rcvg	29	128	11	44	8	29	48	200
% of Total Eligs Receiving	0.05%	0.16%	0.04%	0.12%	0.03%	0.08%	0.04%	0.13
# of Elig Months in period	164,234	692,584	74,532	289,026	72,190	298,231	310,956	1,279,841
% Eligs Receiv'g Annualized	0.05%	0.22%	0.04%	0.18%	0.03%	0.12%	0.05%	0.19
23. Hepatitus B vaccine 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	3,288	11,200	970	2,618	1,579	3,929	5,835	17,675

EXHIBIT A.1.10

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
% of Total Eligs Receiving	3.44%	8.75%	2.15%	4.41%	3.51%	6.35%	3.16%	7.4
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	3.82%	12.29%	2.43%	6.74%	3.87%	9.53%	3.49%	10.33
24. Tuberculin Skin Test, 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	171	905	60	304	125	449	356	1,658
% of Total Eligs Receiving	0.18%	0.71%	0.13%	0.51%	0.28%	0.73%	0.19%	0.69
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	0.20%	0.99%	0.15%	0.78%	0.31%	1.09%	0.21%	0.97
25. Lead Test (Blood), 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	19	55	117	649	125	556	261	1,260
% of Total Eligs Receiving	0.02%	0.04%	0.26%	1.09%	0.28%	0.90%	0.14%	0.53
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	0.02%	0.06%	0.29%	1.67%	0.31%	1.35%	0.16%	0.74
26. Sickle Cell Test, 0-20								
# of Eligibles	95,642	128,044	45,142	59,380	44,945	61,848	184,384	238,729
# of Eligibles Rcvg	0	1	2	13	3	16	5	30
% of Total Eligs Receiving	0.00%	0.00%	0.00%	0.02%	0.01%	0.03%	0.00%	0.01
# of Elig Months in period	258,486	1,093,331	119,908	465,952	122,527	494,835	500,921	2,054,118
% Eligs Receiv'g Annualized	0.00%	0.00%	0.01%	0.03%	0.01%	0.04%	0.00%	0.02

EXHIBIT A.1.11

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
Women's Health Services								
1. Delivery Ages 12-20								
# of Eligibles	15,825	22,491	7,424	10,398	6,929	10,265	29,965	41,503
# of Elig Receiving	268	1,307	206	679	65	263	539	2,249
% of Total Eligs Receiving	1.69%	5.81%	2.77%	6.53%	0.94%	2.56%	1.80%	5.42
# of Elig Months in Period	41,631	174,585	19,250	73,123	18,402	75,774	79,283	323,482
% Elig Receiv'g Annualized	1.93%	8.98%	3.21%	11.14%	1.05%	4.16%	2.03%	8.34
# of Inpat Days (frequency)	900	4,039	587	1,982	183	716	1,670	6,737
Freq per Elig Receiving(ALOS)	3.35	3.09	2.84	2.91	2.81	2.72	3.09	2.99
2. Delivery Ages 21 +								
# of Eligibles	15,464	24,737	7,344	11,597	7,757	12,372	30,268	46,409
# of Elig Receiving	537	2,291	369	1,257	128	482	1,034	4,029
% of Total Eligs Receiving	3.47%	9.26%	5.02%	10.84%	1.65%	3.90%	3.42%	8.68
# of Elig Months in Period	39,539	174,005	18,062	72,376	19,782	81,756	77,383	328,137
% Elig Receiv'g Annualized	4.07%	15.79%	6.12%	20.84%	1.94%	7.07%	4.00%	14.73
# of Inpat Days (frequency)	1,820	7,210	1,090	3,652	361	1,364	3,271	12,226
Freq per Elig Receiving(ALOS)	3.38	3.14	2.95	2.9	2.82	2.82	3.16	3.03
3. Cesarean Sections all ages								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652
# of Eligibles Receiving	126	592	68	214	31	97	225	903
% of all Deliveries	15.65%	16.45%	11.83%	11.05%	16.06%	13.02%	14.30%	14.38
5. Vaginal Births								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652
# of Eligibles Receiving	679	3,005	507	1,723	161	647	1,347	5,374
% of all Deliveries	84.35%	83.52%	88.17%	89.00%	83.42%	86.85%	85.63%	85.6
7. Extreme Low Birth Weights								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652
# of Eligibles Receiving	19	66	9	13	19	34	47	111
% of all Deliveries	2.36%	1.83%	1.57%	0.67%	9.84%	4.56%	2.99%	1.77
9. Sub. Abuse & Preg								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652
# of Eligibles Receiving	42	154	19	65	4	18	65	237
% of all Deliveries	5.22%	4.28%	3.30%	3.36%	2.07%	2.42%	4.13%	3.78
10. Hysterectomies								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652

EXHIBIT A.1.12

NEW MEXICO MEDICAID MANAGEMENT INFORMATION SYSTEM
HUMAN SERVICES DEPARTMENT
MCO COMPARISON REPORT FROM ENCOUNTER DATA
COHORT SUMMARY

QUARTER ENDING: 06/30/2000

	Presbyterian		Lovelace		Cimarron		Combined	
	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD	Cur Qtr	YTD
# of Eligibles Receiving	31	119	10	30	12	42	53	191
% of Total Eligs Receiving	0.10%	0.26%	0.07%	0.14%	0.08%	0.19%	0.09%	0.22
# of Elig Months in Period	81,170	348,590	37,312	145,499	38,184	157,530	156,666	651,619
% Elig Receiv'g Annualized	0.11%	0.40%	0.08%	0.24%	0.09%	0.31%	0.10%	0.35
13. Pap Test, Ages 21-40								
# of Eligibles	10,587	18,257	5,427	9,024	5,186	9,020	20,965	34,620
# of Eligibles Receiving	35	271	129	445	27	214	191	930
% of Total Eligs Receiving	0.33%	1.48%	2.38%	4.93%	0.52%	2.37%	0.91%	2.69
# of Elig Months in Period	25,948	115,196	12,843	51,258	12,627	52,784	51,418	219,238
% Elig Receiv'g Annualized	0.40%	2.82%	3.01%	10.41%	0.64%	4.86%	1.11%	5.09
14. Pap Test, Ages 41 +								
# of Eligibles	4,922	6,755	1,938	2,689	2,582	3,472	9,380	12,303
# of Eligibles Receiving	34	119	32	133	14	73	80	325
% of Total Eligs Receiving	0.69%	1.76%	1.65%	4.95%	0.54%	2.10%	0.85%	2.64
# of Elig Months in Period	13,591	58,809	5,219	21,118	7,155	28,972	25,965	108,899
% Elig Receiv'g Annualized	0.75%	2.42%	1.83%	7.55%	0.58%	3.02%	0.92%	3.58
17. Case Management								
# of Eligibles	31,184	46,584	14,726	21,701	14,636	22,334	60,036	86,652
# of Eligibles Receiving	354	1,903	8	21	156	560	518	2,482
% of Total Eligs Receiving	1.14%	4.09%	0.05%	0.10%	1.07%	2.51%	0.86%	2.86
# of Elig Months in Period	81,170	348,590	37,312	145,499	38,184	157,530	156,666	651,619
% Elig Receiv'g Annualized	1.30%	6.55%	0.06%	0.17%	1.22%	4.26%	0.99%	4.57

EXHIBIT A.1.13

EXHIBIT B

ANALYSIS OF ENCOUNTER DATA MCO COMPARISON REPORTS

The MCO Comparison Reports are produced by the Medical Assistance Division (MAD) of the New Mexico Human Services Department (department). Auditors performed an analysis the MCO Comparison Report and identified 52 of 116 total services in which the reported data appeared illogical when compared between MCOs and/or between fiscal years. MCOs and the department were asked to explain the reasons for such apparent variances. This exhibit reflects the auditors comments about these 52 services. Five of these 52 services and the related MCO responses are specifically discussed in the report. In this exhibit those five are shaded for easy identification and cross reference.

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
Behavioral Health-50%		
1. Inpatient Adult Psych.		**Cimarron** had a significant drop in number of persons serviced and also frequency of services provided from 1999 to 2000
2. Adult Psychotherapy/Counseling		**Cimarron** had a significant drop in frequency of services provided from 1999 to 2000
3a. Psychosocial Rehab Svcs-Crisis Intervention		**Presbyterian and Lovelace** provided no services in 1998, 1999 and 2000. **Cimarron** had a significant drop in number of persons serviced and also frequency of services provided from 1999 to 2000.
3b. Psychosocial Intervention	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
3d. Therapeutic Intervention		**Cimarron** provided no services in 1998, 1999 and 2000. **Presbyterian and Lovelace provided no services in 2000.**
3e. Medication Management	In Year 2000, **Presbyterian and Lovelace** appear to be providing significantly less services when compared to the other MCO(s) and their porportinate share of eligibles.	**Presbyterian Provided few services in years 1998, and no services in 1999 and 2000. There was a significant drop in services provided by Lovelace in Year 2000.**
5. Adult CM Chronic Mental Ill	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in services provided by Cimarron in Year 2000.

EXHIBIT B.1.1

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
7. Inpt Serv for adults w/SA	In Year 2000, **Lovelace** appears to be servicing significantly less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Lovelace in Year 2000.
9. Adult Enhanced Services	In Year 2000, **Lovelace** appears to be servicing significantly less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Cimarron in Year 2000.
10. Inpt Child Psych	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced and services provided by Cimarron and Lovelace in Year 2000.
12. Part Hospitalization-Child	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately and providing no encounters when compared to the other MCO(s) and its proportinate share of eligibles.	
13. Day Treatment	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
14. Residential Treatment Center	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	

EXHIBIT B.1.2

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
15. Treatment Foster Care	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
16. Child Behavior Management	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced and by frequency of services by Lovelace in Year 2000.
19. Inpt Servs for Child w/SA	In Year 2000, **Presbyterian** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced and by frequency of services by Presbyterian and Lovelace in Year 2000.
21. Child Enhanced Services		There was a significant drop in frequency of services by Cimarron in Year 2000.

EXHIBIT B.1.3

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
Acute & Chronic Conditions-33%		
3. AIDS Pat Rcvg Proteas Inhib	In Year 2000, **Presbyterian** appears to be servicing less recipients when compared to the other MCO(s) and its proportinate share of eligibles.	
6. Dialysis Use	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in frequency of services by Lovelace in Year 2000.
19. Triage	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
21. Observation Visits	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced and by frequency of services by Lovelace in Year 2000.
26 DME Purchase	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles	
32. Home Health	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	

EXHIBIT B.1.4

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
33. Urinary Incontinance Supply	In Year 2000, **Cimarron** appear to be servicing significantly less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles. **Presbyterian** provided no services in 2000.	There was a significant drop in recipients serviced by Presbyterian and Cimarron in Year 2000.
34. PT/OT/Speech	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles	
36. Inpatient Rehab	In Year 2000, **Lovelace** and **Cimarron** appear to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
37. 30 day Nursing Home Stays	In Year 2000, **Presbyterian** and **Lovelace** appear to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	

EXHIBIT B.1.5

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
Primary & Specialist Care-33%		
1. Client Rcvg PC 0-20	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in frequency of services by Lovelace in Year 2000.
2. Client Rcvg PC 20+	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in frequency of services by Lovelace in Year 2000.
5. Client Rcvg specialist care 0-20	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced and by frequency of services by Lovelace in Year 2000.
6. Client Rcvg specialist care 21+	In Year 2000, **Lovelace** appears to be providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in frequency of services by Lovelace in Year 2000.
8. Client Rcvg Care from Indian Health Service	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in frequency of services by Cimarron in Year 2000.
9. Client Rcvg Care from FQHC	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles. **Presbyterian** provided no services in 2000.	There was a significant drop in frequency of services by Lovelace and Cimarron in Year 2000.

EXHIBIT B.1.6

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
Children's Health Services-33%		
9. Non EPSDT PCP visits, 0-20	In Year 2000, **Lovelace** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Lovelace in Year 2000 and by frequency of services by Cimarron in Year 2000.
10. EPSDT refs, diag/treat 0-20	There was a signifnicant drop in frequency of services by **Lovelace** in Year 2000.	
15. DTP vaccine, ages 0-5	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Presbyterian and by Cimarron in Year 2000.
18. Tetnus tox, sgl agt, 0-20	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Presbyterian and by Cimarron in Year 2000.
22. HIB vac, sgl angt 6-20	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
23. Hep B vacc, 0-20	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
24. TB skin test 0-20		There was a significant drop in recipients serviced by Presbyterian in Year 2000.

EXHIBIT B.1.7

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
25. Lead (blood) test 0-20	In Year 2000, **Presbyterian** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Presbyterian in Year 2000.
26. Sickle cell test, 0-20	In Year 2000, **Presbyterian** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Presbyterian in Year 2000.

EXHIBIT B.1.8

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
Women's Health Services-33%		
1. Delivery ages 12-20	In Year 2000, **Cimarron** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
2. Delivery ages 21+	In Year 2000, **Cimarron** appears to be servicing less recipients and providing significantly less encounters proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
3. Cesarean Sections all ages	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
5. Vaginal births	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
7. Extreme low birth weight	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	There was a significant drop in recipients serviced by Lovelace in Year 2000.
9. Sub abuse and preg	In Year 2000, **Cimarron** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	

EXHIBIT B.1.9

Legislative Finance Committee
Performance Audit Team
NM Human Services Department
Encounter Data Project
File: BarPieHSD1amended (Exhibits)
cs9/13/01

Services-Year 2000	Pie Charts	Bar Graphs
10. Hysterectomies	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	
13. Pap test, ages 21-40	In Year 2000, **Presbyterian** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	**Cimarron, Lovelace and Presbyterian showed a significant drop in recipients serviced in Year 2000.**
14. Pap test, ages 41 +		**Cimarron, Lovelace and Presbyterian showed a significant drop in recipients serviced in Year 2000.**
17. Case Management	In Year 2000, **Lovelace** appears to be servicing less recipients proportinately when compared to the other MCO(s) and its proportinate share of eligibles.	

Notes:
Negative indicators were selected and prioritized for HSD response. Positive indicators were not reviewed, but may trigger additional inquiry to the data.
Services with less than 100 recepients serviced were not selected and reviewed, since they did not meet the criteria for selection.
The auditors used a criteria of 33% (50% for behavioral health) as the cutoff.
Critical services were identified as priority 'A' for MCO review and response.

EXHIBIT B.1.10

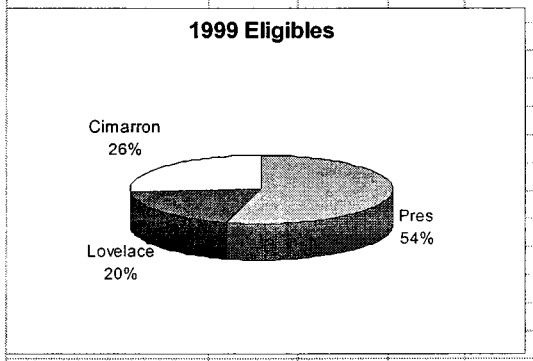
EXHIBIT C

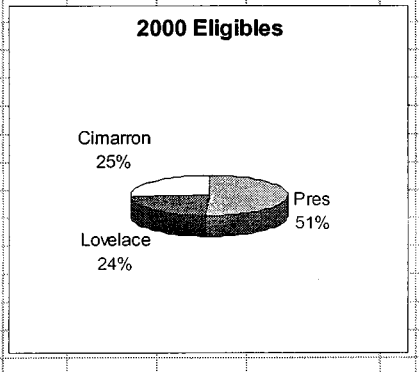
PIE CHARTS AND GRAPHS OF MCO COMPARISON REPORTS

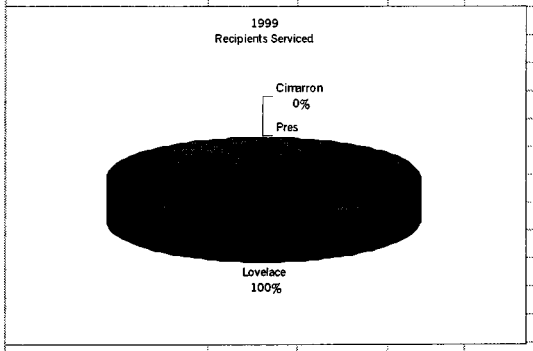
The MCO Comparison Reports are produced by the Medical Assistance Division (MAD) of the New Mexico Human Services Department (department). Auditors performed an analysis the MCO Comparison Report and identified 52 of 116 total services in which the reported data appeared illogical when compared between MCOs and/or between fiscal years. In order to perform this analysis, auditors produced pie charts and bar graphs of the information contained in the MCO Comparison Reports. This exhibit includes such visual representations of the five services that are specifically discussed in the report.

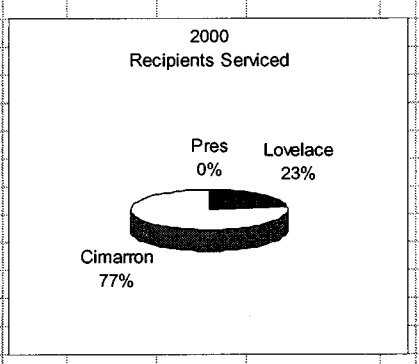
50%	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
Medication Management	36,470	13,382	17,431		32,653	15,265	16,208
	54%	20%	26%		51%	24%	25%
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
Recipients Serviced	0	106	0		0	60	203
	-1	1	-1		-1	0	1
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
# of Sessions	0	1,499	0		0	234	1,879
	-1	1	-1		-1	-1	1
Behavioral Health							

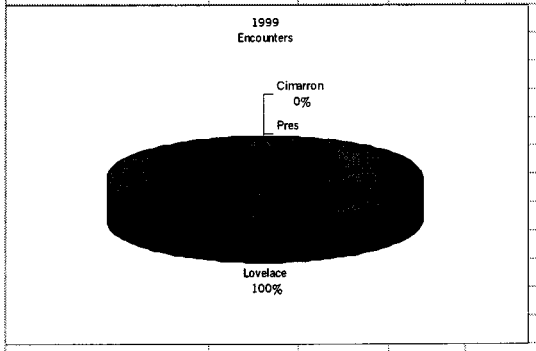
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
30577	36470	32653	12507	13382	15265	16027	17431	16208
		0			0			0
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
6	0	0	110	106	60	0	0	203
		0			0			1
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
7	0	0	735	1499	234	0	0	1879
		0			-1			1

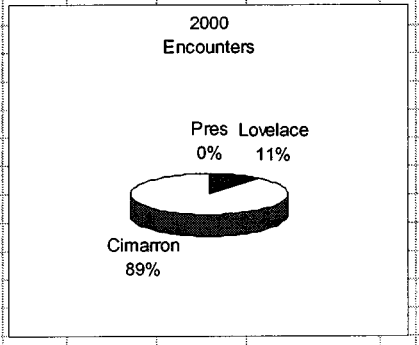


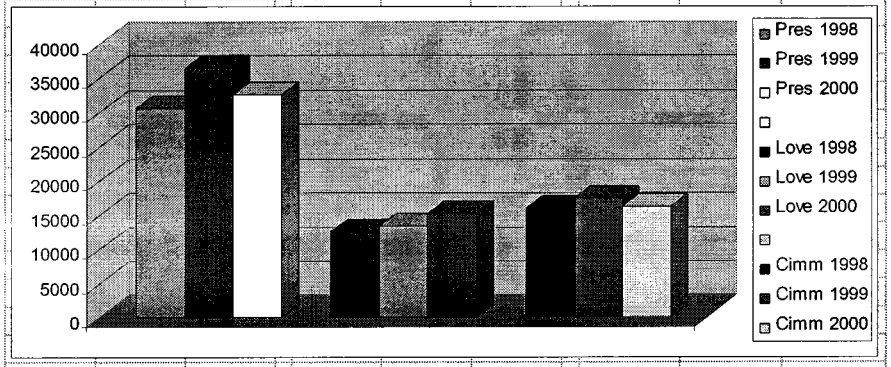


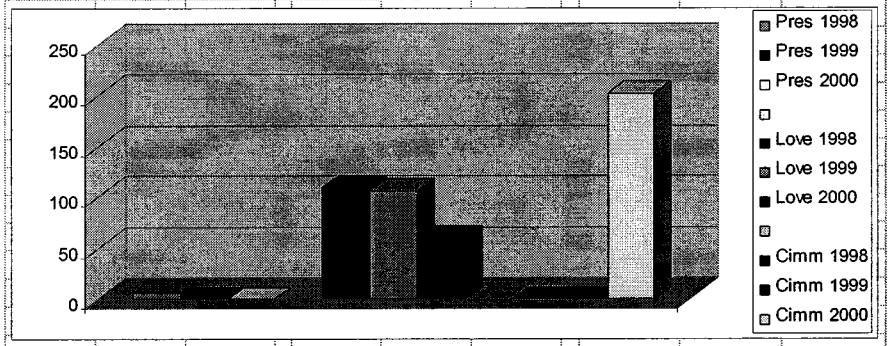












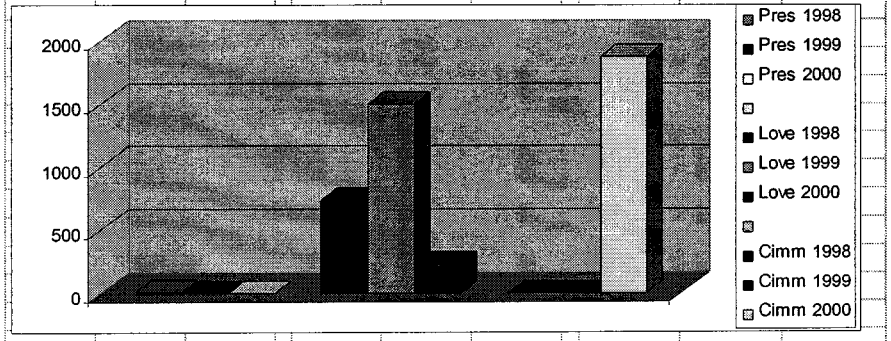
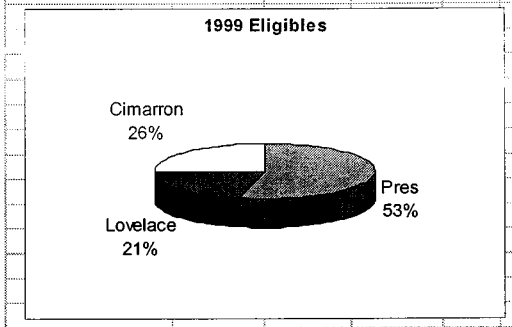


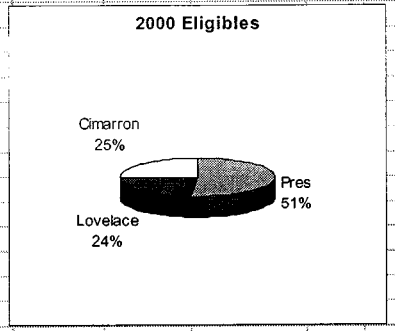
EXHIBIT C.1.1

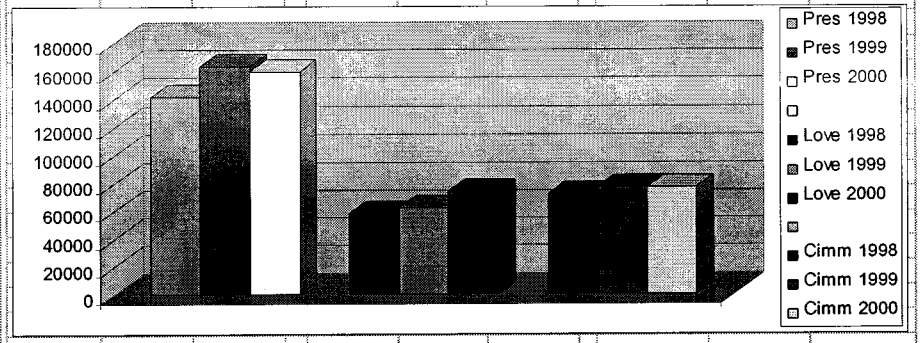
33%	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
33.Urinary Incontinence	163,590	63,200	77,649		159,948	74,307	77,706
Supply	54%	21%	26%		51%	24%	25%
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
Recipients Serviced	22	117	263		0	125	23
	-1	1	1		-1	1	-1

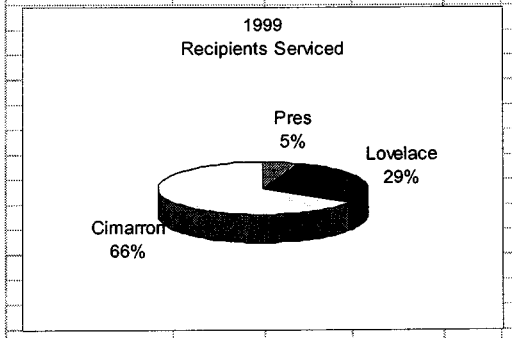
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
141904	163590	159948	58338	63200	74307	72554	77649	77706
		0			0			0
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
13	22	0	61	117	125	164	263	23
		-1			0			-1

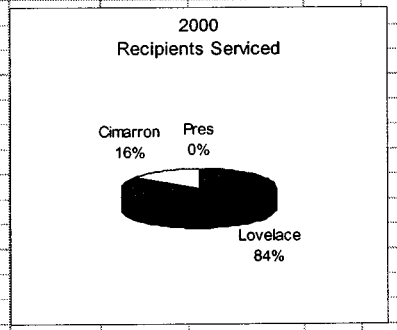
Acute & Chronic Conditions











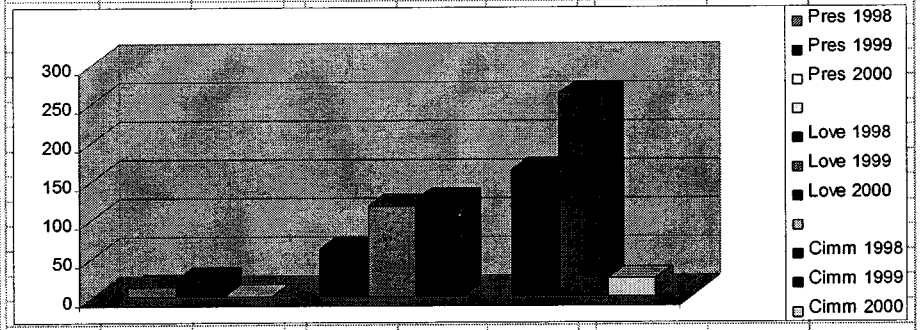
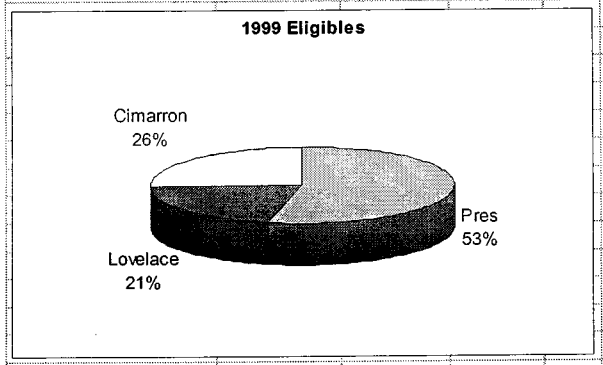
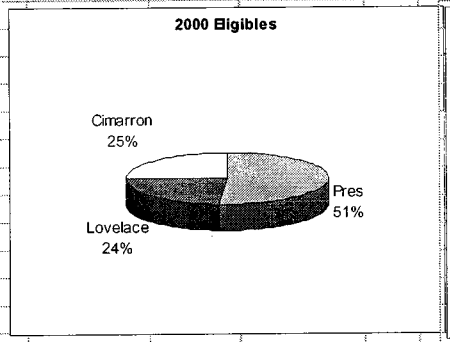


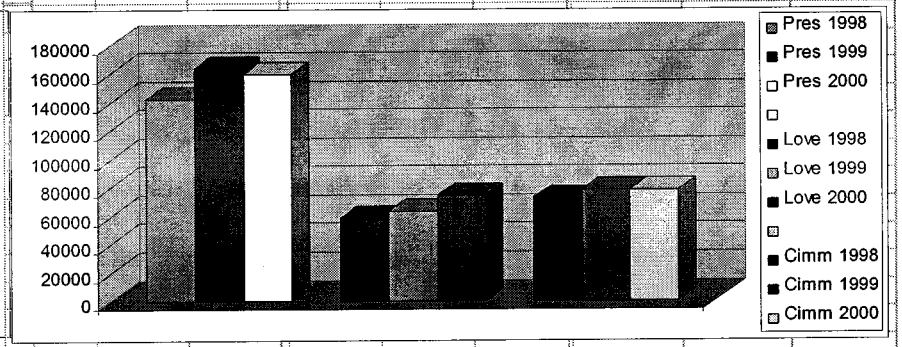
EXHIBIT C.1.2

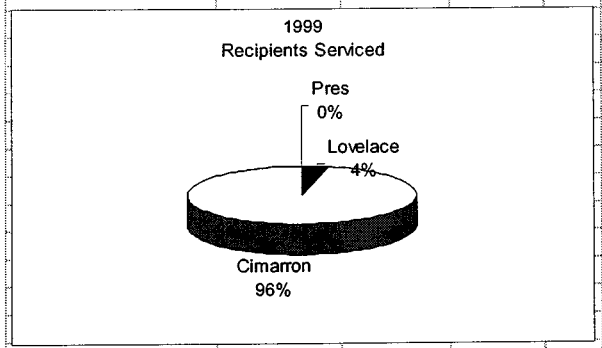
33%	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron		Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
9. Client Rcvg Care	163,590	63,200	77,649		159,948	74,307	77,706		141904	163590	159948	58338	63200	74307	72554	77649	77706
from FQHC	54%	21%	26%		51%	24%	25%				0			0			0
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron		Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
Recipients Serviced	0	103	2,463		0	121	1,939		0	0	0	163	103	121	814	2463	1939
	-1	-1	1		-1	-1	1				0			0			0
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron		Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
# of Visits	0	1,373	5,767		0	525	3,458		0	0	0	2384	1373	525	2022	5767	3458
	-1	0	1		-1	-1	1				0			-1			-1

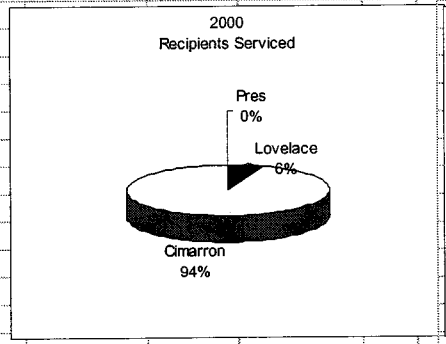
Primary & Specialist Care

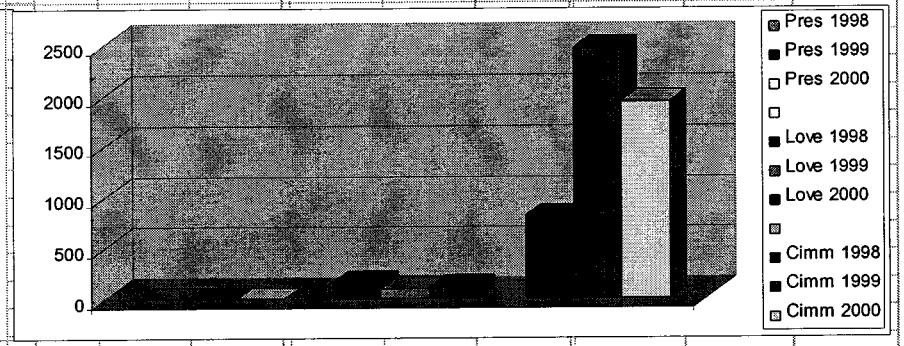


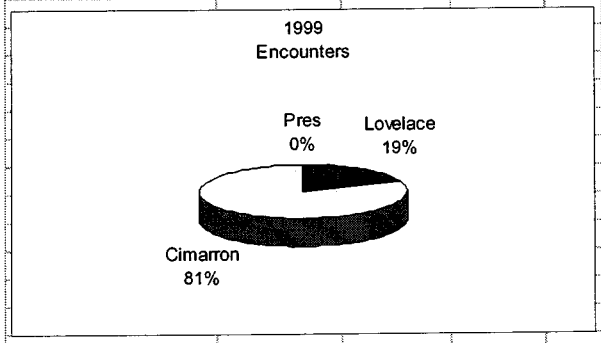


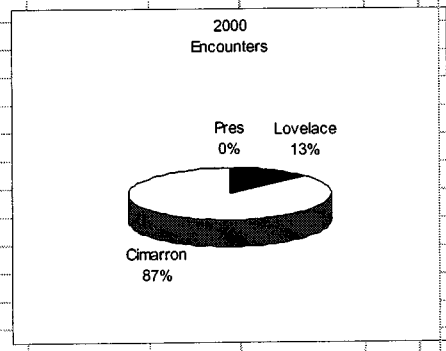












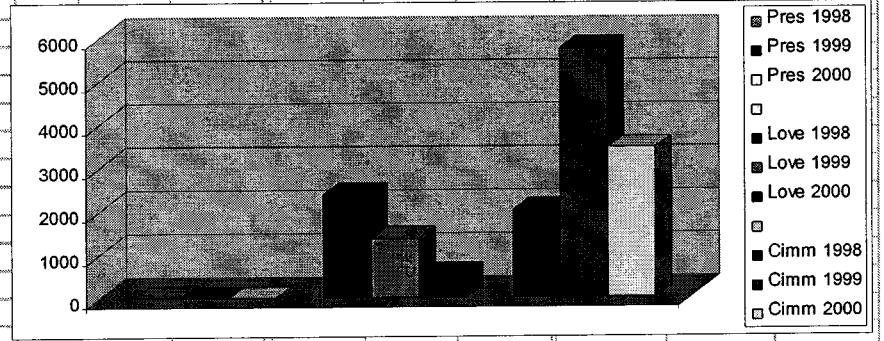
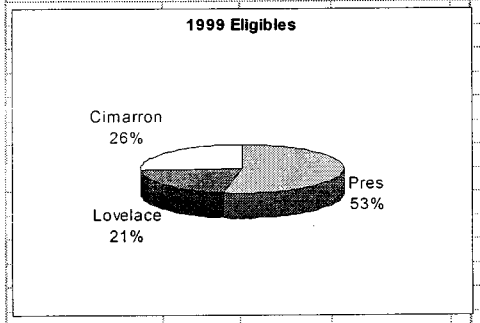


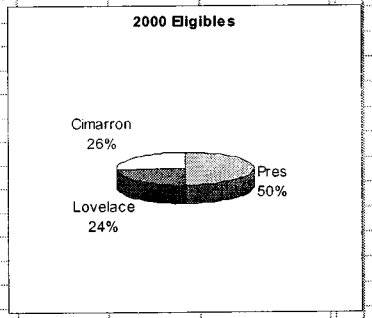
EXHIBIT C.1.3

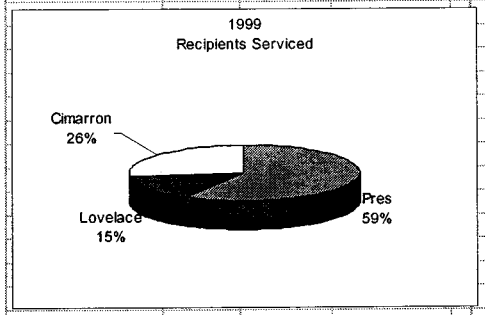
33%	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
15. DTP Vaccine,	51,849	21,038	25,330		50,749	24,061	26,481
Ages 0-5	53%	21%	26%		50%	24%	26%
	Pres	Lovelace	Cimarron		Pres	Lovelace	Cimarron
Recipients Serviced	4,100	1,089	1,854		1,817	1,754	712
	0	0	0		0	1	-1

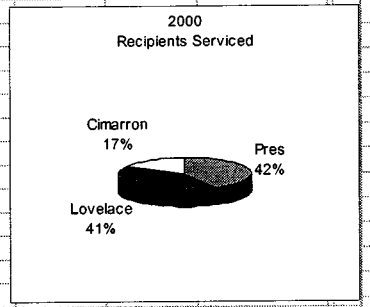
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
45429	51849	50749	18785	21038	24061	23953	25330	26481
		0			0			0
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
2553	4100	1817	753	1089	1754	1683	1854	712
		-1			1			-1

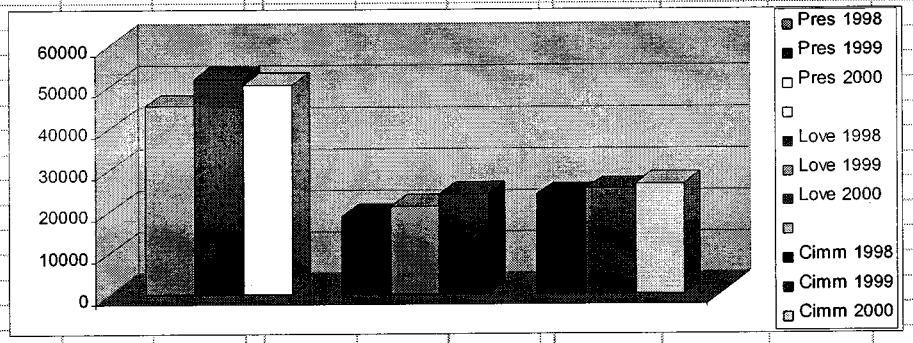
Childrens Health Services











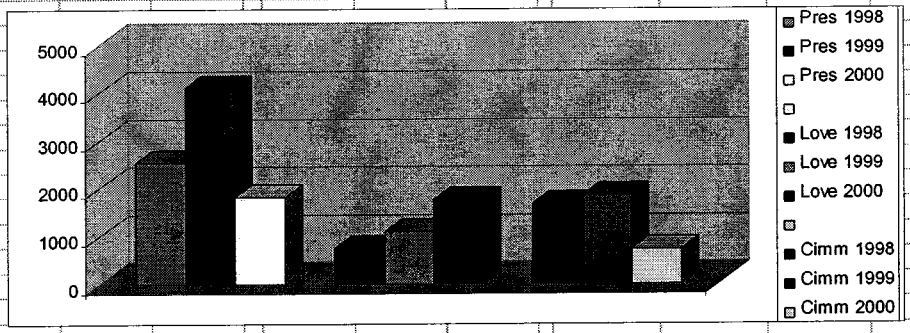


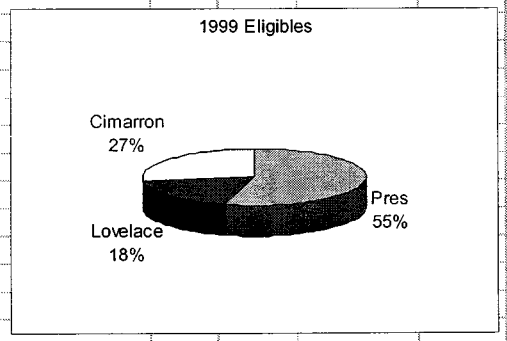
EXHIBIT C.1.4

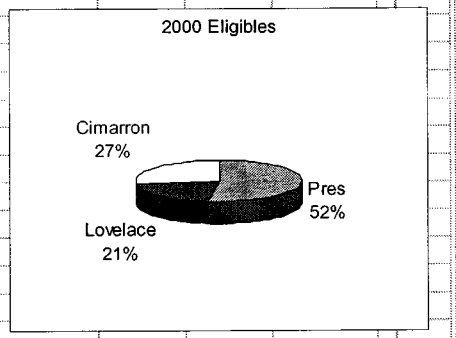
33%	Pres	Lovelace	Cimarron
14. Pap test,	7,217	2,445	3,561
Ages 41 +	55%	18%	27%
	Pres	Lovelace	Cimarron
Recipients Serviced	626	371	306
	0	1	0

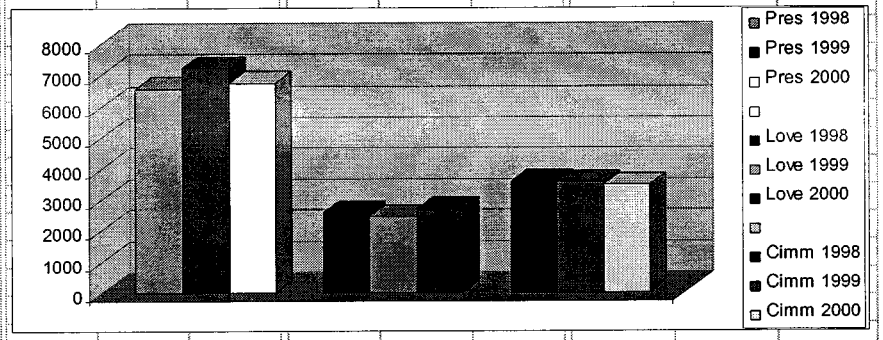
	Pres	Lovelace	Cimarron
	6,755	2,689	3,472
	52%	21%	27%
	Pres	Lovelace	Cimarron
	119	133	73
	0	1	0

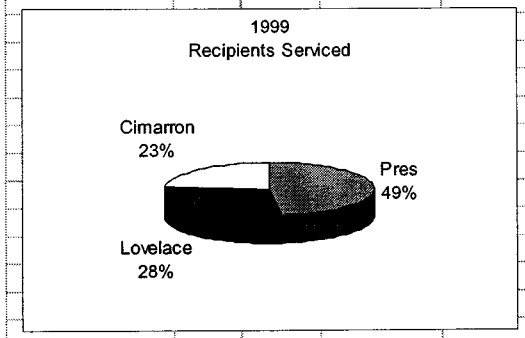
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
6575	7217	6755	2570	2445	2689	3568	3561	3472
		0			0			0
Pres 1998	Pres 1999	Pres 2000	Love 1998	Love 1999	Love 2000	Cimm 1998	Cimm 1999	Cimm 2000
353	626	119	276	371	133	345	306	73
		-1			-1			-1

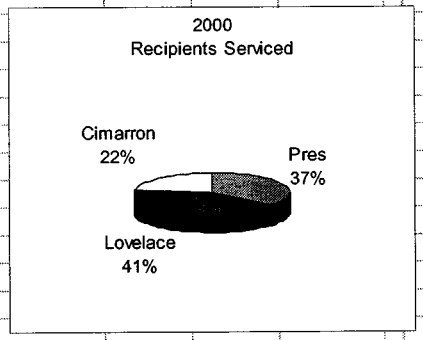
Womens Health Services











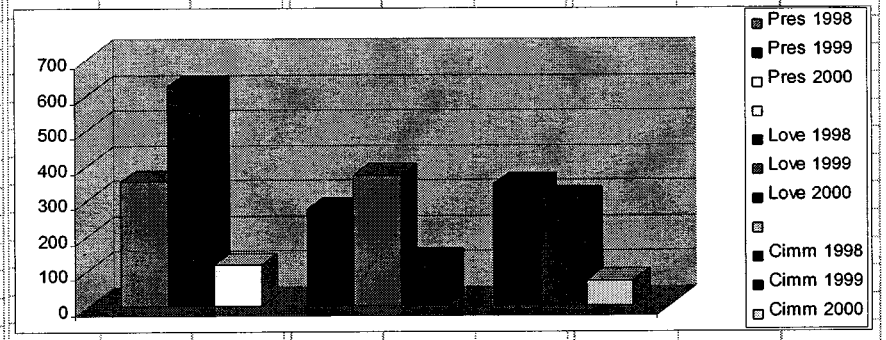


EXHIBIT C-13

EXHIBIT D

ANALYSIS OF SALUD CLIENTS WITH NO REPORTED ENCOUNTERS

The following exhibits are a part of the analysis of Managed Care Clients with no reported encounters in Fiscal Year 2000. This exhibit identifies Salud! recipients by county and by Managed Care Organization (MCO). It compares Salud! clients who had no reported encounters to total Salud clients.

EXHIBIT D.1.1

Analysis of Managed Care Clients With No Encounters
By County and MCO
Fiscal Year 2000

	Salud! Clients with no Encounters Fiscal Year 2000				Salud Clients FY 2000			
County	CIM	LOVE	PRES	All MCOs	CIM	LOVE	PRES	All MCOs
Bernalillo	530	456	940	1,926	12,492	13,545	24,745	50,781
Catron	5	4	14	23	35	42	181	258
Chavez	90	146	107	343	2,612	5,549	1,990	10,152
Colfax	3	2	31	36	58	39	1,499	1,596
Curry	51	30	150	231	1,319	493	4,999	6,810
DeBaca	2	4	6	12	40	71	103	213
DonaAna	321	292	617	1,230	7,445	7,302	12,744	27,491
Eddy	96	48	119	263	2,807	1,246	2,893	6,946
Grant	64	50	79	193	1,315	1,409	1,529	4,253
Guadalupe	7	1	8	16	288	59	356	702
Harding	0	0	0	0	6	4	40	51
Hidalgo	12	20	17	49	251	269	365	885
Lea	83	39	182	304	2,114	987	5,248	8,349
Lincoln	6	9	53	68	227	319	1,329	1,875
Los Alamos	2	1	2	5	18	79	107	205
Luna	71	34	91	196	899	715	2,065	3,679
Mckinley	34	42	121	197	3,373	2,442	6,537	12,352
Mora	21	3	20	44	327	80	494	901
Otero	34	47	86	167	1,229	1,064	2,810	5,103
Quay	7	9	27	43	179	61	1,209	1,449
Rio Arriba	20	45	168	233	619	1,055	3,861	5,535
Roosevelt	37	15	68	120	876	320	1,624	2,820
San Juan	42	33	146	221	1,842	1,341	3,985	7,168
San Miguel	52	22	120	194	2,109	1,569	6,395	10,073
Sandoval	63	47	130	240	1,425	580	2,887	4,892
Santa Fe	52	117	236	405	827	2,290	4,805	7,923
Sierra	17	10	24	51	464	205	865	1,534
Socorro	26	10	72	108	801	360	1,684	2,845
Taos	70	18	74	162	1,454	372	1,894	3,720
Torrence	30	33	110	173	496	673	2,157	3,326
Union	16	1	6	23	255	15	157	427
Valencia	51	53	202	306	1,214	1,435	6,038	8,687
Cibola	16	8	63	87	657	498	2,315	3,470
Total	**1,931**	**1,649**	**4,089**	**7,669**	**50,075**	**46,486**	**109,912**	**206,473**
PMPM	**208**	**216**	**236**	**225**	**199**	**202**	**208**	**205**
Mnthly Cost	**401,648**	**356,184**	**965,004**	**1,725,525**	**9,964,925**	**9,390,172**	**22,861,696**	**42,326,965**
Mnths in Yr	**12**	**12**	**12**	**12**	**12**	**12**	**12**	**12**
Annual Cost	**4,819,776**	**4,274,208**	**11,580,048**	**20,706,300**	**119,579,100**	**112,682,064**	**274,340,352**	**507,923,580**

Highlighted items reflect counties whose clients with no encounters for FY 2000 exceed the average of all MCOs and all counties (3.71%) by more than 50 percent.

Analysis of Managed Care Clients With No Encounters
By County and MCO
Fiscal Year 2000

Clients with no encounters as a Percent of Salud! Clients

County	CIM	LOVE	PRES	All MCOs
Bernalillo	4.24%	3.37%	3.80%	3.79%
Catron	14.32%	9.43%	7.74%	8.91%
Chavez	3.45%	2.63%	5.38%	3.38%
Colfax	5.18%	5.08%	2.07%	2.26%
Curry	3.87%	6.09%	3.00%	3.39%
DeBaca	5.06%	5.66%	5.83%	5.63%
DonaAna	4.31%	4.00%	4.84%	4.47%
Eddy	3.42%	3.85%	4.11%	3.79%
Grant	4.87%	3.55%	5.17%	4.54%
Guadalupe	2.43%	1.71%	2.25%	2.28%
Harding	0.00%	0.00%	0.00%	0.00%
Hidalgo	4.78%	7.44%	4.65%	5.54%
Lea	3.93%	3.95%	3.47%	3.64%
Lincoln	2.64%	2.82%	3.99%	3.63%
Los Alamos	10.88%	1.27%	1.86%	2.44%
Luna	7.90%	4.75%	4.41%	5.33%
Mckinley	1.01%	1.72%	1.85%	1.59%
Mora	6.42%	3.76%	4.05%	4.88%
Otero	2.77%	4.42%	3.06%	3.27%
Quay	3.91%	14.85%	2.23%	2.97%
Rio Arriba	3.23%	4.27%	4.35%	4.21%
Roosevelt	4.23%	4.68%	4.19%	4.25%
San Juan	2.28%	2.46%	3.66%	3.08%
San Miguel	2.47%	1.40%	1.88%	1.93%
Sandoval	4.42%	8.11%	4.50%	4.91%
Santa Fe	6.29%	5.11%	4.91%	5.11%
Sierra	3.66%	4.88%	2.77%	3.32%
Socorro	3.24%	2.78%	4.27%	3.80%
Taos	4.82%	4.84%	3.91%	4.36%
Torrence	6.05%	4.90%	5.10%	5.20%
Union	6.26%	6.60%	3.83%	5.38%
Valencia	4.20%	3.69%	3.35%	3.52%
Cibola	2.44%	1.61%	2.72%	2.51%
AVG ALL COUNTYS	**3.86%**	**3.55%**	**3.72%**	**3.71%**

Highlighted Percentages reflect counties whose clients with no encounters for FY 2000 exceed the average of all MCOs and all counties (3.71%) by more than 50 percent.