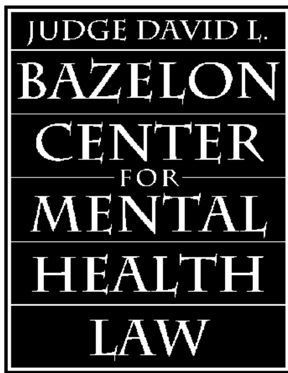

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June 27, 2000

Mr. Timothy Westmoreland
Director
Center for Medicaid and Security Operations
Health Care Financing Administration
7500 Security Boulevard, S2-26-12
Baltimore, MD 21244

Dear Tim:

We have received a copy of the state's response to the data in our earlier report to you concerning New Mexico's managed care system. First, I would stress that even if the state's criticisms were all valid, there is still sufficient data and information available to suggest that this plan has serious problems with respect to the delivery of mental health care. In addition, several of the state's points of rebuttal are themselves quite misleading or inaccurate. Following is our specific response to certain of the state's criticisms.

Selected Response to New Mexico Medical Assistance Department

1. Low rates of mental health case management and other mental health community-based services

a) Low rate of mental health case management

> *"During the first eight months of the current fiscal year (FY 2000) MAD has paid $11,650,529 to the Children, Youth and Families Department (CYFD) and $11,029 to other providers for case management for 2,903 fee-for-service children with serious psychosocial problems."*

Bazelon Center Response: This is irrelevant information. The eleven million dollars paid by MAD to CYFD for case management is not for children enrolled in the Salud! program. CYFD provides case management for children who are in foster care and in the juvenile justice system, not for children enrolled in Salud!.

> "*During the calendar year 1999, there were 8,053 requests for case management services for Behavioral Health. Each individual request for case management services can vary from ten units of client contact to 100*

plus units, depending on individual client needs. Of these 8,053 requests that were made, 8,022 were approved. There were approximately 1,896 case management requests made for SED population and 3,080 requests made for the SDMI population."

Bazelon Center Response: We believe that MAD is including case management provided for Salud! members with serious physical health problems in the 8,053 figure. If this is the case, we do not understand why they are stating that there were 8,053 requests for case management for behavioral health. According to their numbers, only 4,896 (61%) of the 8,022 requests approved for case management in Salud! were for both adults with SMI and children with SED.

Overall, Salud! is providing care to a small proportion of those with serious mental disorders. The federal Center for Mental Health Services estimates that 27,635 to 32,660 of New Mexico children (11% to 13% of the 251,231 in the state's population) have SED which causes substantial functional impairment. Assuming that every Salud! child with a serious emotional disturbance is provided with case management, the 1,896 requests for case management would indicate that only 1.3% of 150,000 Salud! members (*most of whom, by program eligibility criteria, are children*) have serious mental disorders. Rates of serious mental illness for New Mexico children who are on Medicaid, many of whom receive these benefits due to a mental disability, would be expected to be significantly higher than 1.3%. The only possible conclusion is that case management appears to be available to Medicaid-eligible children enrolled in Salud! at a deplorably low rate.

Now that the state now has accurate and valid encounter data, we recommend that HCFA compare units of Case Management under FFS with Salud! managed care rates.

b) Declining rates of community mental health service authorizations

Presbyterian Medical Services, (a Regional Care Coordinator) writes in *Trends in Community-Based and Day Treatment Services*:

"*Recent trends indicate a continuing downward trend in authorization of community-based services and day treatment. This trend in combination with no commensurate increase in authorizations for services that might replace community-based and day treatment services, has been the cause for concern by the Medical Assistance Division of the Human Services Department responsible for the financing of Medicaid Salud! managed care contracts. This situation has led to concerns of possible deliberate withholding of appropriate levels of care*" (Refer to Appendix A: *Trends in Community-Based and Day Treatment Services*, Presbyterian Medical Services, April 10, 2000).

Bazelon Center Response: These data suggest inappropriate denial of service, and possibly a significant decline in services under managed care. Substantial revision of contracting requirements is necessary to address this. Data and other information from two of the Regional Care Coordinators for ValueOptions highlights the problem. For example according to Presbyterian Medical Services' own materials, mental health authorizations were found to decline in all four areas examined, as detailed below:

Presbyterian Medical Services Mental Health Authorizations

Authorizations per 1,000 members	**August 1999**	**February 2000**
Adult community-based service authorizations	900	300
Child and adolescent community-based service authorizations	1,000	300
Child and adolescent home-based treatment service authorizations	160	5
Day treatment service authorizations[1]	400	100

In addition to data management problems, Presbyterian Medical Services identified these causes for this decline in services:

- Absence of sufficient number of providers;
- Insufficiency of reimbursement as an incentive for service;
- Absence of an appropriate continuum of services; and
- Perceived problems of being a Medicaid provider (Medicaid system seen as fraught with bureaucracy, delayed authorization, delayed payment, cumbersome review, etc.).

Rio Grande, one of ValueOptions' Regional Care Coordinators found decreases in 3 out of 5 areas of mental health service authorizations:

Rio Grande Mental Health Authorizations

Authorizations per 1,000 members	**August 1999**	**January 2000**
Adult community-based service authorizations	2250	800
Adult psychosocial rehabilitation authorizations	750	1200
Child and adolescent community-based service authorizations	1500	1250
Child and adolescent home-based treatment service authorizations	260	150
Day treatment service authorizations (per 1,000 members)[2]	150	150

When a managed care organization signs a contract to provide all Medicaid services, the organization is responsible for developing a network with sufficient mental health providers to

[1] Day treatment service rates are for September 1999 and January 2000.

[2] Day treatment rates are for September 1999 and January 2000.

provide the full continuum of child and adult Medicaid-covered mental health services. The organization needs to set reimbursement rates and develop administration procedures that will attract sufficient providers. Furthermore, it needs to develop the array of services that is appropriate. Instead the availability of providers has declined since the introduction of Salud!.

Complaints about under service have been made in New Mexico for some time, but no steps were taken to deal with these concerns. HCFA and the state Medicaid agency should ensure that these problems are corrected. The Center's analysis of provider surveys, member surveys, the external review and evaluations by other state agencies indicates that behavioral health services are hard to find in New Mexico.

2. Excessive Salud! mental health administrative costs have not been disproved.

> *"Third, the documents that are being used in the Bazelon report are very early draft versions of documents that were not audited, nor reviewed by the Department or by the Managed Care Organizations."*
>
> *"Additionally, for calendar year 1999 Medicaid specific Medical Loss Ratios for each of the plans as reported on State Department of Insurance documents are greater than eighty five percent. Each plan's calendar year 1999 Medicaid specific administrative expenses on the same report are less than twelve and one-half percent. The department's analysis of 1999 Department of Insurance Report is attached."*
>
> *"The most recent analysis demonstrates that more than eighty percent of funding attributable to Behavioral Health for the Year ending June 30, 1999, enters the door at the direct service provider level.*"

Bazelon Center Response: The administrative costs and medical loss ratio for health plans determined by MAD present these figures for all health services, not just mental health. Due to the special administrative structure of mental health, with significantly more levels of administrative cost, it is critical to specifically determine the administrative cost for mental health services. The Mercer Audit did just that. It examined mental health administrative costs for each of five levels; 1) MAD; 2) Presbyterian; 3) ValueOptions; 4) Regional Care Coordinator and 5) the mental health provider who directly serves Salud! members.

Mercer did not complete MAD's request to determine mental health administrative costs. MAD initially asked Mercer to examine two specific questions regarding the behavioral health program under Salud!. These two questions were:

> a) Is there vertical duplication of administrative functions between an MCO, their subcontracted BHO partner, and RCC subcontractors responsible for behavioral health services?
> b) What portion of the HSD capitation payment utilized for behavioral health care is used for delivery of care as opposed to administrative/management costs?

The June report, *Salud! Health Administrative Functions: Is There Duplication?* completed by Mercer in June of 1999, only addressed the first question. The January 1999 draft that we cited was answering the second question by estimating the administrative costs for Presbyterian. MAD now says that this estimate is inaccurate. Yet the state has not pursued this question. If there is documented analysis of behavioral health administrative costs, it should be available to HCFA and the public. We urge HCFA to request the complete report that presented the final estimate of behavioral health administrative costs.

3. Explore the differences in the findings of the Mental Health Statistics Improvement Projects (MHSIP) Survey and the Gallup Surveys.

a) <u>MHSIP Survey data issues</u>

> "*While providers may feel that access for patients to their offices is not as good as before SALUD!, members do not appear to agree. The MHSIP results for the first annual report were compared to the MHSIP reports from the Department of Health report that was completed prior to SALUD!. The results were comparable to the MHSIP findings for the clients receiving services through DOH - State General Funds for 1998. These figures have improved for the year 1999.*"

Bazelon Center Response: We recommend that HCFA consult with survey researchers to investigate reasons for the markedly different perceptions of access to mental health identified in the Gallup Surveys (provider and member surveys) and the MHSIP Survey. Due to different methods (MHSIP was a phone survey, Gallup was a mail survey), questions, and response rates, the Gallup and MHSIP surveys indicate that further research is necessary to understand the much lower rates reported in the Gallup survey and the higher rates reported in the MHSIP survey. Member-satisfaction surveys in managed care usually report high rates of satisfaction–80 percent or higher. The lower rates reported in the Gallup Enrollee survey are significant and suggest potential and severe deficiencies in Salud!'s mental health program.

There are several serious issues and limitations to consider when reviewing the MHSIP Survey:

- The survey was developed to gather the opinion of adult consumers on outpatient services. The use of the survey to assess all services (inpatient as well as outpatient) is inappropriate.

- The survey was developed for adults. The state's decision to use this survey for the care provided to children and adolescents is a poor one. SAMHSA and NASMHPD are currently developing versions of the MHSIP Survey for adults in inpatient facilities and for children and adolescents.
- We have heard that the MHSIP response rate has been falling and that, for 1999, it was 10%. It is unusual not to report the response rate for a survey. This suggests that it may be quite low. When a response rate is below 50%, survey researchers become concerned about differences between those who respond and those who do not. MAD should look into the differences between respondents and nonrespondents.

b) Misinterpretation of consumer-satisfaction trends

MAD refers to a 1997 Department of Health Survey as the pre-Salud! consumer satisfaction baseline.

Bazelon Center Response: We understand that the survey was conducted for non-Medicaid populations in public programs funded only by state general funds. This survey is not a valid pre-Salud! baseline.

We recommend that HCFA:

1) Analyze trends for adults and children/adolescents separately. Historically, Medicaid mental health services for adults and children have been in different stages of development, with children's services less well developed. Looking at adults and children together obscures the different experiences of these two groups.
2) Compare survey-respondent demographics for the 1998 and 1999 MHSIP surveys. Since age, gender, racial demographics, urban/rural, time on Medicaid, and severity of illness affect member-satisfaction rates, it is critical that surveys examine comparable populations. Without this information, the state agency does not have strong evidence to assert that it has trend data since it cannot prove that similar groups were surveyed.
3) Consider the impact of differences in survey administration on the results. In fact, Summit Quest's (a health care consulting company) analysis of the 1999 MHSIP Child Adolescent Consumer Satisfaction Survey for Presbyterian Salud states, "The survey data collection project was completely different between the two surveys [MHSIP 1998, 1999].... If the MHSIP is repeated in 2000 using the same data collection method as 1999, only those two years should be compared, and 1998 data should be ignored" (*Presbyterian Salud Behavioral Health Care/OPTIONS 1999 MHSIP Child Adolescent Consumer Satisfaction Survey*, February 2000).

4. Violations of the state mandated 14-day maximum wait for nonurgent mental health visits

"Furthermore, the 1999 MHSIP data has since been reviewed. The data reflects that for Access Question #1, The Average length of Time (Days) from Request for Services to the First Face to Face Meeting with a Behavioral Health Professional, the following information was reported by the three plans for emergent and non-emergent situations. For this indicator the average for all consumers access to services with emergent situations does not exceed 0.18 days. For all three plans the average length of time for a consumer to access services from the initial contact is no more than 10.42 days."

Bazelon Center Response: In addition to delays in initial assessment visits, we have heard about significant problems with access to ongoing treatment for adults with SMI and children with SED. The HEDIS data on follow-up after hospitalization for mental illness collected by HSD indicates that there are delays in the system for those with serious mental health problems who need follow-up care. The rate of follow-up for all Salud! plans is 14% to 26% within seven days of discharge and 27% to 42% within 30 days of discharge. These rates fall well below the national

average of 45% within seven days of discharge and 68% within 30 days of discharge, reported by the National Commission on Quality Assurance (NCQA) in 1998 (HEDIS, 1999).

Follow-Up Visit after Psychiatric Hospitalization, 1998

MCO	**WITHIN 7 DAYS OF DISCHARGE**	**WITHIN 30 DAYS OF DISCHARGE**
PRESBYTERIAN	16.18%	33.59%
CIMARRON	14.63%	27.13%
LOVELACE	26.44%	42.31%
National Average	45%	68%

We recommend that HCFA examine wait time in the following ways:

- Separate the wait times for adults and children. Historically, the two groups have had different levels of access to mental health services under New Mexico's Medicaid program. A further consideration is the difference in the types of services and providers that adults and children require.
- Examine the wait time for nonurgent mental health care for the ValueOptions members who waited more than 14 days. Since the average is 10.2, some ValueOptions members probably have waited more than 14 days, in violation of the state contract requirements.
- Examine the wait time for nonurgent mental health care for Cimarron members who waited more than 14 days. Since the average is 8.60, some Cimarron members may have waited more than 14 days, in violation of the state contract requirements.
- Explore urban versus rural differences in wait time. Under fee-for-service Salud!, access was worse outside of the more urban areas of Albuquerque/Santa Fe/Las Cruces. HCFA should explore with data whether access to mental health services has improved in rural areas under Salud!.

5. Mental health authorization data is used instead of encounter data to monitor behavioral health.

> "*These encounters as well as other reports required by contractual provisions have provided the Department with sufficient data to adequately monitor the SALUD! program.*"

Bazelon Center Response: Finding a mental health provider outside of the urban areas of Albuquerque/Santa Fe/Las Cruces has been a consistent problem for Salud! Presbyterian Medical Service, a Regional Care Coordinator, states in a report on mental health authorizations:

> "Anecdotal information based on discussions with providers and applicants for services as well as information provided by representatives of other organizations and agencies

indicates an insufficient number of providers of community-based and day-treatment services. This observation is corroborated by information provided by care coordinators responsible for the authorizations of services in the service center. They have often reported difficulty identifying providers capable of providing community-based, day treatment and similar services" (*Trends in Community-Based and Day Treatment Services*, 2000).

Examining mental health *authorizations* does not indicate whether a member was able to obtain the service. Yet the Quality Management Committees are continuing to use service authorization rates to track actual mental health use by Salud! members. As late as April 2000, ValueOptions was using mental health service authorizations to oversee the care provided in Presbyterian Medical Services and Rio Grande, two Regional Care Coordinators (*Trends in Community-Based and Day Treatment Services,* April 10, 2000). Without actual mental health data, the plans and the Medical Assistance Department cannot identify areas of mental health service underutilization, the primary quality concern for managed care arrangements.

We recommend that HCFA:

1) Discuss with MAD why the Health Plan Quality Committees are still not using encounter data to monitor the delivery of mental health services.
2) Compare the percentage of community-based mental health service authorizations for community-based behavioral health services that are actually provided (mental health services provided/mental health authorizations) with the percent of authorizations for outpatient physical health services (outpatient physical health services provided/outpatient physical health authorizations).
3) Examine trends per month and per year for the following community-based services: mental health case management for children, mental health case management for adults, behavioral management specialists for children, day treatment for children, and psychosocial rehabilitation for adults.

6. Differences and suspiciously large increases in EPSDT rates

a) <u>Previous reported rates for Cimarron were much lower than reported to HCFA.</u>

"We are not certain where Bazelon obtained these data. We so far have EPSDT data only from the first year of the SALUD! program when all three managed care providers began delivering care in a newly created system."

Bazelon Center Response: We obtained our data from HCFA-416 data reported by Cimarron. We urge HCFA to explore the reasons for the different EPSDT rates reported for Cimarron in Fiscal Year 1997 and the significant increase from 1997/1998 to 1999. Cimarron's HCFA-416 for Fiscal Year 1997 reported an EPSDT participation rate of 0.5% and rate of required screens performed of 0.2% (refer to Appendix B). Cimarron's EPSDT rates now reported by MAD were 13% for 1997 and 14% for 1998. In 1999, the EPSDT participation for Cimarron rose to 59%, a 320% increase. We urge HCFA to find out from MAD the reason for the change in

rates and whether Cimarron is accurately counting only screening visits for EPSDT.

b) MAD now reports significant increases in EPSDT under Salud!.

> *"Data for the most recent year for which we have data (FY 1999) shows that Presbyterian Health Plan provided 62 percent of the targeted number of screens; Lovelace provided 76 percent; and Cimarron provided 59 percent. The huge difference between these data and the numbers quoted in the Bazelon Report is due to management of data, not to a more than one thousand percent increase in the number of children visiting their doctors!"*

Bazelon Center Response: The latest data released by MAD indicate significant improvement from the FFS rates (30% of children were screened, 39% of screens were completed in 1994, 1996) and Salud! rates reported in Fiscal Year 1999. We recommend that HCFA request from New Mexico:

1) An independent audit of health plan encounter data to assure that only EPSDT screening visits are counted.
2) Detailed information on the number of children with EPSDT screening information and the method for counting a child as a Salud! member.

7. Improper grievances and appeals

> *"During the IPRO 1999 Evaluation 5 BHO files were reviewed per plan. Five files are too small of a sample to have statistical validity. In addition see above for explanations."*

Bazelon Center Response: Medicaid due process rights are broader than the rights of members in commercial insurance. Commercial health plans often do not understand the right of Medicaid members to receive written denials when any physician-recommended service is reduced, altered or denied. Medicaid members also have the right to appeal directly to the Medicaid agency. In addition, grievances and appeals are a major area of concern in monitoring Medicaid managed care plans. The IPRO sample indicated serious problems with these processes. If the state disagrees with the IPRO utilization findings due to the lack of a statistically valid sample, then the state should review a statistically valid sample of cases to confirm or disprove that the changes made were sufficient to correct the identified deficiencies in the grievance and appeal processes. These are serious charges and issues. Ignoring them due to the lack of statistical validity implies a lack of concern for member rights.

8. Slow utilization decisions

> *"In fact The IPRO score page indicates that a total of 5 files were reviewed for ValueOptions and that reviewers were unable to determine timeliness in 3 of them (60 percent), not as Bazelon alleges that they "failed to adhere". (See Attachment #18). Furthermore, MAD Policy 606.7.4.4, referring to timeliness of decisions, is one of eleven (11) sub standards under the UM category. The UM category is one of eight (8) standards that are reviewed. The IPRO file review of five files can in no way be*

considered statistically valid. It can be used as an indicator, however. MAD is using it as it was intended to be used."

Bazelon Center Response: If the state disagrees with the IPRO findings due to the small sample size, then the state should review a statistically valid sample of cases to confirm that the changes made were sufficient to correct the identified deficiencies.

Overall, there is significant data to suggest major problems with Salud! This data is reinforced from anecdotal evidence from consumers, families and providers in the state, particularly from state-wide associations representing them. The Bazelon Center continues to believe that major revisions to this plan are necessary, and urges you not to approve a renewal of the Section 1915 waiver as it applies to mental health care unless or until the state makes significant revisions designed specifically to address the problems we have cited in our reports or that HCFA has identified in its own review.

Sincerely,

Chris Koyanagi
Director, Federal Relations