Independent Assessment of New Mexico’s Medicaid Managed Care Program – Behavioral Health Statewide Entity

Final Report
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By HealthInsight New Mexico External Quality Review Organization (EQRO):

Denise Anderson, MAOM, CQPA, Analyst

Reviewed by:
Greg Lujan, LISW, Project Manager
Sabrina Villalobos, BBA, Project Coordinator
Margaret White, RN, BSN, MSHA, EQR Director
Herb Koffler, MD, EQR Medical Director
Anna Dykeman, MA, Senior Communications Specialist
Boyd Kleefisch, Executive Director

HealthInsight
New Mexico

5801 Osuna Road NE, Suite 200
Albuquerque, NM 87109-2587
Table of Contents

I. Executive Summary ............................................................................................................. 4
   Access Findings .................................................................................................................. 4
   Quality Findings ................................................................................................................ 5
   Cost-effectiveness Findings ............................................................................................... 7
   Overall Findings ................................................................................................................ 8
II. Background .......................................................................................................................... 8
    Future Plans ....................................................................................................................... 9
III. Assessment Methodology ................................................................................................. 10
IV. Access Assessment ........................................................................................................... 11
   A. Introduction ..................................................................................................................... 11
   B. NMAC Regulations and Contract Requirements ............................................................. 11
   C. Distribution of Consumers and Providers ...................................................................... 12
   Geoaccess .......................................................................................................................... 12
   Provider-to-Consumer Comparisons ................................................................................. 13
   D. Availability of Providers ................................................................................................. 14
   E. Accessibility of Providers and Services ........................................................................ 15
   F. Telehealth ....................................................................................................................... 16
   G. Timely Access to Care .................................................................................................... 18
   Appointment Scheduling Timeliness ............................................................................... 18
   Customer Service Response Time ..................................................................................... 19
   H. Access to Information ..................................................................................................... 21
   Website .............................................................................................................................. 21
   Consumer Handbook ........................................................................................................ 21
   Provider Network ............................................................................................................... 22
   Services Support Lines ...................................................................................................... 22
   I. Actions Taken to Improve Access .................................................................................. 23
   J. Summary of Access Findings ......................................................................................... 23
V. Quality of Care Assessment ............................................................................................... 24
   A. Introduction ..................................................................................................................... 24
   B. NMAC Regulations and Contract Requirements ............................................................. 24
   C. Quality Management/Quality Improvement Program ..................................................... 25
   QM/QI Plan .......................................................................................................................... 26
   Communication and Transparency ..................................................................................... 26
   Cultural Competency Plan ................................................................................................. 26
I. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) requires regular and periodic independent assessment for all state-waivered Medicaid managed care systems by an External Quality Review Organization (EQRO). The New Mexico Human Services Department (HSD) has oversight of the state’s managed care system, which is currently split into three programs: Physical Health (PH) Salud!, Behavioral Health (BH) Statewide Entity (SE), and the Coordination of Long Term Services (CoLTS). HSD has contracted with HealthInsight New Mexico as its EQRO to perform the assessments for these three programs on a biennial basis. The following report is the assessment of the BH SE program, which operates under a 1915(b) waiver of the Social Security Act granted by CMS.¹

During the assessment period, OptumHealth New Mexico (OHNM) served as the sole BH SE. It has held the contract with HSD since July 2009, making this the second independent assessment for OHNM. The audit period covered here is the state Fiscal Year (FY) 2012: July 1, 2011 to June 30, 2012.

This Independent Assessment report is an in-depth analysis of quantitative and qualitative information obtained regarding OHNM that focuses on:

- Access to care
- Quality of care
- Cost-effectiveness

The findings of the analysis for each section are summarized below. A full description of the analysis is provided in the main body of the report.

Access Findings

Based on a review and analysis of the documentation provided by HSD, it appears that OHNM met the requirements for access, but there were opportunities to improve in physical access and timely access to providers and services.

The BH SE is required to provide a full array of covered services in close proximity to the consumer’s place of residence. OHNM has 20 provider group categories, which do provide a wide array of services. Distribution of the services across the state is a challenge, though. The amount of providers in the urban areas is more than sufficient to meet the needs of the consumers with 64.6 percent of the providers located there. Rural and frontier areas, however, are under-served in comparison (27.7 percent and 7.7 percent, respectively).

To address the gap in services, OHNM implemented a project called Telehealth in various locations around the state. This computer application facilitates interactive, audio-visual communication between consumers and providers via personal computers. About 2.0 percent of the BH consumers used Telehealth in FY 2012. In an effort to improve this service and encourage usage, OHNM surveys Telehealth users on a

¹ It should be noted that only the BH Statewide Entity aspects of New Mexico managed care were included in this report. Separate independent assessments have been prepared for the PH Salud! and CoLTS programs.
quarterly basis to measure customer satisfaction levels. Survey results are posted to its website.

Customer service telephone measurements collected by OHNM for FY 2012 and outlined in its Consumer Services Report revealed that no less than 98 percent of the incoming calls were being answered within 30 seconds or less, and only 1.2 percent or less of waiting calls were being abandoned.

Appointment scheduling timeliness, however, was reported by OHNM to have met the requirements only 85.3 percent of the time for crisis events, 50.9 percent for urgent situations, and 59.5 percent for routine appointments in FY 2012. The data showed a downward pattern for timely access in each category when comparing performance among the last three years (see Figure 4, pages 18-19). The state BH Oversight Team questioned the validity of the data and requested investigation and corrective action for any discrepancies found. OHNM delved into this and determined that inadequate personnel resources led to an insufficient number of calls being made and that there were inconsistent data collection and recording methods being used for calls answered by an answering machine, which may have contributed to the downward pattern seen. OHNM corrected the understaffing issue and retrained all staff on the correct method for data collection. Subsequent measurements reported in the Access Standards Time to Treatment Semi-Annual Report to HSD have been comparable to prior fiscal year results for appointment scheduling and substantiated by accompanying data pertinent to each call. The Oversight Team was satisfied with the actions and considered the matter resolved.

OHNM met the requirements for informational access outlined in the New Mexico Administrative Code (NMAC) regulations (see page 12). It offered information from various sources and in multiple formats, including information in a format that accommodates the hearing-impaired and consumers speaking languages other than English.

Quality Findings
All applicable quality reports and documents provided by HSD were reviewed, and based on this information it appears that OHNM met the requirements for quality of care.

The Quality Management and Quality Improvement (QM/QI) Program developed by OHNM, along with the accompanying QM/QI Plan, were examined for this assessment. Evidence was found that the plan was reviewed, evaluated, and updated annually by OHNM. Communication and transparency of the plan were maintained with the stakeholders through interactions at various planning, committee, and council meetings. OHNM also showed evidence of being sensitive to the cultural and linguistic needs of the committees it serves. An annual self-assessment was performed to evaluate how well the consumer needs were being met, and the results were used to develop learning objectives and to update the OHNM Diversity Work Plan.

Three performance measures (PMs) and two performance improvement projects (PIPs) were established when OHNM became the BH SE:

- PM 1: Residential Treatment Center (RTC) readmissions within 30 days to same level of care or higher
• PM 2: Psychiatric hospital discharge follow-up within seven (7) days
• PM 3: Psychiatric hospital discharge follow-up within 30 days
• PIP #1: Reduction of RTC readmissions within 30 days
• PIP #2: Individuals with Special Health Care Needs (ISHCN) outpatient follow-up

The performance percentages over the last three years had only a slight variation for each of the PMs. There was a downward pattern for readmissions and an upward pattern for increased follow-up activity. Both were positive results.

RTC Readmissions Reduction (PIP #1) showed little change over the three years measured. Starting at 4.6 percent in FY 2010, it was at 4.1 percent in FY 2012. For ISHCN Follow-up (PIP #2), OHNM’s scores improved over time and exceeded the 80.0 percent goal in FY 2012, with 84.3 percent of consumers remaining in outpatient care for 90 days or more.

Utilization management (UM) was examined through service utilization rates, denials, critical incident reports, and grievances and appeals.

BH consumers visited a provider group/service an average of 7.0 times in FY 2012. This utilization rate has declined over the last three years, and OHNM attributed that to the reduction of hospital or treatment facility readmissions resulting from improved follow-up activity.

In FY 2011, OHNM made some changes to the clinical trigger criteria of the utilization review process that caused an increase in denials, and consequently, in grievances and appeals. During FY 2011 and FY 2012, the cases were re-reviewed and many of the originally denied cases were later approved. After this adjustment period, the denial rate showed a decline, down to 8.8 percent in FY 2012, but the impact of these changes was also visible in the appeals measurements and in the BH SE’s financial reports.

Consumers filed the most grievances regarding “Quality of Care” issues (59 out of the 69 grievances filed in FY 2012). The amount of provider grievances was at a total of eight (8) in FY 2012, down from 58 in FY 2011. Appeals rose sharply over the last three years, starting at 340 in FY 2010, rising to 656 in FY 2011, and finally up to 1,178 in FY 2012.

Critical incidents were also on the rise, with 1,574 reported in FY 2012. OHNM tracked these incidents and used the data to implement improvements. For instance, OHNM began conducting monthly meetings between OHNM's Chief Medical Officer and the investigating Quality Improvement Specialist for cases requested by the state Oversight Team. These meetings focused on cases involving consumer suicides and homicides in an effort to identify potential causes and solutions, thereby reducing the number of new incidents.

Both providers and consumers were surveyed annually to collect data regarding satisfaction levels with the services provided by OHNM. In FY 2012, 88.8 percent of providers who responded to their survey were “Somewhat Satisfied” or “Very Satisfied” overall, and 91.8 percent felt that the “Trend of Service” was “Staying the Same” or “Improving.”
Consumer satisfaction was measured through one of three separate surveys based on age breakdowns: Adult, Child/Family, and Youth. The Adult and Child/Family surveys looked at six domains of service satisfaction, while the Youth survey looked at two domains. The Adult survey showed highest satisfaction in “ Appropriateness” (of services) at 82.0 percent and the lowest satisfaction with “ Effectiveness” (of services) at 62.0 percent. Child/Family results showed the highest satisfaction in “ Empowerment” (of consumer) at 90.0 percent and the lowest satisfaction with “ Effectiveness” at 56.0 percent. The Youth survey ratings were: “Satisfaction with Services,” 87.2 percent, and “Effectiveness of Services,” 81.8 percent.

OHNM met the requirements for external quality review through three audits conducted by HealthInsight New Mexico. The FY 2012 audit results were:

- Compliance with regulations/contract: 99.4 percent, Full Compliance
- PMs evaluation: 100.0 percent, Full Compliance
- PIP #1: 80.2 percent, Moderate Compliance
- PIP #2: 98.9 percent, Full Compliance

**Cost-effectiveness Findings**
After reviewing all available financial reports provided by HSD and comparing the data to national reports, the BH SE program appeared to be cost-effective.

OHNM’s financial status was evaluated by examining and analyzing several financial reports, bank statements, insurance forms, and independent audit reports. Comparisons were made to state and national statistics or benchmarks when available.

OHNM demonstrated fiscal responsibility by maintaining financial viability and stability and by meeting all contractual reporting requirements.

The three-year period of the contract was reviewed and the operational summary reports showed a wide fluctuation between years, with costs exceeding revenue in FY 2010 and FY 2011, resulting in an operating loss for those two years. However, total medical expenses decreased while total revenue increased in FY 2012, thus leading to an operating gain of 5.1. The cause of this positive financial shift was a reduction in claims payments of 15.9 percent in late FY 2011 due to the clinical trigger criteria adjustment, and then the subsequent re-evaluation and approval of many previously denied claims.

Annual costs per consumer in FY 2012 averaged $53.00 per person in the program, while the allowable per person rate was an average of $55.84. This showed OHNM was being fiscally responsible with state funds.

HSD contracted with Mercer Government Services Consulting (Mercer) as an external, independent organization to provide actuarial rate certification. Mercer certified that the rates were developed in accordance with generally accepted actuarial practices and principles, and in accordance with the rate-setting guidelines established by CMS. The methodology of the rate development was detailed, and an overview of the analyses was provided along with the rate tables as evidence of actuarial soundness.
Capitation rates for OHNM averaged an increase of 3.1 percent over the last three years. Looking historically, the program rates increased annually between 2005 (when it was carved out of PH Salud!) and 2008. In 2009, the rates dropped and the program has maintained a relatively flat trend since that time. In comparison, the national rates have steadily increased each year over time.

A direct state-to-federal capitation rate comparison was not performed because New Mexico has carved out the BH SE and CoLTS program costs from the PH Salud! program costs, while the national rates are all inclusive. If the current rates were combined for the three programs, the expenses would be higher than the national average due to the inclusion of additional fees and taxes in New Mexico that are not included in many other states.

Although there have been some notable ups and downs in the program, currently it is being managed well and is fiscally sound.

Overall Findings
Based upon review and analysis of all available data, OHNM was found to have met the overall requirements for access, quality of care, and cost-effectiveness as outlined in the New Mexico Administrative Code (NMAC) regulations and the HSD/OHNM contract.

II. Background
Over the years, New Mexico underwent a number of changes to deliver high quality, well-coordinated, and cost-effective BH services to the state’s Medicaid population. Originally, there was a simple fee-for-service (FFS) system called the Primary Care Network, which later was replaced with the state Medicaid Managed Care (Salud!) program. When this program was first implemented in New Mexico in 1997, the Salud! program included both PH and BH services. BH consumers in publically-funded programs were primarily covered under Medicaid, but other state agencies also had some responsibility for BH services for their specific populations, such as Children, Youth, and Families Department and the Department of Corrections.

To identify potential problem areas, the Behavioral Health Needs and Gaps in New Mexico (Gaps Analysis) report was ordered in 2002 to examine statewide BH services and care. The resulting report stated that there were multiple deficiencies.

In 2005, behavioral health was carved out. The transformation, which affected between 400,000 and 500,000 potential consumers, involved coordination among 17 different state agencies. The New Mexico Behavioral Health Interagency Purchasing Collaborative (the Collaborative) was established as the funding and oversight organization over BH services and programs.

The Collaborative has legal responsibilities for planning, designing, and implementing the single statewide BH system and exists within a statutory framework that also...

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currently encompasses 18 Local Collaboratives (LCs) and the Behavioral Health Planning Council (BHPC). The LCs are organized around judicial districts, as well as Native American tribes, nations, and pueblos. They are made up of consumers, family members, advocates, provider agency staff, individual practitioners, and other stakeholders. Each LC’s make-up is unique to its geography and demographics.

Also in 2005, the state released a detailed request for proposals (RFP) and received several bids for consideration to become the BH SE. ValueOptions New Mexico (VONM) was selected through a competitive procurement process to become New Mexico’s sole provider of BH services with up to a four-year contract.

The transition to a single BH SE was designed to be implemented in three phases:

Phase One: FY 2006 – The Collaborative and BH SE had to successfully transition the multiple systems to one BH delivery system in a timely manner and to maintain continuity of care and system stability to the satisfaction of the Collaborative. This led to the higher costs in this contract than originally expected.

Phase Two: FY 2007 and FY 2008 – The BH SE had to develop performance objectives and deliverables that identified more effective ways of combining multiple funding sources and funding mechanisms that would increase service capacity, support LCs, include additional funding streams, and facilitate the consumer outcomes and system performance that the Collaborative desired.

Phase Three: FY 2009 – The BH SE had to work with the Collaborative to design a work plan for this phase through a contract amendment that focused on improvements identified as still remaining from the initial gap assessment.

Toward the end of this contract, another RFP went out for bid. OHNM was selected from among the many bidders to replace VONM in FY 2010, and OHNM continued on with any remaining planned improvements identified by the Gaps Analysis that were still outstanding at the time of transition from one BH SE to another.

Future Plans

OHNM’s contract originally was written with a projected end date of June 30, 2013, which would be the end of FY 2013. However, the contract has been extended past the scheduled end date to go through the end of calendar year 2013 due to upcoming changes in New Mexico’s Managed Care system.

Beginning in 2014, a new program known as Centennial Care will replace the state’s existing three-prong managed care system. Under Centennial Care, the PH Salud!, BH SE, and CoLTS programs will be recombined into one comprehensive program designed to improve cost-effectiveness without reducing needed services to the Medicaid consumers in the state. When introducing the new program, the New Mexico Medical Advisory Committee stated that the goals of recombining the three programs were to reduce costs of running three separate programs, eliminate duplication of efforts, and enable better coordination of care for the consumers between the BH service provider and the PH or CoLTS primary care providers.
Using the RFP method, four new MCOs have been selected to start providing services under Centennial Care effective January 1, 2014:

- Blue Cross Blue Shield of New Mexico
- Molina Healthcare of New Mexico
- Presbyterian Health Plan
- UnitedHealthcare Community Plan

III. Assessment Methodology
Pertinent information was reviewed from a variety of sources to evaluate the accessibility and availability of care, the quality of care, and the cost-effectiveness of the BH SE during the assessment period of July 2011 to June 2012. Current data were compared to previous findings to look for trends or patterns. The results of this detailed analysis are provided in narrative form in this report, as well as visually displayed in tables, charts, and figures.

The majority of OHNM’s enrollment is in the managed care (Medicaid) population—83 percent are managed care and 17 percent are FFS consumers. Information and data reported in this assessment pertains to Medicaid consumers, unless otherwise stated.

The information for the access and quality of care assessments was obtained from the following sources:

- HSD-required monitoring reports
- State contracts
- HSD/Medical Assistance Division (MAD) managed care standards
- NMAC regulations, 8.305 series
- CMS 42 Code of Federal Regulations (CFR) 438
- CMS and HSD websites
- Local, state, and federal statistical reports
- Consumer and provider satisfaction surveys
- BH SE educational and marketing materials
- EQRO audit reports
- Quantitative analysis reports
- PMs
- PIPs
- Quality and process improvement initiative results

Several sources were used to evaluate the cost-effectiveness of the BH SE program through review and analysis of:

- Financial reports and statements provided to HSD by OHNM
- Independently audited financial reports provided by OHNM, HSD, and other state agencies
- State and federal financial benchmarks
- Actuarial Rate Certifications required under 42 CFR 438.6(c) for the BH SE program
- BH SE capitation rate history, prior to and after BH separation from PH Salud! services
The 2011 and 2012 Actuarial Reports on the Financial Outlook for Medicaid from the Office of the Actuary, CMS
- Publically-reported state and federal Medicaid spending data

IV. Access Assessment

A. Introduction
Access to and availability of providers and services is the first step in meeting the needs of the BH consumers. State regulations, plus OHNM’s contract with HSD, spell out in detail what the requirements for access are, but they are not prescriptive in how to meet any given part of the standard. Instead, OHNM may choose its own methods by which the access requirements are met.

This section examines OHNM’s systems and processes for providing adequate accessibility and availability of BH providers and services to evaluate how well OHNM is meeting its regulatory and contractual requirements. Specific factors examined were:
- Geographical access (Geoaccess)
- Provider-to-consumer comparisons
- Proximity of providers and services to consumers
- Telehealth
- Appointment scheduling
- Timeliness of obtaining information
- Avenues of informational access
- BH SE self-evaluation and actions to improve access

B. NMAC Regulations and Contract Requirements
A requirement of BH SE participation includes compliance with the NMAC Medicaid managed care regulations. These conform to the CMS 42 CFR 438 and stipulate the standards for:
- Access
- Structure and operations
- Timeliness
- Quality measurement and improvement

Two of these standards were used in the access assessment: the Standards for Access (found in NMAC 8.305.8.18 and in the HSD/OHN M contract in Article 3, 3.12, H) and the Standards for Customer Services (found in NMAC 8.305.2.9 and in the HSD/OHN M contract in Article 3, 3.11). These requirements outlined in the standards and contracts can be broken down into three categories:

Physical Access
- Full array of covered services
- Providers for each medically, clinically, or psychosocially necessary service
- Service locations in close proximity to consumer’s place of residence
- Hospital or other licensed emergency facility, regardless if the provider is or is not contracted with OHNM, in the event of an emergency
- Transportation services for medically necessary physical and behavioral health needs
Timely Access

- Appointment time for routine, urgent, and crisis event services set within the contract scheduling criteria
- No clinically significant delay caused by OHNM’s Utilization Management control measures
- In-person prescription fill time no longer than 40 minutes and the provider phone-in prescription filled within 90 minutes
- Timing consistent with clinical need for scheduled follow-up outpatient visits with practitioners
- Medically necessary pharmaceutical agents provided in a clinically timely manner
- Coordinated and uninterrupted continuity of care provided for needed BH treatment and support services

Informational Access

- Service Access Plan (describes OHNM’s system for consumer access to services)
- Provider directory and consumer handbook in a variety of formats, languages, cultural sensitivity needs, and appropriate reading levels
- 24/7 toll-free communication system for providers, consumers, and other interested parties to include:
  - Access for non-English speaking or hearing impaired
  - Assessment by a trained BH specialist of the caller’s current situational status and individual needs
- Health education opportunities at no cost to consumer
- Consumer notification of changes in providers or services

C. Distribution of Consumers and Providers

Geoaccess

New Mexico is the fifth largest state by landmass, consisting of 121,598 square miles. The population is just over two million, with 43 percent living in cities or large towns. The remaining 57 percent is spread throughout the rural and frontier areas of the state. Counties are classified by the state based on the density of the population per square mile as:

- Urban: 40 or more persons
- Rural: 7-39 persons
- Frontier: 6 or less persons

Figure 1 illustrates the New Mexico counties by state classification.
Provider-to-Consumer Comparisons
The breakdown of how OHNM’s consumers and provider groups are distributed throughout the state is shown in the Table 1. Consumer enrollment figures were obtained from the Managed Care Accessibility Analysis reports.

Table 1: OHNM Medicaid Managed Care Consumers and Providers, FY 2012

<table>
<thead>
<tr>
<th>GeoAccess Category</th>
<th>Number of Consumers Enrolled</th>
<th>Percentage</th>
<th>Number of Provider Groups Available</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>217,075</td>
<td>45.2%</td>
<td>1185</td>
<td>64.6%</td>
</tr>
<tr>
<td>Rural</td>
<td>216,181</td>
<td>45.0%</td>
<td>507</td>
<td>27.7%</td>
</tr>
<tr>
<td>Frontier</td>
<td>46,761</td>
<td>9.7%</td>
<td>141</td>
<td>7.7%</td>
</tr>
<tr>
<td>TOTALS</td>
<td>480,017</td>
<td>100.0%</td>
<td>1833</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Because the population is primarily located in rural or frontier areas, it is important to provide an adequate number of behavioral health services and providers in close proximity to the consumers to allow for a reasonable choice. Figure 2 provides a visual comparison of the percentage of consumers to providers by geoaccess category.
Figure 2 shows that in FY 2012 there was an abundance of providers in the urban areas when compared to the population living there, while the rural areas were under-served. The frontier areas had a close ratio between percentage of population and percentage of providers.

D. Availability of Providers
The BH SE is required to offer a full array of behavioral health providers and services. OHNM has 20 provider groups that serve consumers residing throughout all the counties in New Mexico, which meets the requirement for a full array of provider and service availability:

- Psychiatrists
- Certified Nurses with Prescriptive Authority
- Psychologists
- All Other Licensed Providers
- Group Practices
- Inpatient Hospital Facilities
- Partial Hospital Facilities
- Indian Health Services (IHS) and Tribal 638
- Outpatient Therapy
- Community Mental Health Centers (CMHCs)
- Rural and Federally Qualified Health Centers
- Psychosocial Rehabilitation/Psychosocial (adults)
- Accredited Residential Treatment Centers (RTCs)
- Non-accredited RTCs and Group Homes
- Treatment Foster Care (TFC) I and II
- Behavioral Management Services (BMS)
- Day Treatment Programs
- Comprehensive Community Support Services (CCSS)
- Assertive Community Treatment (ACT)
- Multi-system Therapy (MST)

E. Accessibility of Providers and Services

The accessibility for consumers to these provider groups is monitored quarterly and reported in the Managed Care Accessibility Analysis report. This report measures the percentage of consumers with access to the provider groups/services, as defined by the NMAC access distance standards shown in Table 2.

NMAC has established standards for access to PCPs and pharmacies, but standards for other types of specialist providers or services have not been established. To maintain a uniform measurement, OHNM uses the NMAC standards for access for all BH providers and services.

**Table 2: Access Distance Standards for Behavioral Health Services**

<table>
<thead>
<tr>
<th>Geoaccess Category</th>
<th>Access Requirement</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>One provider within 30 miles</td>
<td>90.0%</td>
</tr>
<tr>
<td>Rural</td>
<td>One provider within 60 miles</td>
<td>90.0%</td>
</tr>
<tr>
<td>Frontier</td>
<td>One provider within 90 miles</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

Table 3 shows a summary of how many of the provider groups met the standard for one provider located within 30, 60, or 90 miles of the consumer’s residence for urban, rural, and frontier areas, respectively, at least 90 percent of the time. Also displayed are the percentages of consumers who were provided the desired access for their locations and for those who did not receive the desired access.

**Table 3: Status of Provider Groups Meeting Standards for Access in FY 2012**

<table>
<thead>
<tr>
<th>Geoaccess Category</th>
<th>Total Provider Groups</th>
<th>Provider Groups Met Standard</th>
<th>Percent of Consumers with Desired Access</th>
<th>Percent of Consumers without Desired Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>20</td>
<td>16</td>
<td>88.9%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Rural</td>
<td>20</td>
<td>7</td>
<td>73.7%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Frontier</td>
<td>20</td>
<td>6</td>
<td>66.9%</td>
<td>33.1%</td>
</tr>
</tbody>
</table>

Using the data provided in the Managed Care Accessibility Analysis report measured against the NMAC Standards for Access, it was found that 16 out of 20 provider groups met the standard in the urban areas, while only seven (7) out of 20 met the standard in rural communities and six (6) out of 20 met the standard in frontier counties.

It was noteworthy that six provider groups had a high percentage of accessibility for all three geoaccess categories (93.1 percent or higher):
- All Other Licensed Providers
- CMHCs
- Psychosocial Rehabilitation/Psychosocial (adults)
In comparison, there were three providers groups that did not have adequate accessibility across the three geoaaccess categories:

- Partial Hospital Facilities
- Accredited RTCs
- MST

Although the amount and type of providers varies from year to year, the overall ratio of providers-to-consumers has remained consistently higher in urban areas and lower in the rural and frontier parts, where a greater percentage of consumers have to travel longer and farther to reach needed care.

F. Telehealth

One method that OHNM uses to fill in the service gaps, especially in the rural and frontier areas, is a video-conferencing service called Telehealth. This computer application facilitates interactive, audio-visual communication between consumers and providers via personal computers or web-accessible cellular telephones. There are three types of services being offered:

- Pharmacological management
- Diagnostic services
- Individual psychotherapy, face-to-face, 45-50 minute sessions

The Telehealth system was designed and implemented as a project a few years ago with limited use. Table 4 shows the usage of unique consumers by fiscal year.

Table 4: Telehealth Usage Comparison

<table>
<thead>
<tr>
<th>GeoAccess Category</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>1092</td>
<td>1540</td>
<td>1554</td>
</tr>
<tr>
<td>Rural</td>
<td>4214</td>
<td>5894</td>
<td>5202</td>
</tr>
<tr>
<td>Frontier</td>
<td>1782</td>
<td>2162</td>
<td>2492</td>
</tr>
<tr>
<td>Unknown</td>
<td>196</td>
<td>256</td>
<td>154</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>7284</strong></td>
<td><strong>9852</strong></td>
<td><strong>9402</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage of BH Population Using Telehealth</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.9%</td>
<td>2.1%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

An average of 2.0 percent of consumers used Telehealth in FY 2012. A breakdown by fiscal year quarter, shown in Figure 3, displays a pattern of increased usage over the first two years of the chart. But then there was a period of decline followed by a leveling off of usage toward the end of FY 2012.
In partnership with the Collaborative and the University of New Mexico’s Consortium for Behavioral Health Training & Research, OHNM has reached out to the consumers to identify why there has been a drop off in usage. OHNM is now sending consumer satisfaction surveys to Telehealth users in an effort to improve the quality of the service and better serve the consumers using the product. Surveys were not sent to previous users, so it is unclear why those consumers were no longer using the Telehealth system.

The surveys are conducted monthly and the results are updated and posted regularly on the OHNM website for public viewing. A study of these responses showed that consumers currently using Telehealth at the time of this report were happy with the service: 89.0 percent reported that they either “Agreed” or “Strongly Agreed” with the survey questions that asked for their satisfaction levels.

To get more participation in the current areas and subsequently expand the service throughout the state, OHNM has taken the following steps:

- WebEx educational sessions offered each May and November
- OHNM attendance at New Mexico Telehealth Alliance meeting for information sharing and development effort coordination
- Technology upgrade to Vidyo, a cloud-based technology to allow for simultaneous connections by multiple consumers
- Coordination with other organizations in New Mexico offering Telehealth services
- Expansion of services to include:
  - IHS and Tribal 638 sites
  - School-based health centers

OHNM’s Telehealth Project Reports sent to HSD indicate the BH SE continues to be challenged by the high costs of connectivity and difficulties in coordinating with state regions to identify potential expansion sites in rural and frontier locations.
G. Timely Access to Care

Appointment Scheduling Timeliness
When calling for an appointment, a patient can expect to be seen at a facility or in a provider’s office, based upon medical or clinical need, within the following NMAC-specified timelines:

- Crisis services: within two (2) hours
- Urgent conditions: within 24 hours
- Routine (non-urgent): within no more than 14 days, unless the consumer requests a later time

OHNM randomly tests the timeliness of providers and facilities through a “secret shopper” process. Different scenarios are devised for an OHNM Quality Improvement (QI) Specialist to act as a consumer needing one of the three types of appointments. A minimum of 10 providers or locations are to be called each month.

Figure 4 shows the percentage of providers/facilities that OHNM reported to have met the appointment standards over the last three fiscal years based on the results of the “secret shopper” telephone calls.

![Appointment Scheduling Timeliness](chart)

**Figure 4: Provider Performance for Meeting Timeliness Standards**

The data shows a downward pattern for each category over the last three years. Timely access to crisis services dropped an average of 1.3 percent, urgent conditions appointments dropped an average of 17.3 percent, and routine appointments dropped an average of 7.5 percent.

Validity of the data for FY 2011 and FY 2012 was questioned by the Collaborative when OHNM reported that there were several months during the audit period when the 10 provider contact-per-month requirement was not met. The state’s BH Oversight Team (established by the Collaborative) determined that a formal corrective action plan was required to investigate and address this situation.
In the Access Standards Time to Treatment Semi-Annual Report to HSD and in the Corrective Action Plan submitted to the Oversight Team, OHNM reported it had found that the insufficient number of calls made per month and the questionable results were caused by:

- A staffing shortage of Quality Improvement (QI) Specialists during FY 2011 and the beginning of FY 2012
- Confusion about the interpretation of the Guidance Memorandum instructions for what action to take when the calls being made connected to the provider’s answering machine instead of reaching a live person

Re-measurement of the FY 2012 data was not possible since the measurement periods had passed. Going forward, OHNM hired additional personnel and provided training to all QI Specialists, with emphasis placed on clarifying that there needs to be a minimum of 10 calls answered by a live person. Answering machine contacts are to be excluded from the measurement. The Collaborative was satisfied with the actions taken and considered the corrective action plan closed.

**Customer Service Response Time**

Many consumers choose to use the telephone to communicate their needs or ask for information. If callers do not make contact with a customer service representative in a timely manner, many will hang up. Two measures of consumer satisfaction are the timeliness of answering and the call abandonment rate. Monthly statistics are tracked by OHNM for the number of calls received, answered, and abandoned. The service call standards established by OHNM are: 90 percent of the calls must be answered within 30 seconds or less, and the abandonment rate must be 10 percent or less.

Table 5 and Figure 5 show the aggregated data and trending over time for three categories:

- English-speaking consumers calling for general customer service
- English-speaking consumers calling for care management services
- Spanish-speaking consumers calling for general customer service and/or care management services
Table 5: Aggregated Annual Telephone Call Answering Rates

<table>
<thead>
<tr>
<th>Type of Calls</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>English Customer Service</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls Received</td>
<td>51,713</td>
<td>42,934</td>
<td>36,598</td>
</tr>
<tr>
<td>Number of Calls Answered</td>
<td>51,171</td>
<td>42,714</td>
<td>36,238</td>
</tr>
<tr>
<td>Number of Calls Abandoned</td>
<td>542</td>
<td>220</td>
<td>132</td>
</tr>
<tr>
<td>Number of Calls Answered within 30 seconds</td>
<td>49,286</td>
<td>42,709</td>
<td>35,717</td>
</tr>
<tr>
<td>Percent Calls Answered within 30 seconds</td>
<td>96.3%</td>
<td>100.0%</td>
<td>98.6%</td>
</tr>
<tr>
<td>English Care Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls Received</td>
<td>3,250</td>
<td>2,813</td>
<td>3,153</td>
</tr>
<tr>
<td>Number of Calls Answered</td>
<td>3,219</td>
<td>2,795</td>
<td>3,113</td>
</tr>
<tr>
<td>Number of Calls Abandoned</td>
<td>31</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>Number of Calls Answered within 30 seconds</td>
<td>3,219</td>
<td>2,792</td>
<td>3,105</td>
</tr>
<tr>
<td>Percent Calls Answered within 30 seconds</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Spanish Care Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calls Received</td>
<td>690</td>
<td>531</td>
<td>478</td>
</tr>
<tr>
<td>Number of Calls Answered</td>
<td>675</td>
<td>505</td>
<td>465</td>
</tr>
<tr>
<td>Number of Calls Abandoned</td>
<td>15</td>
<td>26</td>
<td>10</td>
</tr>
<tr>
<td>Number of Calls Answered within 30 seconds</td>
<td>644</td>
<td>505</td>
<td>459</td>
</tr>
<tr>
<td>Percent Calls Answered within 30 seconds</td>
<td>95.4%</td>
<td>100.0%</td>
<td>98.7%</td>
</tr>
</tbody>
</table>

Incoming service calls in all measurements were answered within appropriate timeframes by OHNM. No less than 98.6 percent were answered within 30 seconds in FY 2012. In concert with that, the abandonment rate was very low: 1.2 percent or less. The Spanish-speaking care measurements were higher than the other categories in FY
2010 and FY 2011. OHNM has attributed this to new staff experiencing technical difficulties that resulted in longer wait times and subsequently more calls being abandoned. In FY 2012, the answering times and abandonment rates for both English- and Spanish-speaking customers were comparable. OHNM exceeded the standard for the three categories in all three years for both answering time and abandonment rates.

H. Access to Information
OHNM offers various avenues for consumers to obtain information and is sensitive to the cultural, linguistic, and special physical and behavioral needs of the consumers. Information can be obtained through oral, written, and electronic formats. Each of the following can be accessed by a consumer or caregiver.

Website
The OHNM website at http://www.optumhealth.com fills the role of access to the organization’s service plan. The site provides both physical and behavioral health information, links, short videos, collaborative services, financial assistance, and more for the consumer and/or family members.

Its “Resource Center for Health and Well-being” section offers educational opportunities for the consumers through subsections under the following categories:
- Featured Publications
- Upcoming Events
- Recent News

The “Building Innovations” section outlines projects created by OptumHealth Care Solutions that are being undertaken to meet the requirement for continual improvement of BH healthcare via the following methods:
- Internet access to doctors, clinicians, and specialists via webcam and secure live chat
- Cellular telephone applications for:
  - Social interacting with others for online health competitions
  - Locating physicians and other care professionals via nationwide care provider network
- Proprietary software to synchronize health information and customize healthcare interactions to fit the consumer’s personal needs

Consumer Handbook
OHNM provides each consumer with an instructional handbook in either English or Spanish at the time of enrollment with OHNM. The handbook also can be obtained in an electronic version, as well as a hard copy book. It outlines the basic benefits and services and gives key contact information for various situations. The Q & A format guides consumers to quickly find answers to commonly asked questions.

The handbooks are updated regularly to provide the most current information (at time of publishing) and correct any omissions that are discovered during regular compliance auditing. The most recent version available was dated June 2011 and was found to be in compliance with the NMAC regulation and the HSD contract. Because hard copy materials go out of date, consumers are encouraged to check the website for the
Provider Network
Along with a consumer handbook, OHNM supplies a hardcopy manual containing a current listing of the core service array of providers at the time of enrollment. This book is written in both English and Spanish and is updated annually.

The website contains a link to the entire provider network. These listings are updated as needed, but at least quarterly, and offer the most up-to-date information. For consumers who do not have Internet access or otherwise may need assistance in selecting a provider or facility, they can contact a Peer Specialist or Family Specialist in their local/regional offices.

Both the hard copy manual and the on-line provider network has complete information regarding how to select a provider, descriptions of the types of providers, definitions of often-used terms, listing of the different funding sources (Medicaid and Non-Medicaid), and shows a sample provider listing with a breakdown of what each line of information means.

OHNM’s Network Management and Contracting staff monitors the network to identify gaps to access and availability for OHNM consumers in rural, urban, and frontier areas. The Network Operations staff continuously and actively seeks out and recruits qualified providers to add to the network that are intended to meet the needs of the consumers. OHNM’s Network Provider Relations department monitors the provider listings for both accuracy and adequate accessibility, and reports its findings to the Statewide Quality Improvement/Quality Management Council and relevant Collaborative oversight committees.

Services Support Lines
OHNM offers a 24/7 toll-free telephone line to consumers and their family members. The Language Line is available for providers and for consumers with limited English. It can be accessed through a customer service representative for brief conversations or help in an emergency. Additionally, there is a toll-free TTY line for hearing-impaired consumers needing customer service.

OHNM provides a listing of several telephone numbers for related services and publishes them in the handbook and on the website. These include:

- Pharmacy services
- Provider relations
- Utilization management
- Fraud, waste, and abuse hotline
- Physical Health MCO medical and dental services
- Statewide hotlines to report adult/child abuse or neglect
- HSD/MAD
- Department of Health (DOH)/Developmental Disabilities Support Division
- Social Security Administration
- Aging and Long-Term Services Department
- Care coordinator or family/peer support specialist
I. Actions Taken to Improve Access
The BH SE evaluates itself at least annually and implements corrective actions or quality improvements when appropriate. Beginning in FY 2012, OHNM developed the following list of corrective actions to affect improvement for access to care:

- On an annual basis, give providers an alert/announcement on access standards and requirements
- Provide a QI Specialist presentation at all regional provider meetings on access data and standards
- Provide technical assistance during on-site facility reviews for providers with identified deficiencies
- Assign a Provider Relations Specialist or QI Specialist to perform targeted outreach to providers with identified deficiencies, present them with their specific results, educate them on the access standards, and offer technical assistance
- Identify and select providers for additional measurement during the six-month period following technical assistance education
- At the QI Council and regional provider meetings, offer opportunities for education on the provider network by sharing the performance information on access data and standards

J. Summary of Access Findings
After reviewing and analyzing the relevant reports and data for OHNM, it appears that OHNM met the access requirements. However, there was room for improvement for physical access and timely access to providers and/or services.

- **Geoaccess:** During FY 2012, there was accessibility to providers and services in all parts of the state. Overall BH SE population breakdown: urban 45 percent, rural 45 percent, frontier ten (10) percent. Provider population: urban 64 percent, rural 28 percent, frontier eight (8) percent. Approximately 80 percent of the consumers had access that met the NMAC standards, while 20 percent may have needed to travel further or longer to access a provider or service location. (See pages 12-13, Figure 1-2, Tables 1-2.)

- **Provider-to-consumer comparisons:** There was an abundance of providers in urban areas when compared to the population living there, while the rural areas were under-served. The frontier areas had a close ratio between percentage of population and percentage of providers. (See pages 13-14, Figure 2, Table 1.)

- **Proximity of providers and services to consumers:** 16 out of 20 provider groups met the standard in the urban areas, while only seven (7) out of 20 met the standard in rural communities and six (6) out of 20 met the standard in frontier counties. (See pages 14-16, Tables 2-3)

- **Telehealth:** OHNM implemented a project using a video-conferencing service called Telehealth to fill in the service gaps, especially in the rural and frontier areas. There are three types of services being offered: Pharmacological management; Diagnostic services; and Individual psychotherapy, face-to-face, 45-50 minute sessions. About 2.0 percent of the
BH population used Telehealth in FY 2012. (See pages 16-17, Figure 3, Table 4.)

- **Appointment scheduling timeliness**: The appointment scheduling data provided showed only 85 percent of crisis events, 51 percent of urgent, and 60 percent of routine appointments met the scheduling standards in FY 2012. This data is questionable and re-measurement is not possible since the measurement periods have passed. OHNM investigated and corrected issues with understaffing and confusion about collecting and recording data for calls answered by an answering machine. The Oversight Team of the Collaborative was satisfied that data are being collected and recorded correctly now and closed the corrective action plan which had been requested of OHNM. (See pages 18-19, Figure 4.)

- **Timeliness of obtaining information**: 98.6 percent or more of service center calls were answered within 30 seconds in FY 2012 and the abandonment rate was 1.2 percent or less. (See pages 19-21, Figure 5, Table 5.)

- **Avenues of informational access**: Consumers and/or caregivers can obtain information through: website, consumer handbooks, provider network listings, and service support telephone lines. Formats available are oral, written, and electronic. Cultural and linguistic needs have been taken into account. (See pages 21-23.)

- **Self-evaluation and improvement**: OHNM performs regular and periodic self-evaluations, creates improvement work plans, and implements actions to facilitate positive changes regarding access to care. (See page 23.)

V. **Quality of Care Assessment**

A. **Introduction**

While the assessment for access to care looks at what kind and how much service is being provided to consumers, quality of care is examined to determine the level of excellence of those services and the strength of the foundation upon which the services are built. The following topics were reviewed and analyzed to ascertain the quality of care provided to consumers by OHNM and how well consumer needs were being met:

- QM/QI program
- PMs
- PIPs
- Utilization management
- Grievances and appeals
- Provider and consumer satisfaction surveys
- External quality review and audits

B. **NMAC Regulations and Contract Requirements**

The requirements for quality of care are found in NMAC 8.305.8.12 (Standards of Quality Management) and in the HSD/OHNM contract in various parts of Article 3, especially in Section 3.12, Quality Assurance. The contract is very detailed and many of the HSD-required reports that must be submitted are measurements of the quality of care and services provided by the BH SE.
While the contractual obligations and requirements are specific, how it is accomplished is at the discretion of the BH SE. The program that is established must be based on the Continuous Quality Improvement/Total Quality Management (CQI/TQM) model. Additionally, there must be an annual QM/QI work plan created outlining specific interventions to be utilized to improve quality targets and timelines for evaluation.

Contract requirements can be broken down into three main categories:

**Establishment of a Quality Program**
- Institute QM/QI Plan to address NMAC requirements
- Establish a committee to oversee and implement QM/QI activities
- Create transparency in the system through communication and exchanges of non-confidential information with stakeholders
- Devise a Cultural Competency Plan to demonstrate an understanding of cultural issues and proficiency to address the needs of diverse populations
- Apply the QM/QI Program to the entire range of covered services and all major demographic population groups; conduct internal surveys for consumer satisfaction levels to obtain feedback for these services

**Continuous Improvement**
- Conduct an annual evaluation of overall effectiveness to demonstrate improvements in quality of clinical and non-clinical services to consumers
- Include activities that provide continuous monitoring and regular evaluation; show evidence that corrective action is implemented, as necessary
- Identify opportunities for improvement, initiate targeted quality interventions, and monitor the interventions’ effectiveness
- Conduct Collaborative-selected quality studies (PIPs), one of which relates to ISHCN consumers
- Develop and implement a statewide critical incident management system that identifies and tracks critical incidents, corrects case-specific issues, and identifies systems’ issues that place consumers at risk
- Submit to external audits and use the findings as a basis for continuous improvement activities

**Quality Measurement**
- Conduct data-driven evaluations of clinical practices to improve quality of care
- Establish, measure, and track PMs
- Survey consumers and providers annually for satisfaction levels and feedback
- Monitor and evaluate providers; provide training and technical assistance to providers to improve their performance, as needed
- Collect, track, and analyze grievances and appeals filed by consumers and providers

**C. Quality Management/Quality Improvement Program**
A QM/QI program starts by looking at the organization and the internal quality programs or structures that are in place within the organization. This is followed by collecting data
on organizational performance measures, customer satisfaction surveys, and outreach interactions. All that information is combined into a plan of action to address quality issues and implement improvement projects. An examination of applicable reports revealed that OHNM created a comprehensive QM/QI Program Description and evaluated itself annually on its quality performance.

QM/QI Plan
OHNM established a QM/QI Plan based on the QM/QI Program Description and maintained several measurement and tracking reports to collect the data to monitor this plan on a regular and continuous basis. In addition, OHNM compiled an annual QM/QI program evaluation, divided into three reports consisting of: a current program description, the work plan outlining the steps to achieve the goals of the program, and a data-driven evaluation. These evaluation summaries and supporting measurement and tracking reports were reviewed, and OHNM was found to be compliant with the contract and applicable NMAC regulations.

Communication and Transparency
OHNM communicated and maintained transparency by gathering and conferring with the following stakeholders at various planning, committee, and council meetings:

- Consumers, youth, and families
- Providers
- The Collaborative
- Local Collaboratives
- Consortium for Behavioral Health Training & Research
- Native American tribes, nations, pueblos
- Other stakeholders

In addition to regular and inclusive meetings, various other methods were used to maintain communication and transparency, such as:

- Education and training sessions
- Newsletters
- Website news and updates sections

Cultural Competency Plan
OHNM’s Cultural Competency Plan focused on developing policies and practices that incorporate the concepts of equal and nondiscriminatory services matched to the unique cultural and linguistic needs of New Mexico consumers.

OHNM established several committees to assure inclusion of the multiple cultural and linguistic groups in the state, and met with representatives either monthly or quarterly.

- Multicultural Services Advisory Committee (MSAC)
- The Tribal Advisory Committee (TAC)
- Hispanic Advisory Committee (HAC)
- Lesbian, Gay, Bi-sexual Transgender Advisory Committee (LGBTAC)
- Disability Advisory Council (DAC)

A self-assessment survey was implemented in FY 2011 that provided a quantitative examination of OHNM’s demographic profile and staff knowledge of practices and procedures essential for producing services that are culturally and linguistically
accessible. The MSAC, HAC, TAC, DAC, LGBTAC, and HSD approved the survey tool. Data from this tool was used to develop learning objectives and update the OHNM Diversity Work Plan.

Table 6 shows a breakdown of the OHNM consumer demographics as they relate to culture and primary language spoken (for those not speaking English as the first language).

**Table 6: OHNM Percentage by Culture and Linguistics**

<table>
<thead>
<tr>
<th>Race and Language</th>
<th>Number of Consumers Served</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ethnic Background</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian/Pacific Islander/Alaskan</td>
<td>144</td>
<td>0.2%</td>
</tr>
<tr>
<td>Black (African American)</td>
<td>1,722</td>
<td>2.0%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>40,192</td>
<td>46.6%</td>
</tr>
<tr>
<td>Native American</td>
<td>7,222</td>
<td>8.4%</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>23,379</td>
<td>27.1%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>1,020</td>
<td>1.2%</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>12,505</td>
<td>14.5%</td>
</tr>
<tr>
<td><strong>Languages other than English spoken</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td></td>
<td>31.0%</td>
</tr>
<tr>
<td>French</td>
<td></td>
<td>4.0%</td>
</tr>
<tr>
<td>Navajo</td>
<td></td>
<td>1.0%</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>64.0%</td>
</tr>
</tbody>
</table>

D. Performance Measures

HSD and the Collaborative identified three PMs as quality indicators for OHNM. Although there is a long list of potential PMs, the following were selected at the time of the BH carve-out and have remained the same over time:

- PM 1: Residential Treatment Center (RTC) readmissions within 30 days to same level of care or higher
- PM 2: Psychiatric hospital discharge follow-up within seven (7) days
- PM 3: Psychiatric hospital discharge follow-up within 30 days

Table 7 shows OHNM's PM results, which measure all BH consumers (i.e. both Medicaid and FFS)\(^3\). Data for this report were obtained from OHNM’s quarterly Residential Treatment Center Readmissions reports (CI-24) for PM 1 and from the Discharge Follow-Up Within 7 & 30 Days reports (PM 4.2 i.1 and PM 4.2 i.2) for PM 2 and PM 3, respectively. The percentages listed in the table refer to percentage of occurrence. Lower numbers are desired for readmissions and higher numbers are desired for follow-up activity.

---

\(^3\) The Guidance Memorandum (instruction to the BH SE for HSD report construction) requires OHNM to track all consumers for the performance measures and does not break down the information into separate lines of business. Therefore, Table 7 is all inclusive.
Table 7: OHNM’s Performance Measures Results

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>PM #1 - RTC Readmissions within 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions to an RTC</td>
<td>3.2%</td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Admission to an inpatient psychiatric hospital</td>
<td>5.3%</td>
<td>10.3%</td>
<td>7.6%</td>
</tr>
<tr>
<td>Adults Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions to an RTC</td>
<td>1.9%</td>
<td>0.8%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Admission to an inpatient psychiatric hospital</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Combined (Adult and Children)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions to an RTC</td>
<td>2.8%</td>
<td>0.7%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Admission to an inpatient psychiatric hospital</td>
<td>3.7%</td>
<td>3.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Treatment Foster Care (Post-TFC Discharge)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmissions to TFC</td>
<td>3.9%</td>
<td>2.3%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Admissions to RTC</td>
<td>3.3%</td>
<td>2.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Admission to an inpatient psychiatric hospital</td>
<td>3.1%</td>
<td>7.9%</td>
<td>6.0%</td>
</tr>
<tr>
<td>PM #2 - Psychiatric Hospital Discharge Follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up within 7 days</td>
<td>34.5%</td>
<td>36.5%</td>
<td>39.7%</td>
</tr>
<tr>
<td>PM #3 - Psychiatric Hospital Discharge Follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-up within 30 days</td>
<td>52.7%</td>
<td>57.6%</td>
<td>60.3%</td>
</tr>
</tbody>
</table>

PM #1: The percentage of combined (adults and children) readmissions increased slightly from 0.7 percent in FY 2011 to 1.1 percent in FY 2012, but because of the noticeable improvement from the FY 2010 percentage (2.8 percent), it shows an overall downward pattern.

PM #2 and PM #3: For these two measures, the FY 2012 percentages (39.7 and 60.3 percent, respectively) were slightly higher than in FY 2011 (36.5 and 57.6 percent) and in FY 2010 (34.5 and 52.7 percent), indicating that discharge follow-up activity is increasing.

E. Performance Improvement Projects

OHNM engages in various PIPs that are identified during internal quality process self-audits. Only two of the PIPs are required by contract to be externally audited. As stated in the contract, one PIP must relate to the Individuals with Special Health Care Needs (ISHCN) consumers. The other PIP needs to be a clinically-related issue identified by, and based on, internal quality process findings and/or on recommendations from HSD, EQRO, or the Collaborative. The following PIPs were selected at the beginning of the contract and continue to be measured for improvement over time:

- PIP #1: Reduction of RTC Readmissions within 30 Days
- PIP #2: ISHCN Outpatient Follow-up

Table 8 shows the OHNM PIPs results. Red font indicates that the rate is below the target goal.
### Table 8: OHNM Performance Improvement Project Results

<table>
<thead>
<tr>
<th>Performance Improvement Projects</th>
<th>Goal</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PIP #1 - Reduction of RTC Readmission w/in 30 Days</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Consumers Readmitted to an RTC or Inpatient Psychiatric Hospital</td>
<td>2.0% reduction</td>
<td>4.6%</td>
<td>3.5%</td>
<td>4.1%</td>
</tr>
<tr>
<td><strong>PIP #2 - ISHCN Outpatient Follow-up</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of Consumers who Initiated Outpatient Treatment within 7 days of Inpatient Stay</td>
<td>44.5%*</td>
<td>40.6%</td>
<td>43.4%</td>
<td>47.5%</td>
</tr>
<tr>
<td>Percentage of Consumers who remain in Outpatient Care for longer than 90 days</td>
<td>80%**</td>
<td>76.0%</td>
<td>77.8%</td>
<td>84.3%</td>
</tr>
</tbody>
</table>

* Industry Benchmark  
** Internal benchmark set by OHNM

PIP #1 showed little change over the three years measured and did not meet the BH SE’s internal goal of a 2.0 percent reduction from the baseline year. For PIP #2, OHNM’s scores improved over time, and exceeded the goals in FY 2012.

### F. Utilization Management

Utilization management (UM) touches on all aspects of the quality of care provided by OHNM. The goal of a UM program is to manage the medical care of its consumers by effectively utilizing existing resources, while assuring that quality care is delivered in the most cost-effective and safest manner possible. NMAC 8.305.8.13 states that the UM program shall be based on standard external national criteria and established clinical criteria that are congruent with HSD’s definition of medical necessity. This is to make sure that each decision is as fair, impartial, and consistent as possible.

The Level of Care (LOC) guidelines that were established by OHNM in conjunction with the Collaborative are used to make medical necessity determinations. They are derived from the American Society of Addiction Medicine Patient Placement Criteria, Second Edition-Revised (ASAM PPC-2R) and the Best Practice Guidelines approved for use by United Behavioral Health (UBH) Behavioral Solutions. The LOC guidelines are established to meet the needs of the BH target population within the state.

Medical necessity is determined by the severity of illness, intensity of service, and appropriateness of level of care. Utilization activities are reviewed to determine whether or not the service rendered is medically necessary. Appropriately licensed and experienced healthcare practitioners are contracted with OHNM to perform the following types of review for both inpatient and outpatient services:

- Prospective
- Pre-determinations
- Concurrent
- Retrospective
- Medical claims

### Service Utilization Rates

UM standards are to be applied consistently so the services provided are not either over- or under-utilized. OHNM had 480,017 consumers in FY 2012, 84,487 of which used BH
services. Table 9 shows OHNM’s service utilization rates for the last three years. Figure 6 shows the percentage of usage in each service category.

Table 9: OHNM Overall Service Utilization Rates

<table>
<thead>
<tr>
<th>Service Utilization Rates</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters</td>
<td>3,878,153</td>
<td>3,921,666</td>
<td>3,341,001</td>
</tr>
<tr>
<td>Plan Population</td>
<td>385,058</td>
<td>479,982</td>
<td>480,017</td>
</tr>
<tr>
<td>Utilization Rate (# consumer visits/yr)</td>
<td>10.1</td>
<td>8.2</td>
<td>7.0</td>
</tr>
</tbody>
</table>

The overall service utilization rate for OHNM has shown a steady decline over the last three years. In FY 2012, it averaged 7.0 visits per consumer to a service provider per year. OHNM attributes this decline in utilization to a reduction in consumers being readmitted into hospitals or other treatment facilities brought about by better follow-up after the initial hospitalization.

OHNM added a new section in the OHNM Level of Care Guidelines document toward the end of FY 2011 dedicated exclusively to discharge planning. This discharge planning guide helps communicate expectations and responsibilities. OHNM trained its internal UM team and the BH providers about discharge planning in general, as well as on the process for asking about providing appropriate discharge planning during clinical reviews.

Data collected by OHNM regarding various service utilization categories and reported in the Service Utilization (Encounters) Report to HSD, shown in Figure 6, seems to support OHNM’s conclusion that educating the UM staff and the providers about discharge activities led to a reduction in readmissions and better follow-up after hospitalization.

Figure 6: Service Utilization by Category

<table>
<thead>
<tr>
<th>Service Utilization by Category</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>9.4%</td>
<td>8.6%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>4.0%</td>
<td>5.0%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Outliers</td>
<td>1.4%</td>
<td>0.7%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>27.4%</td>
<td>31.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Recovery</td>
<td>15.4%</td>
<td>15.2%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Residential</td>
<td>38.5%</td>
<td>35.5%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Value Added Services</td>
<td>3.9%</td>
<td>3.9%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

Independent Assessment of Behavioral Health Statewide Entity
The percentages of usage within each service category remained about the same over the three-year period, except for Outpatient services (which increased from 27 percent to 36 percent) and Residential (which decreased from 39 percent to 32 percent). The focus has been in keeping consumers in community-based services.

**Denials**

If a consumer’s request does not meet the specified UM criteria, the service will be denied. A comparison of the amount of denials to the amount of claims submitted is shown in Table 10.

<table>
<thead>
<tr>
<th>Table 10: Denial of Claims Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Denial Rates</strong></td>
</tr>
<tr>
<td>Total Claims Lines</td>
</tr>
<tr>
<td>Total Denied Claim Lines</td>
</tr>
<tr>
<td>Percent Denied</td>
</tr>
</tbody>
</table>

The table shows the percentage of denials has been decreasing over the last two years. OHNM reported to HSD in its BH Detail Denials report and the Annual UM Plan Evaluation report that denial rates dropped in FY 2011 and FY 2012 due to extensive provider education to bring about more timely claims and reduce duplicate submissions (the top two reasons for denials).

During FY 2011 and beginning of FY 2012, OHNM was completing the FY 2010 Reconciliation project for all providers and the reprocessing of claims for the Clinical Trigger project. Denial criteria had been changed during FY 2010 that resulted in an increase in the amount of denials, along with an increase in grievances and appeals received due to this tightening of the clinical trigger criteria. The two projects were conducted to re-examine the claims and/or appeals and adjust the UM approval/denial status, as appropriate. Because of this re-examination, many previously denied claims were subsequently approved, as evidenced in the reduced amount of denials in FY 2011 and FY 2012.

**Critical Incidents**

OHNM collected and tracked data for critical incidents around the state. A critical incident is an occurrence that represents actual or potentially serious harm to the well-being of the OHNM consumer (or to others by an OHNM consumer) who is in active BH treatment or has been recently discharged from BH treatment. Table 11 shows the total amount and type of incidents that have occurred over the last three years.
Incidents have been increasing, especially in the Detention for Criminal Activity, Injuries/Emergency Services, and Medication or Treatment Errors categories.

In addition to collecting data and monitoring the incidents, OHNM is also expected to review the information to identify systems issues and implement performance improvement activities. In FY 2012, OHNM focused on the following areas:

- Routing of all reported incidents to one individual to provide consistency in reporting/tracking
- Creation of an MS Access database for centralized, electronic data collection and evaluation
- Increase of training and technical assistance to providers regarding incident criteria and submittal process
- Review of aggregated incident data of elopements (the third highest incident reported) for causes and possible interventions
- Focus on consumer suicides and homicides through monthly meetings between OHNM’s Chief Medical Officer and the investigating QI Specialist for cases requested by the state Oversight Team
- Identification of six specific quality of care issues that appear to be common to most sentinel events during FY 2012

<table>
<thead>
<tr>
<th>Critical Incidents</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect</td>
<td>59</td>
<td>134</td>
<td>96</td>
</tr>
<tr>
<td>Adverse Reaction to Treatment</td>
<td>2</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Assault</td>
<td>98</td>
<td>116</td>
<td>62</td>
</tr>
<tr>
<td>Attempted Homicide</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Attempted Suicide</td>
<td>35</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Damage to Property</td>
<td>47</td>
<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Detention for Criminal Activity</td>
<td>177</td>
<td>372</td>
<td>422</td>
</tr>
<tr>
<td>Detention for Protective Custody</td>
<td>4</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Elopement</td>
<td>229</td>
<td>186</td>
<td>172</td>
</tr>
<tr>
<td>Emergency Services</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Environmental Hazard</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Financial Exploitation</td>
<td>0</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Homicide</td>
<td>0</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Injuries</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Injuries/Emergency Services</td>
<td>314</td>
<td>272</td>
<td>479</td>
</tr>
<tr>
<td>Involuntary Hospitalizations</td>
<td>29</td>
<td>22</td>
<td>13</td>
</tr>
<tr>
<td>Medication or Treatment Errors</td>
<td>2</td>
<td>21</td>
<td>57</td>
</tr>
<tr>
<td>Other</td>
<td>26</td>
<td>23</td>
<td>30</td>
</tr>
<tr>
<td>Other Death</td>
<td>40</td>
<td>34</td>
<td>49</td>
</tr>
<tr>
<td>Self-Injurious Behavior (non-lethal intent)</td>
<td>28</td>
<td>31</td>
<td>26</td>
</tr>
<tr>
<td>Sexual Behavior</td>
<td>108</td>
<td>62</td>
<td>97</td>
</tr>
<tr>
<td>Suicide</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>1205</strong></td>
<td><strong>1359</strong></td>
<td><strong>1574</strong></td>
</tr>
</tbody>
</table>
G. Grievances and Appeals
The Member Grievance System allows the consumers to formally voice their concerns to OHNM. These concerns are taken seriously since any grievance (complaint) may indicate a problem that OHNM needs to address across its system. OHNM has established procedures in accordance with NMAC regulation 8.305.12 and the HSD/OHN M contract to provide thorough and consistent investigation and responses to the concerns.

A grievance is any expression of dissatisfaction, either oral or written, and can be either:
- Consumer grievance – dissatisfaction with OHNM or its operation
- Provider grievance – dissatisfaction with OHNM and/or to OHNM regarding UM decisions, any provider payment issues, or other provider-related issues

An appeal is a request from a consumer or a provider to change a previous decision made by OHNM, usually in response to denial of service or claim payment. This could include an expedited appeal (where an immediate response is needed) and/or a fair hearing process (which is a request made to HSD for reconsideration of the original appeal resolution made by the BH SE).

Grievances
OHNM tracked the number and type of grievances and appeals received. Table 12 shows the amount received and percentage of each category.

Table 12: Total Consumer and Provider Grievances by Complaint Category

<table>
<thead>
<tr>
<th>Type of Grievance</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consumer</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>3.0%</td>
</tr>
<tr>
<td>Consumer Services</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>5.1%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>38</td>
<td>45</td>
<td>59</td>
<td>71.7%</td>
</tr>
<tr>
<td>Claims Issues</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>6.1%</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2.0%</td>
</tr>
<tr>
<td>Pharmacy Formulary/Prior Authorization</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>2.5%</td>
</tr>
<tr>
<td>Transportation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>13</td>
<td>5</td>
<td>1</td>
<td>9.6%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>68</strong></td>
<td><strong>61</strong></td>
<td><strong>69</strong></td>
<td><strong>100.0%</strong></td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3.6%</td>
</tr>
<tr>
<td>Consumer Services</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3.6%</td>
</tr>
<tr>
<td>Quality of Care</td>
<td>6</td>
<td>9</td>
<td>3</td>
<td>21.4%</td>
</tr>
<tr>
<td>Claims Issues</td>
<td>4</td>
<td>35</td>
<td>3</td>
<td>50.0%</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>4.8%</td>
</tr>
<tr>
<td>Pharmacy Formulary/Prior Authorization</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2.4%</td>
</tr>
<tr>
<td>Transportation</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>14.3%</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>18</strong></td>
<td><strong>58</strong></td>
<td><strong>8</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>
Looking at the aggregate for the last three years, the highest percentage of consumer grievances was in the “Quality of Care” (QOC) category (71.7 percent). When looked at on a year-by-year basis, QOC complaints totaled 38 (55.9 percent) in FY 2010, 45 (73.8 percent) in FY 2011, and 59 (85.5 percent) in FY 2012. There is a sharp upward pattern during this time period. OHNM’s CI-02 Collaborative Complaints and Grievances report analysis lists the predominant reason for QOC complaints received to be related to the quality or appropriateness of the care provided by a practitioner or facility. OHNM contends that any grievance with the potential to be QOC is categorized and counted as such upon receipt, but the grievance may be re-categorized upon review. There was no indication provided by OHNM of what might be causing the rise in QOC complaints while the overall amount of grievances received remained fairly steady.

Although the three-year aggregate shows that 50.0 percent of the provider grievances were mostly related to “Claims Issues,” this high aggregate percentage was caused by a spike seen in FY 2011. OHNM attributes this to one or more providers filing grievances over the denial of transitional living services (TLS). The normal process of filing an appeal was not available to the provider(s) because TLS is a value-added service. The overall amount of provider grievances received in FY 2012 returned to that comparable to FY 2010.

**Appeals**

Consumers and providers voiced their concerns regarding denials of service and/or claims payments by filing appeals to OHNM to reconsider its decisions. The amounts of appeals and comparative ratios (one [1] out of “X” number of consumers) are shown in Table 13.

**Table 13: OHNM Appeals**

<table>
<thead>
<tr>
<th></th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine &amp; Expedited Appeals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Population</td>
<td>385,058</td>
<td>479,982</td>
<td>480,017</td>
</tr>
<tr>
<td>Number of Consumer Appeals</td>
<td>186</td>
<td>308</td>
<td>398</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 2,070</td>
<td>1 : 1,558</td>
<td>1 : 1,206</td>
</tr>
<tr>
<td>Number of Provider Appeals</td>
<td>9</td>
<td>80</td>
<td>450</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 42,784</td>
<td>1 : 6,000</td>
<td>1 : 1,067</td>
</tr>
<tr>
<td>Number of Expedited Appeals</td>
<td>145</td>
<td>268</td>
<td>330</td>
</tr>
<tr>
<td>Ratio</td>
<td>1 : 2,656</td>
<td>1 : 1,791</td>
<td>1 : 1,455</td>
</tr>
<tr>
<td><strong>Total Appeals</strong></td>
<td>340</td>
<td>656</td>
<td>1,178</td>
</tr>
<tr>
<td><strong>Overall Ratio</strong></td>
<td>1 : 1,133</td>
<td>1 : 732</td>
<td>1 : 407</td>
</tr>
</tbody>
</table>

Although all categories of appeals show an increase over the last three years, there was a sharp rise in the amount of provider appeals. OHNM investigated this at the request of HSD and the Collaborative and reported that these were primarily in the Claims Issues category and related to the Clinical Triggers project.
H. Provider and Customer Satisfaction

Provider Satisfaction
The BH SE conducts annual provider surveys to gauge the satisfaction of providers with the services they receive from OHNM. The information collected is used to improve service to the providers going forward.

Fact Finders, an independent research organization, conducted the FY 2012 survey, tabulated the results, and provided an analysis report to OHNM. They compiled a stratified, random sample (N=930) selected from among all of OHNM’s providers. The sample included individual providers, as well as facilities, and was representative of all six regions. Data was collected via telephonic and on-line questionnaires. A total of 232 providers participated, making it a 24.9 percent response rate.

The questionnaire consisted of 86 questions related to seven topics:
- Overall Satisfaction
- Customer Service
- Communications
- Training
- Website
- Claims
- Authorizations/Registration

Two questions most pertinent to OHNM and highlighted in the report provided by Fact Finders related to “Overall Satisfaction” and the perceived “Trend in Service” being provided. A summary of the results can be seen in the figures below.

**Figure 7: Overall Satisfaction of Providers with OHNM**

Overall satisfaction with services has risen since OHNM became the BH SE in FY 2009. In FY 2010, 75.1 percent of providers were “Very Satisfied” or “Somewhat Satisfied.” In FY 2012, the percentage had risen to 88.8 percent.
Over the last three years, the percentage of providers who felt that service was “Staying the Same” rose steadily—starting at 43.7 percent and rising to 54.3. A small percentage (3.0 percent or less) voiced “No Opinion” during this time period. The remaining providers surveyed felt services were either “Improving” or “Getting Worse.” In FY 2010 and FY 2012, the majority of those felt the services were “Improving” (44.7 and 37.5 percent, respectively), with a small percentage of respondents feeling that services were “Getting Worse” (8.8 and 5.2 percent). But in FY 2011, there was a significant change in the responses. Those who felt services were “Improving” dropped to 29.6 percent and those who felt services were “Getting Worse” rose to 18.5 percent.

In addition to the established survey questions, participants were also asked for their feedback and suggestions. OHNM used that information from the providers given on the FY 2011 survey and implemented changes that resulted in improved overall satisfaction, as reflected by the scores on the FY 2012 survey.

**Customer Satisfaction**

BH consumers were surveyed by the New Mexico Consumer/Family Satisfaction Project at the direction of the Collaborative to determine their satisfaction levels with OHNM. The results of the surveys were reviewed by the QM/QI Council, and the feedback obtained was used in making adjustments and improvements to the quality plan with a focus on the domains that scored the lowest. Three surveys were conducted:

- Adult: 18 years old and older
- Child/Family: Infant - 13 years old (adult family member responded for child)
- Youth: 12 - 18 years old (adolescent responded him/herself)

The Adult and Child/Family surveys were combined into one report, and the Youth survey was scored and reported separately.
Adult and Child/Family Surveys
Participants were randomly selected from among all OHNM consumers and consisted of consumers from all six regions of the state and all demographic groups (race, ethnicity, age, and gender). They were polled through either face-to-face interviews or via telephone.

Questions on the survey referred to services received during the first six months of the fiscal year. There were five categories of questions, called Domains of Service, defined in the report as:

- **Access** – “Entry into behavioral health services is quick, easy, and convenient”
- ** Appropriateness** – “Services are individualized to address a consumer’s strengths and needs, cultural context, preference, and recovery goals”
- **Satisfaction** – “Adults, youth, children, and families are generally happy with the services they are provided”
- **Effectiveness** – “The extent to which services provided to individuals with behavioral health needs have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery”
- **Empowerment** – “The perception by individuals and families that they have more control of their situations and the available encouragement, support, and techniques offered by the providers”

The answers were scored with a five-point scale or a “not applicable” selection, divided into the following response categories:

- **Positive**
  - 1 = Strongly Agree
  - 2 = Agree
- **Neutral**
  - 3 = Neutral/No Opinion
- **Negative**
  - 4 = Disagree
  - 5 = Strongly Disagree
- **Not Applicable**
  - 9 = N/A

Table 14 shows a comparison of consumer satisfaction levels for the past three years for the Adult and the Child/Family surveys.
Table 14: OHNM Customer Satisfaction with Behavioral Health Services

<table>
<thead>
<tr>
<th>Survey Domains</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Survey</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>81.0%</td>
<td>83.0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>80.0%</td>
<td>83.0%</td>
<td>82.0%</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>80.0%</td>
<td>83.0%</td>
<td>81.0%</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>61.0%</td>
<td>63.0%</td>
<td>62.0%</td>
</tr>
<tr>
<td>Empowerment</td>
<td>75.0%</td>
<td>79.0%</td>
<td>77.0%</td>
</tr>
<tr>
<td><strong>Average - Overall Satisfaction</strong></td>
<td>75.4%</td>
<td>78.2%</td>
<td>76.6%</td>
</tr>
<tr>
<td><strong>Child/Family Survey</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access</td>
<td>85.0%</td>
<td>85.0%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Appropriateness</td>
<td>88.0%</td>
<td>89.0%</td>
<td>89.0%</td>
</tr>
<tr>
<td>Satisfaction</td>
<td>87.0%</td>
<td>88.0%</td>
<td>86.0%</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>54.0%</td>
<td>53.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Empowerment</td>
<td>90.0%</td>
<td>91.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td><strong>Average - Overall Satisfaction</strong></td>
<td>80.8%</td>
<td>81.2%</td>
<td>81.4%</td>
</tr>
</tbody>
</table>

The table shows a slight decrease in satisfaction in all categories of the Adult survey for FY 2012, but the overall pattern for each domain over time was upward. “Access,” “Appropriateness,” “Satisfaction,” and “Empowerment” were running fairly even (between 77 and 82 percent) and they have been so for the last several years. Consumer satisfaction with “Effectiveness” was much lower than the other domains at 62 percent.

For the Child/Family survey results, “Empowerment” ranked the highest at 90 percent. “Appropriateness,” “Satisfaction,” and “Access” ranked between 86 and 89 percent. Again, “Effectiveness” was the lowest ranking domain at 56 percent.

**Youth Satisfaction Survey**

The Youth Satisfaction survey is administered by trained youth evaluators through telephone interviews. It is designed to be a survey developed and implemented by youth, for youth, to give this group a way to voice their level of satisfaction with services received. The survey is an abbreviated format compared to the Child/Family survey, focusing on just two domains:

- Satisfaction with Services
- Effectiveness of Services

Figure 9 shows the Youth Satisfaction levels for the last three years.
The percentage for “Satisfaction with Services” for youth remained steady over the last three years, varying only two percentage points during that time. This level of satisfaction for the youth consumers (87.2 percent) was very comparable to the child/family consumers (86.0 percent positive responses for “Satisfaction”).

The percentage for “Effectiveness of Services” displayed a downward pattern for the last three years, (ranging from 84.2 percent down to 81.8 percent). It is interesting to note that the FY 2012 Youth survey result was considerably higher than the Child/Family response of 56.0 percent.

I. External Reviews

EQRO

External quality review is a contract requirement designed to achieve compliance with the CMS protocols. As HSD’s EQRO, HealthInsight New Mexico performs three annual audits of the BH SE:

- Compliance with regulations and HSD/OHNMT contract
- PMs evaluation
- PIPs evaluation

Each of the audits is planned and the tools are created based on the CMS protocols for EQRO. Protocol 42 CFR 438.352 applies to the Compliance audit and 42 CFR 438.240 (Conducting Performance Improvement Projects) is for the PMs and PIPs. These protocols have been designed to be consistent with industry standards, accommodate evolution of quality assessment, and provide state Medicaid agencies with technical assistance.
A numeric score is assigned to each element in the performance criteria in the tools and the maximum total points determined. The individual measurement scores are summed and aggregated. Then an overall percentage score is determined and interpreted as follows:

- Full compliance: 90%-100%
- Moderate compliance: 80%-89%
- Minimal compliance: 50%-79%
- Non-compliance: < 50%

**FY 2012 Audits**

Compliance was evaluated by comparing OHNM’s documentation (policies, procedures, and processes) along with a stratified and randomly selected sample of case files against 15 applicable NMAC 8.305 regulations and subsets and the HSD Letter of Direction (LOD) #174 for Program Integrity. Scores were recorded on the HSD-approved audit tools. The audit approach and methodology used consisted of document reviews, file reviews, and interviews with OHNM staff. Findings were combined into one report.

The PMs and PIPs were reviewed together and, although they were scored separately, the results were combined into one report because the PMs and PIPs are closely related. The audit approach and methodology were designed to align the audit process with OHNM’s contractual requirements and HSD specifications. The identified PMs and PIPs were evaluated by comparing OHNM’s documentation to the contract and protocols. The EQRO looked at the PM and PIP processes, as well as the BH SE’s internal performance measurement results, and focused on the following elements:

- Rationale (understanding of the regulations and LOD specifications)
- Evidence required (documentation)
- Interpretive guidelines
- Data collection tools
- Scoring criteria

Table 15 shows the overall scores and rating designations for the three audits (compliance, PMs, and PIPs) for the past three years.
Table 15: External Quality Review Audit Results

<table>
<thead>
<tr>
<th>EQRO Audit Results</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>84.4%</td>
<td>96.8%</td>
<td>99.4%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Moderate</td>
<td>Full</td>
<td>Full</td>
</tr>
<tr>
<td>Performance Measures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>85.7%</td>
<td>87.5%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Full</td>
</tr>
<tr>
<td>Performance Improvement Projects</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PIP #1: Reduction of RTC Readmission w/in 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>95.1%</td>
<td>86.9%</td>
<td>80.2%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Full</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>PIP #2: ISHCN Outpatient Follow-up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Composite Score</td>
<td>86.9%</td>
<td>87.9%</td>
<td>98.9%</td>
</tr>
<tr>
<td>Compliance Level</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Full</td>
</tr>
</tbody>
</table>

The increase in the compliance scores from Moderate Compliance to Full Compliance indicates that OHNM is using the feedback and recommendations from the audit reports to continuously improve its QM/QI program.

The PMs and the ISHCN PIP audit scores have been steadily improving, but the Reduction of RTC Readmissions PIP has been declining. The audit revealed that compared with the baseline rate, the readmission rate had decreased less than 0.5 percent over two years, and OHNM had not reached its internal goal of a 2.0 percent reduction. Although OHNM implemented several internal referral process changes to improve the care coordination activities associated with readmission, and is specifically focusing on the TFC service delivery, the changes have not yet proved successful.

J. Summary of Quality of Care Findings

The review and analysis of the reports obtained from HSD revealed that OHNM met the quality of care requirements, as evidenced by the following:

- **QM/QI program:** OHNM had a comprehensive QM/QI Program Description and a QM/QI Plan that was evaluated annually. There was a Cultural Competency Plan to address the needs of all consumers, which built transparency and communication into the program. (See pages 25-27, Table 6.)

- **PMs:** Although the PM performance percentages have remained fairly steady over the last three years, there was a slight upward pattern for improvement in each of the measures. (See pages 27-28, Table 7.)

- **PIPs:** RTC Readmissions (PIP #1) showed little change over the three years measured. It was at 4.1 percent in FY 2012. For ISHCN Follow-up (PIP #2), OHNM’s scores improved over time, and exceeded the 80 percent goal in FY 2012 with 84.3 percent remaining in outpatient care for 90 days or more. (See pages 28-29, Table 8.)
Utilization management: Service utilization rates went down, averaging 7.0 consumer visits to a provider/service facility per year. The percentage of denials has been decreasing over the last two years, down to 8.8 percent in FY 2012. OHNM reported this was due to extensive provider education to bring about more timely claims and reduce duplicate submissions, which were the top two reasons for denials. Critical incidents rates increased to 1,574 in FY 2012. The following categories had the largest increases: Detention for Criminal Activity, Injuries/Emergency Services, and Medication or Treatment Errors. (See pages 29-32, Figure 6, Tables 9-11.)

Grievances: The highest percentage of consumer grievances was with “Quality of Care” (QOC) at 85.5 percent in FY 2012, and it has been on a sharp upward pattern for the last three years. The predominant reason for complaints received was related to the quality or appropriateness of the care provided by a practitioner or facility. Provider grievances were very low in FY 2012 with only eight (8) filed. This low followed a spike seen in FY 2011 caused by one or more providers filing grievances over the denial of transitional living services (TLS). The normal process of filing an appeal was not available to the provider(s) because TLS is a value-added service. (See pages 33-34, Table 12.)

Appeals: Total amount of appeals has increased significantly, from 340 appeals filed in FY 2010 to 1,178 in FY 2012. The ratio averaged one (1) out of every 407 consumers filing an appeal in FY 2012. This is a big increase from one (1) out of every 732 consumers that was seen in FY 2011 and one (1) out of every 1,133 consumers seen in FY 2010. (See page 34, Table 13.)

Provider satisfaction: Questions concerning “Overall Satisfaction” with OHNM and the perceived “Trend of Service” resulted in 88.8 percent of providers reporting they were “Somewhat Satisfied” or “Very Satisfied” with OHNM overall and 91.8 percent felt that the “Trend of Service” was “Staying the Same” or “Improving.” Only 5.2 percent responded that services were “Getting Worse”. (Three [3] percent had “No opinion.”) (See pages 35-36, Figures 7-8.)

Customer satisfaction: Adults and Child/Family consumers were surveyed for customer satisfaction in five domains and Youth were surveyed in two domains. Overall “Satisfaction” with OHNM scored an average of 76.6 for Adults, 81.4 for Child/Family, and 84.5 percent for Youth. Adult and Child/Family consumers surveyed appeared to be dissatisfied with the “Effectiveness” of the services being provided by OHNM with results for these questions of only 62.0 percent and 56.0 percent, respectively, but Youth responded more favorably at 81.8 percent for this domain. Satisfaction levels with “Empowerment” were at 77.0 percent for Adults and 90.0 percent for Child/Family consumers. (See pages 36-39, Figure 9, Table 14.)

External audits: OHNM submitted to three regular, scheduled external audits from HealthInsight New Mexico. OHNM was found to be in Full Compliance for the annual Compliance audit, in Full Compliance for PMs, and in Moderate Compliance for PIP #1 and Full Compliance for PIP #2. (See pages 39-41, Table 15.)
VI. Cost-effectiveness Assessment

A. Introduction
Access and quality of care are reviewed to determine how well the consumer’s needs are being met. The cost-effectiveness analysis examines how well the BH SE uses the funds provided to meet these needs while still being fiscally responsible with state funds. As a state-funded program, it is essential that it be run as cost-effectively and efficiently as possible.

Several of OHNM’s financial documents were examined along with publically available medical trending information. The BH SE’s cost-effectiveness was evaluated using the following:

- Contact requirements
- Operational summary statistics
- Average consumer cost comparison
- Capitation rate ranges and actuarial rate certification
- Capitation rate progression
- Cost comparisons of New Mexico rates to national norms
- Medicaid spending trends

B. Contract Requirements
The requirements for cost-effectiveness are found in the HSD/OHNM contract in Article 3, Section 3.16, Fiduciary Responsibilities, and can be broken down into two main categories:

Financial Viability
- Net worth in compliance with New Mexico Insurance Code, NMSA 1978
- Positive working capital balance (current assets minus current liabilities)

Financial Stability
- Compliance with state and federal laws and regulations regarding solvency and risk
- Soundness and stability of the BH SE and its subcontractors (with immediate notification to the Collaborative if not able to maintain)
- Insolvency reserve maintained with an independent trustee to ensure consumers are not at risk
- Independent financial audit performed annually
- Identification of third party coverage of consumers and coordination of benefits with those third parties
- Reinsurance protection against financial loss due to catastrophic events

Per the HSD/OHNM contract, evidence in the form of reports and financial statements must be provided at regular intervals (monthly, quarterly, semi-annually, and/or annually) to show financial stability and viability. These documents were examined to determine compliance with the fiduciary requirements of the HSD/OHNM contract. The results are shown in Table 16. A check-marked column indicates compliance.
Table 16: OHNM Contract Fiduciary Requirements Compliance

<table>
<thead>
<tr>
<th>Contract Requirements</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Worth</td>
<td>√</td>
</tr>
<tr>
<td>Working Capital</td>
<td>√</td>
</tr>
<tr>
<td>Financial Stability Plan</td>
<td>√</td>
</tr>
<tr>
<td>Timely Reporting</td>
<td>√</td>
</tr>
<tr>
<td>Fidelity Bond</td>
<td>√</td>
</tr>
<tr>
<td>Independent Financial Audit</td>
<td>√</td>
</tr>
<tr>
<td>Insolvency Reserve</td>
<td>√</td>
</tr>
<tr>
<td>Inspection &amp; Audit for Solvency Requirements</td>
<td></td>
</tr>
<tr>
<td>Third-Party Liability*</td>
<td>N/A</td>
</tr>
<tr>
<td>Reinsurance</td>
<td></td>
</tr>
</tbody>
</table>

* Although included in the HSD/OHNMC contract, this requirement is not a standard report. It is an ad hoc report occasionally requested by HSD and deliverable within 20 days of request. No reports were requested during FY 2012.

C. Operational Summary

Revenue and expense reports were reviewed, and OHNM, along with its parent company UnitedHealthcare Insurance Company, was found to be in good financial condition. The economic performance for FY 2012 was assessed through three key operational statistics:

- Medical Loss Ratio – medical costs divided by premium revenue
- Administrative Cost Ratio – administrative costs divided by premium revenue
- Operating Margin Gain (or Loss) – derived by subtracting both medical costs and administrative costs from premium revenue

The data used to derive these statistics were obtained from OHNM’s Administrative vs. Direct Costs report. The results are shown in Table 17.

Table 17: OHNM Financial Performance and Rate of Improvement

<table>
<thead>
<tr>
<th>Financial Performance</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Loss Ratio</td>
<td>102.5%</td>
<td>99.7%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Administrative Cost Ratio</td>
<td>13.7%</td>
<td>10.4%</td>
<td>13.6%</td>
</tr>
<tr>
<td>Operating Margin Gain/(Loss)</td>
<td>(16.3%)</td>
<td>(10.1%)</td>
<td>5.1%</td>
</tr>
<tr>
<td>Rate of Change/Improvement (from previous year)</td>
<td>37.8%</td>
<td>150.2%</td>
<td></td>
</tr>
</tbody>
</table>

The operational summary varied widely over the three years examined. The medical loss ratio in FY 2010 was very high (102.5 percent), but by FY 2012 it had dropped down into alignment with the statutory requirement (85 percent) when it reached 81.3 percent.

The administrative cost ratio has stayed fairly level over the three years and was close to the statutory requirement of 15 percent.

The operating margin was -16.3 percent (operating loss) in FY 2010. This was caused by the medical expenses exceeding the amount of revenue brought in. There was still an operational loss in FY 2011, but the shortfall was less than the previous year (-10.1 percent). The operating margin continued to improve in FY 2012 when it reached 5.1...
percent (operating gain). The rate of change was three times the operating margin from the previous year.

The change in FY 2012 was brought about by a 15.9 percent reduction in claims from the previous year. OHNM reported that the changes in the clinical triggers and subsequent re-evaluation of numerous claims caused the wide fluctuations over the three year period, and it anticipated a return to a more balanced operating margin and ratios in future since this issue has been resolved.

D. Average Cost per Consumer Comparison

Capitation is a payment arrangement between the state and the contracted healthcare providers to pay a set amount for established services associated with the managed care programs. Payment, in the form of premiums, is made for each enrolled consumer in the program, whether or not the individual seeks care. An estimated maximum allowable per person capitation payment amount can be derived by dividing the annual premium revenue (capitation income provided by the state) by the annualized population (member months). When the total expenses incurred in the fiscal year are divided by the member months, the estimated average annual program cost per person is obtained.

Table 18 shows the average annual costs per person comparisons. Data were obtained from the BH SE’s annual Administrative vs. Direct Costs reports for the financial entries and from the state’s MCO Enrollment reports to obtain consumer population.

Table 18: Comparison of Average Annual Costs to Average Allowable Expenses

<table>
<thead>
<tr>
<th>Annual Cost Comparisons</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrolled Consumers*</td>
<td>363,070</td>
<td>371,002</td>
<td>373,698</td>
</tr>
<tr>
<td>Member Months</td>
<td>4,356,840</td>
<td>4,452,024</td>
<td>4,484,376</td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>$244,114,077.00</td>
<td>$240,243,696.00</td>
<td>$203,548,338.72</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>$32,733,213.00</td>
<td>$25,075,710.00</td>
<td>$34,135,475.90</td>
</tr>
<tr>
<td>Average Cost per Consumer</td>
<td>$63.54</td>
<td>$59.60</td>
<td>$53.00</td>
</tr>
<tr>
<td>Total Revenue</td>
<td>$238,081,183.00</td>
<td>$240,926,773.00</td>
<td>$250,407,584.02</td>
</tr>
<tr>
<td>Average Allowable Amount per Consumer</td>
<td>$54.65</td>
<td>$54.12</td>
<td>$55.84</td>
</tr>
</tbody>
</table>

* Refers to the number of unique consumers enrolled in the BH program at one specific point in time during the fiscal year. Point selected for this table was the July report of total BH enrollment for each fiscal year, which documented the capitated member months for July (the first month of the fiscal year).

Looking at Table 18, the average annual cost per consumer exceeded the average allowable amount for FY 2010 and FY 2011. This was due to the higher amount of claims during those years. Once this situation normalized, so did the balance between expenses and allowances. The annual expense rates for FY 2012 averaged $53.00 per consumer. This was slightly lower than the average annual allowable amount of $55.84 per consumer, and indicates that the BH SE was being fiscally responsible with state funds in FY 2012.
Enrollment varies month-by-month as consumers enter or leave the BH program. Using the same month for each of the three years to annualize the enrollment data provided a comparable point in time to calculate average per person costs and allowances. But it should be noted that selecting a different specific measurement date or using another report which listed a different enrollment count would yield a slightly different dollar amount for the average annual cost and average allowable amount per consumer.

E. Capitation Rate Ranges and Actuarial Rate Certification
The total amount of capitation income allotted to the BH SE is divided up into categories designed to cover services for seven consumer population groups known as cohorts. These groupings are determined by factors such as program eligibility qualifications, age, and gender. Each of the seven cohort categories is given a capitation rate range (low point, mid-range point, and high point) payment amount determined by an external, independent organization.

HSD contracted with Mercer Government Services Consulting (Mercer) to develop the capitation rate ranges and provide actuarial rate certification. Rate ranges were determined by studying the following factors and projecting expenses in order to bring the average expected service utilization and the amount of funds paid as close together as possible:

- Recent claims payment amounts
- Encounters
- Federal and state legislative changes
- Managed care program changes
- Medical trends for utilization and unit costs
- Member demographic mixes
- Past and prospective trends

Mercer certified that the rates were developed in accordance with generally accepted actuarial practices and principles and in accordance with the rate-setting guidelines established by CMS. The methodology of the rate development was detailed, and an overview of the analyses was included in a narrative report, along with a set of rate tables, provided to HSD as evidence of actuarial soundness.

F. BH SE Capitation Rate Progression
Capitation rates can change over time due to a variety of factors. Rates are revised at least annually, although they are analyzed and updated more frequently if major changes have occurred on a state or federal level. Program changes during the year also may affect the rate-setting process. Any of these events can cause a new rate range to be issued during a fiscal year and the rates may be adjusted up or down, as needed.

To see how the capitation rates have changed over time, an annual weighted average capitation rate was determined. Data for this calculation were obtained from the MCOs’ Expenditures by Category report provided monthly to HSD for member month service utilization and from the cohort mid-range point amount of the capitation rate ranges provided to HSD by Mercer. The rates in the table have been quantified across the MCOs and payment rate categories then weighted by each MCO’s enrollment level and
mix to get an average amount for each rate adjustment period. Table 19 shows the weighted average capitation rates over the last three years and the rate of change.

### Table 19: Weighted Average Capitation Rates for Behavioral Health

<table>
<thead>
<tr>
<th>Capitation Rates</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted Average Capitation Rate</td>
<td>$55.41</td>
<td>$54.91</td>
<td>$58.82</td>
</tr>
<tr>
<td>Percent Increase Over Previous Year</td>
<td>(0.9%)</td>
<td>7.1%</td>
<td></td>
</tr>
<tr>
<td>Average Annual Rate of Increase</td>
<td></td>
<td></td>
<td>3.1%</td>
</tr>
</tbody>
</table>

The weighted average capitation rate for behavioral health services declined slightly between FY 2010 and FY 2011, but rose by 7.1 percent in FY 2012. Since capitation rate development relies heavily on encounter data, eligibility, and reimbursement level provided by OHNM, which outlines the service utilization and cost trend data, the increase in the average capitation rate was expected and paralleled the projected increase in enrollment.

### G. Comparisons of New Mexico Rates to National Norms

Medicaid managed care services are established and monitored by each state, as opposed to having one standard program on a federal level. In New Mexico there is a transportation component, a premium tax component, and a pharmaceutical component which are not included in the medical services component of the Consumer Price Index (CPI). Also, providers must pay a gross receipts tax of approximately seven (7) percent of receipts in New Mexico. As this tax is imposed on most medical services, it is reflected in somewhat higher capitation rates relative to other states which do not tax medical services in this manner.

Because of this, a direct comparison of the capitation rate progression to other states or to the national averages collected by the CPI is not possible. As an alternative, the rate of change over the last 10 years was compared for the New Mexico capitation rates and the national (United States average) rates and shown in Table 20.

### Table 20: Comparison of Rate of Change for State and National Capitation Rates

<table>
<thead>
<tr>
<th>Program Level</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Average Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>NM BH SE</td>
<td>7.7%</td>
<td>7.4%</td>
<td>(17.8%)</td>
<td>(5.2%)</td>
<td>(0.9%)</td>
<td>7.1%</td>
<td>(0.3%)</td>
</tr>
<tr>
<td>US National</td>
<td>5.3%</td>
<td>4.2%</td>
<td>3.2%</td>
<td>3.5%</td>
<td>3.1%</td>
<td>3.9%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

The BH SE program rates rose for the first few years after the carve-out from PH Salud!, then experienced a decrease in 2009. Since then the rates have been fairly level. The national rates, however, experienced a steadily rising trend over time.

Since the BH SE rates are just one portion out of the three that make up New Mexico’s managed care system, comparing just the BH portion to the all-inclusive national rates would not be feasible.
H. Medicaid Spending Trends
Since the Medicaid program was introduced in the 1960s, its cost has generally increased each year. Total spending is directly related to cost and enrollment. However, cost and enrollment are the results of state and/or federal policy changes, such as fee schedules, special financing programs, eligibility changes, benefit changes, access to care, or medical utilization.

Table 21 shows the average annual growth (by percentage) in Medicaid spending from FY 1990 to FY 2012. The information provided in Table 21 and Table 22 was obtained from www.statehealthfacts.org.4

Table 21: Average Annual Growth in Medicaid Spending, FY1990 - FY2010

<table>
<thead>
<tr>
<th>Medicaid Spending</th>
<th>NM Percent</th>
<th>Rate of Change</th>
<th>US Percent</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 1990-2001</td>
<td>15.7%</td>
<td>-</td>
<td>10.9%</td>
<td>-</td>
</tr>
<tr>
<td>FY 2001-2004</td>
<td>14.8%</td>
<td>(5.7%)</td>
<td>9.4%</td>
<td>(13.8%)</td>
</tr>
<tr>
<td>FY 2004-2007</td>
<td>5.9%</td>
<td>(60.1%)</td>
<td>3.6%</td>
<td>(61.7%)</td>
</tr>
<tr>
<td>FY 2007-2010</td>
<td>9.3%</td>
<td>57.6%</td>
<td>6.8%</td>
<td>88.9%</td>
</tr>
<tr>
<td>Overall Rate of Change</td>
<td>(2.7%)</td>
<td>-</td>
<td>4.5%</td>
<td>-</td>
</tr>
</tbody>
</table>

Over the last 20 years, while New Mexico averaged a decrease of -2.7 percent for its Medicaid spending, there was an average increase of 4.5 percent for national (US) Medicaid spending. In the most recent measurement period, the amount of money spent for Medicaid services in New Mexico increased 9.3 percent. During the same period, Medicaid spending for the US grew by 6.8 percent.

Medicaid programs are funded through a combination of federal and state money. Each state has a separate agreement with CMS and a customized breakdown of programs designed to serve the needs of its Medicaid population. The Managed Care system (PH Salud¡!, BH SE, and CoLTS programs) in New Mexico is only a portion of the state’s Medicaid services and activities.

Table 22 shows the percentages of the federal and state portions for New Mexico and compares it to the nationwide averages for Medicaid spending. Because state Medicaid programs are unique, no comparisons were made to other states.

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4 State Health Facts website is owned by The Henry J. Kaiser Family Foundation. The sources cited by the website for the data obtained from the website and used in this independent assessment were attributed to annual CMS forms 64 (Quarterly Expense Report, which provides expenditures by date of payment) and CMS 2010 and 2011 Medicaid MC Enrollment Reports.
Table 22: Federal and State Share of Medicaid Spending, FY2010 and FY2011*

<table>
<thead>
<tr>
<th>FY 2010 Medicaid Spending</th>
<th>In New Mexico</th>
<th>Nationwide Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Portion</td>
<td>80.4%</td>
<td>67.7%</td>
</tr>
<tr>
<td></td>
<td>$2,768,728,590</td>
<td>$263,376,784,409</td>
</tr>
<tr>
<td>State Portion</td>
<td>19.6%</td>
<td>32.3%</td>
</tr>
<tr>
<td></td>
<td>$674,429,808</td>
<td>$125,707,549,543</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>$3,443,158,398</td>
<td>$389,084,333,952</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY 2011 Medicaid Spending</th>
<th>In New Mexico</th>
<th>Nationwide Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Portion</td>
<td>76.9%</td>
<td>63.7%</td>
</tr>
<tr>
<td></td>
<td>$2,609,745,664</td>
<td>$263,675,199,003</td>
</tr>
<tr>
<td>State Portion</td>
<td>23.1%</td>
<td>36.3%</td>
</tr>
<tr>
<td></td>
<td>$785,495,050</td>
<td>$150,180,438,088</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>$3,395,240,714</td>
<td>$413,855,637,091</td>
</tr>
</tbody>
</table>

*No data available for FY 2012 at time of this report.

According to the 2012 Actuarial Report on the Financial Outlook for Medicaid, in 2010 the federal portion for Medicaid spending was 68 percent and the state portion was 32 percent. In 2011, the federal portion went down to 64 percent and the state portion rose to 36 percent. The drop in the federal portion was due to the expiration of the American Recovery and Reinvestment Act (ARRA) of 2009.

Looking at New Mexico (in Table 22), the state received a higher than average federal share and paid a lower state portion than the average. Although the rate of spending in New Mexico was 2.5 percent higher than the national average in the latest measurement period (2007-2010), New Mexico paid much less than most states at 19.6 percent in 2010 and 23.1 percent in 2011. This was due to New Mexico’s lower per capita income compared to the US per capita income.

I. Summary of Cost-effectiveness Findings

After reviewing and analyzing the financial reports and data, it appears the BH SE program has demonstrated cost-effectiveness through the following:

- **Contract requirements:** All contract requirements for financial viability and stability were met, and reports documenting this were submitted to HSD.
  (See pages 43-44, Table 16.)

- **Operational summary statistics:** The financial data in the operational summary varied widely over the three-year period due to clinical trigger claims payment fluctuations. OHNM improved in financial performance in FY 2012 by reducing expenses and improving the Medical Loss Ratio to 81.3 percent, thereby bringing it closer to the statutory requirement of 85 percent than it had been in the previous two years. The overall program went from an operating loss for FY 2010 (-16.3 percent) and for FY 2011 (-10.1 percent) to an operating gain of 5.1 percent in FY 2012. This rate of change showed an improvement of three times the operating margin from the previous year.
  (See pages 44-45, Table 17.)

- **Average cost per consumer comparison:** The average cost per consumer, as established with enrollment data and total annual program spending (medical and administrative costs), was $53.00 per person in the overall...
program in FY 2012. With an average of $55.84 allowed, this showed good fiscal management of state funds in FY 2012. (See pages 45-46, Table 18.)

- **Capitation rate ranges and actuarial rate certification:** Mercer developed the capitation rate ranges and provided actuarial rate certification. The program showed evidence of being actuarially sound. (See page 46.)

- **Capitation rate progression:** The weighted average capitation rates, as established by service utilization expenses and the mid-range point of the capitation payment rate range, only varied an average of 3.1 percent over the last three years. The relatively level line of progression indicates that the BH SE program is stable overall. (See pages 46-47, Table 19.)

- **Cost comparisons to national norms:** The analysis revealed that the BH SE program is considerably below the national norms because New Mexico has separated the BH SE, CoLTS, and PH Salud! program costs. (See page 47, Table 20.)

- **Medicaid spending trends:** In comparing state and federal Medicaid spending, the rate of spending in New Mexico was 2.5 percent higher than the national average in the latest measurement period (2007-2010), but New Mexico paid much less for its share than most states at 19.6 percent in 2010 and 23.1 percent in 2011. The New Mexico Managed Care system, which includes the PH Salud!, BH SE, and CoLTS programs, is only one of many Medicaid services/activities being managed within New Mexico. (See pages 48-49, Tables 21-22.)

**VII. Overall Summary of Findings and Conclusions**

The BH SE program has provided access and quality of care to its consumers since FY 2005 when it was carved out from the PH Salud! program. Although it has met the HSD access, quality, and cost-effectiveness standards overall, there were places where opportunities existed for improvement. As these opportunities were identified, the BH SE implemented corrective action or quality improvements, thus showing improvement over time to the BH SE program.

HSD has shown good management of the state’s Medicaid Managed Care system, and it is anticipated that this will continue with the future changes. As New Mexico moves forward with the new combined (PH Salud!, BH SE, and CoLTS) program, Centennial Care, it will continue to look for ways to maintain or improve the access and quality of care to the consumers and increase the cost-effectiveness of the overall managed care system by addressing any weaknesses found since program inception and building on the strengths revealed through analysis.