



The LEWIN GROUP

Independent Assessment of New Mexico's Behavioral Health Program

Prepared for: New Mexico Medical Review Association

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I. EXECUTIVE SUMMARY

This report conveys the findings of the Independent Assessment of the access and quality of health care services delivered under New Mexico's Behavioral Health Collaborative. This report fulfills the requirement of the Centers for Medicare and Medicaid Services (CMS) that state Medicaid authorities arrange for an independent assessment of a state's 1915(b) waiver programs. An assessment of the initiative's cost-effectiveness is also provided.

An Interagency Behavioral Health Purchasing Collaborative (the Collaborative) has legal responsibilities for planning, designing, and implementing the single statewide behavioral health system. Subsequently, ValueOptions reports to the Collaborative.

The Lewin Group has reviewed the access- and quality-related state contractual requirements, ValueOptions' proposal to the State of New Mexico, Managed Care Audit, ValueOptions' provider network, selected reports, provider satisfaction survey, national performance standards and MHSIP performance, and ValueOptions' Quality Management Program.

We found that ValueOptions is providing increased levels of access to care as compared to the previous behavioral health system. Although the behavioral health system has been only recently implemented, the Collaborative and ValueOptions have taken significant steps to ensure continuity of care. Our key findings related to access are summarized below.

- Based on their proposal to the State of New Mexico, ValueOptions is committed to maintaining an extensive provider network by continuing use of the same reimbursement strategies and accepting all network providers for at least six months.
- The Collaborative and ValueOptions allow for input from local communities, minorities, families, and consumers in key decisions and emphasizes member empowerment. As a result, member satisfaction survey results show increases in comparison to the previous behavioral health system.
- Both the contract between the State of New Mexico and ValueOptions and ValueOptions' proposal to the State of New Mexico create high access standards for the system. Although ValueOptions has not immediately complied with all performance standards reviewed in our analysis, it is clear that ValueOptions is making progress to meet them and in some cases, already exceeding performance in comparison to the previous behavioral health system.

We also found that the Behavioral Health program is structured to promote and deliver quality health services. The contract with ValueOptions puts in a place a structure for a comprehensive system of behavioral health to occur, while ValueOptions ensures it. Our key findings related to quality are summarized below.

- Providers are somewhat divided in their overall assessment of ValueOptions' management of behavioral services. Many providers (44%) are not satisfied with ValueOptions. Providers who have 45 consumers or more and are managed by ValueOptions were most likely to be dissatisfied with various aspects of care.

- ValueOptions has demonstrated its responsiveness to consumer and provider grievances. For example, a consistent grievance was unreturned phone calls to the Claims department. In response, the ValueOptions CEO mandated a policy that requires all staff to return telephone calls to providers and consumers within 24 hours from the time of the receipt and changed its system to allow providers the ability to route calls about claims questions directly to the Claims Department and began its provider training in December 2005. Consequently, the number of grievances concerning this issue was zero after three months. The reason for this decrease is not known.
- ValueOptions' performance on the various measures reviewed are above the National Committee for Quality Assurance (NCQA) rates and the MCOs' rates from previous years when behavioral health services were rendered under the Salud! program. The ValueOptions rate was higher than or equal to the MCO baseline and performance measure rates improved each quarter.
- Member satisfaction (MHSIP) survey results show improvements between ValueOptions and New Mexico's experience during previous years under Salud!. The least rated MHSIP scores were above 70 percent, which means that a majority of consumers are currently satisfied with their behavioral health care.
- ValueOptions' current Quality Management Program is comprehensive as it includes procedures for data collection, performance improvement, risk management, and evaluation of ValueOptions' quality processes. Since ValueOptions is still in the process of implementing its program and policies, it has created a detailed work plan, which specifies targeted activities, key measures, responsible persons, and deadlines.

Finally, we found that it is not yet possible to make a determination as to where the newly established behavioral health system under the Collaborative and ValueOptions is cost-effective. Our key finding related to cost-effectiveness is summarized below.

- The State estimates that behavioral health costs increased by 26.3 percent in total dollars, and by 34.5 percent on a PMPM basis from FY05-FY06. This is clearly a large-scale, intentional increase designed to strengthen the behavioral health services delivery system and improve patient outcomes. It is not yet possible to make a determination as to whether these investments will prove to be "cost-effective," although several aspects of this report have shown short-term improvements in the service delivery under the carve-out program.

Based on the comprehensive review of submitted reports and data related to consumer and provider satisfaction, the program is off to a strong start in some respects and a challenging start in others. ValueOptions and the Collaborative have implemented a behavioral health system that is designed to not only provide access to quality health services, but also integrate other non-medical health member needs. The State of New Mexico has set extensive and specific requirements for performance, which ValueOptions has already met or appears to be making significant progress towards. New Mexico's behavioral health system meets CMS guidelines and requirements in terms of access, quality, and cost-effectiveness.

II. INTRODUCTION

Prior to the establishment of a single mental health system for Medicaid beneficiaries, members had inconsistent access to resources and high quality health care.¹ Salud!, New Mexico's managed care program, provided care to a small proportion of those with serious mental disorders. Under the previous behavioral health system, many state agencies funded, contracted for, or provided behavioral health services. Additional state agencies had responsibility for population groups that may have behavioral health service needs in addition to the services for which that agency is primarily responsible. The four state agencies with the greatest responsibilities for behavioral health services were the Department of Health (DOH), Human Services Department (HSD), Children, Youth, and Families Department (CYFD), and the Administrative Services Division of the Department of Health.

Uninsured and Under-Insured Subgroups: The Behavioral Health Services Division (BHSD) of the Department of Health provided funding for the non-Medicaid uninsured adult mental health and substance abuse services in the form of global budgets (fixed dollar allocations) to three Regional Care Coordination (RCC) entities managing services in five regions. The RCCs developed a plan for behavioral health services within their regions, contracted with providers for behavioral health service provision, managed access to and utilization of care, and oversaw quality and performance of services under their jurisdiction.

Medicaid Subgroups: The Medical Assistance Division contracted with three managed care organizations (MCOs), which managed both primary and behavioral health for the child, adolescent, and adult Medicaid enrollee, and through a fee-for-service (FFS) program. The FFS program covered newly eligible Medicaid recipients who had not yet enrolled in one of the MCOs, Native Americans who did not proactively opt in to the MCO program, and individuals in special eligibility categories excluded from mandatory enrollment.

Under Salud!, Medicaid had a very limited benefit for substance abuse for adults. The FFS program allowed up to 12 hours of psychiatric therapy for alcohol abuse. In contrast, Medicaid had a relatively generous behavioral health benefit for youth under the Early Periodic, Screening, Diagnosis, and Treatment Program, but relatively few youth accessed this benefit. The MCOs also had the ability to expand the substance abuse benefit for adults, but only limited substance abuse services were provided for both youth and adults.

In 2002, the *Behavioral Health Needs and Gaps in New Mexico* (Gaps Analysis) report found that the behavioral health system in New Mexico was fragmented, lacked evidence-based practices, and did not have sufficient consumer and family participation in the planning and implementation processes. Only 19 percent of adults needing public sector mental health services were being served. In addition, the cost of psychiatric inpatient services more than doubled from FY1997 to FY2001 (increasing from \$17 million to \$38 million), after having been reduced the year prior to implementation of managed care. Finally, all regions had high

¹ Information on the previous behavioral health system under the Salud! program was obtained from the Behavioral Health Needs and Gaps in New Mexico report, available at http://www.hsd.state.nm.us/mad/pdf_files/Reports/BHGapanalysis.pdf, July 15, 2002.

utilization of inpatient and residential care compared to the more desirable and effective community-service modalities.

The report found that the following populations most needed additional services:

- Children and adolescents, including infants to school age and adolescents transitioning into adulthood
- Persons with co-occurring disorders (e.g., mental illness and substance abuse or other mental illness)
- Persons with special cultural needs

A high proportion of provider agencies were single service provider agencies. In other words, most did not serve multiple populations or offer a range of mental health services.

The report outlined the need to adopt a statewide comprehensive approach to behavioral health programming, planning, treatment, and prevention. It documented that the system offered varying degrees of accessibility and uneven quality of service across the state. Multiple behavioral health care systems evidenced a lack of necessary development in community and home-based services for adults, children, youth, and their families. Available and credentialed in-state child psychiatrists and other critical behavioral health professionals were found to be in short supply. Finally, there was a long-term need to increase the overall capacity of behavioral management and rehabilitative services as well as the capacity of case management and intensive outpatient services for adults. ValueOptions was selected through a competitive procurement process in which several bidders submitted proposals in response to the State's detailed RFP.

As a result, the State of New Mexico initiated the behavioral health transformation process, which began on July 1, 2005. The transformation affected between 400,000 and 500,000 potential consumers as well as 17 different State agencies that are responsible for funding or oversight of behavioral health programs. An Interagency Behavioral Health Purchasing Collaborative (the Collaborative) has legal responsibilities for planning, designing, and implementing the single statewide behavioral health system. The Collaborative exists within a statutory framework that also encompasses 15 Local Collaboratives (LC) and the Behavioral Health Planning Council (BHPC). The Local Collaboratives, which are organized around judicial districts as well as the Native American tribes, nations, and pueblos, 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. Among each of the LC's early tasks have been the organization and facilitation of focus groups aimed at developing a comprehensive behavioral health needs assessment and resource inventory for its area, and the development of a list of pressing legislative priorities.

The transition to ValueOptions has three phases:

- Phase One: FY2006 – The Collaborative and ValueOptions successfully transitioned the multiple systems to one behavioral health delivery system in a timely manner. Specifically, ValueOptions maintained continuity of care and system stability to the satisfaction of the Collaborative.

- Phase Two: FY2007 and FY2008 – ValueOptions develops performance objectives and deliverables for Phase Two that identify more effective ways of combining multiple funding sources and funding mechanisms to increase service capacity, supporting local collaboratives, inclusion of additional funding streams, and facilitating the customer outcomes and system performance the Collaborative desires.
- Phase Three: FY2009 – ValueOptions will work with the Collaborative to design a plan for work for this phase through a contract amendment.

Performance indicators and expectations of the new program will increase with the completion of each phase.

When ValueOptions initially began covering behavioral health services, the MCOs were concerned about their members continuity of care. The MCOs still provide behavioral health service and hold responsibility for psychiatric medications prescribed by any of the practitioners within the MCO networks. The MCOs supported the Collaborative even though they were wary of the transition issues experienced when Salud! was initially implemented. The MCOs felt that the shift to ValueOptions for behavioral health services might be disruptive due to extensive lead times that were needed in order to develop the processes and relationships that the MCOs had previously established. Nevertheless, during the past year, the MCOs realized that the decision to carve out behavioral health services through ValueOptions was not a reflection on them, but rather a reflection of national health care trends in the behavioral health field.

The following sections analyze the degree of access, quality, and cost-effectiveness of services available to ValueOptions members.

III. ACCESS ASSESSMENT

A. Background

The establishment of the Medicaid program in 1965 provided the financial means for low-income children and adults, as well as low-income elderly and disabled individuals, to obtain health care. However, as it has become increasingly apparent over the past several decades, financial coverage does not, in and of itself, ensure true access to needed health and medical services. Lack of access to care comes at a high cost to those with medical needs as well as for the health care system because these individuals may present in the emergency department for routine care or delay care until their condition is serious enough to require hospitalization. Access to and receipt of needed care is affected by many factors, including but not limited to the following:

- **Level of physician participation.** Low payments have been a longstanding issue in many states' Medicaid programs and have clearly affected doctors' willingness to treat Medicaid beneficiaries. Fee levels for front-line health professionals play a critical role in the way health care is accessed by and delivered to Medicaid beneficiaries.
- **Degree to which participating physicians are accepting new patients.** Low fees also make it more difficult to access even those providers who already participate in Medicaid. These providers often find it necessary to close their practices to new Medicaid patients.
- **Proximity, appointment availability, and other "ease of accessibility" factors.** Geographic location, physical structure, convenience of office hours, and appointment waiting times are generally more important indicators of access than is the size of the provider network. Medicaid-participating physicians also are more likely to carry a very high patient load, which can create further concerns regarding in-office and appointment waiting times and the amount of time practitioners are able to spend with each patient.
- **The degree to which cultural, language, and other barriers exist and the extent to which the recipient's health care delivery system addresses them.** Medicaid recipients often face significant cultural, language, socioeconomic, and psychosocial barriers to accessing health care. Compared to the general population, they are more likely to have lower literacy levels, have a primary language other than English, have less formal education, belong to racial/ethnic minorities, face difficulties such as substandard housing or homelessness, and/or have belief systems that are in conflict with traditional Western medicine. Such barriers make it difficult for Medicaid beneficiaries to navigate an already complicated health care system and therefore interfere with their health care needs being fully met. The structure of the individual's health care delivery system is a key determinant of access to and appropriate utilization of services.

In the remainder of this chapter, we discuss the state of access in the State of New Mexico's behavioral health program implemented by ValueOptions. We present data, both quantitative and qualitative, that provide insights into the level of access that exists.

B. State of New Mexico Contract Requirements

New Mexico's contract with ValueOptions mandates that certain requirements are met regarding Access. The main areas are physical and communication accessibility, outreach to high-risk patients, GeoAccess, level of provider payments, and cultural competency.

1. General Access Requirements

The Collaborative requires that ValueOptions provide access to services for eligible individuals and use diagnostic criteria and risk factors to prioritize such access. Among others, some of the most important contract requirements related to access are as follow:

- Work proactively to maximize the availability of ADA-accessible transportation services
- Implement a plan to ensure that behavioral health providers work in an integrated fashion with public schools throughout the State
- Implement policies designed to maximize the coordination of physical and behavioral health services
- Address both physical and communication accessibility
- Ensure providers appropriately deliver case management services
- Implement, maintain, and evaluate a Cultural Competency Plan for ValueOptions
- Operate a 24-hour, 365-day a year toll-free referral and communication system for referrals. Individuals who staff the call center are required to be behavioral health professionals who are culturally competent and trained to screen crisis or emergency calls.
- Meet regional targets for new member enrollment

2. Physical and Communication Accessibility

Among the many provisions related to provider sites and member communication, some of the most important requirements include:

- All provider facilities are to be ADA (American Disabilities Act) compliant including entrances, restrooms, business offices, therapy locations, and all service delivery sites
- All telecommunications systems for intake and throughout the service delivery systems are to have TTY services and/or be accessible through the "711" telecommunication system
- Information that is verbally presented or in written form must be linguistically appropriate and culturally sensitive. This includes commonly understood language and avoidance of professional jargon and the availability of interpreters for both sign language and when the primary home language is not English.
- Written materials shall be provided in a variety of formats for consumers and families to ensure access to information and may include reduced reading level, large print, translation into languages other than English, and electronic formats

3. Transportation Support

The contract specifies that ValueOptions work proactively to maximize the availability of ADA-accessible transportation services for Medicaid and non-Medicaid eligible behavioral health consumers. ValueOptions shall assist the Collaborative to prevent reduction of access to existing transportation benefits or resources, and to increase access to behavioral health services for children in schools and their families. For example, ValueOptions must provide care coordination services to facilitate timely access to and utilization of appropriate services to non-Medicaid eligible Children, Youth, and Families Department (CYFD) target populations. Care coordination actively involves children and their families through the decision making process from initial planning through implementation and evaluation.

4. Care Coordination and Collaboration

The contract requires that ValueOptions has an extensive coordination and collaboration plan. ValueOptions shall cooperate with state facilities and community organizations, promote the coordination of the referral process, and implement policies that ensure providers coordinate with local primary care resources. ValueOptions must ensure that all behavioral health subcontractors establish continuity of care for registered clients who become detained by the Criminal Justice System or the Department of Corrections. ValueOptions must also maintain contracts with the Indian Health Services (IHS) of Albuquerque and in the Navajo Area IHS and with all tribal or pueblo providers.

A unique feature of the contract is the requirement to work with regional organizations such as Local Collaboratives (LCs) or the Behavioral Health Planning Council (BHPC). The Collaborative designated Local Collaboratives for each of the 13 Judicial Districts and for Native American tribes or pueblos. The Local Collaboratives may include schools, justice, faith-based organizations, public health entities, local housing and jobs organizations, disability-related organizations, and representatives of business community organizations. ValueOptions must disseminate data to the LCs, structure committees so that there is optimal Local Collaborative representation, establish formal communications and share information at management levels, and utilize the BHPC for advice and input.

The contract requires that ValueOptions develop new ways of identifying and serving individuals who have or are at an increased risk for evidencing a chronic mental, developmental, behavioral, neurobiological, or emotional condition. For example, with the assistance of the Collaborative, ValueOptions designed criteria for determining which consumers and families with multiple, complex and special cognitive, behavioral, and physical health care needs will have their care coordinated by ValueOptions. Criteria includes such issues as the acuity of need, need for multiple services or systems, past high use of behavioral health services, and high risk of needing intensive behavioral health services.

Finally, ValueOptions ensures that providers appropriately deliver case management services in each community in which there are customers who need the services with the understanding that case management services are incorporated into the community support service in the future. Subsequently, ValueOptions will ensure that providers appropriately deliver community support services once those services come on-line.

5. GeoAccess Requirements

The ValueOptions contract does not delineate specific GeoAccess requirements. Instead, the contract mandates that ValueOptions shall develop statewide behavioral health provider access based on GeoAccess standards, including appropriate and timely access to out-of-network providers.

6. Cultural Competency

ValueOptions is also required to demonstrate cultural competency and proficiency in a Cultural Competency Plan. Some of the most important requirements related to cultural competency are as follows:

- Provide culturally competent and culturally specific services to address the need of ethnically/racially diverse populations
- Actively recruit culturally and linguistically fluent providers
- Ensure that the content of education material provided by ValueOptions can be easily understood, available in other languages, and written at not more than a sixth-grade reading level

7. Summary of Contract Requirements

The requirements set forth by the contract between ValueOptions and the State of New Mexico are extensive. The contract emphasizes the creation of a comprehensive system of behavioral health. Consequently, the contract requires care coordination and collaboration with community organizations, Native American and Hispanic minority populations, the State of New Mexico, and Local Collaboratives.

The requirement to work with Local Collaboratives that represent community interests is an original feature of the contract. Ultimately, this partnership is intended to create a network in which behavioral health patients have increased access to care in the State of New Mexico.

The contract also strives to ensure that minority populations are delivered quality health services. The requirement to develop a comprehensive Cultural Competency Plan and work with regional organizations is innovative. Since New Mexico has significant Native American and Hispanic minority populations, the contract promotes a program through which minority consumers are able to obtain health services from providers.

To oversee these contract requirements, the Collaborative established an Oversight Committee that meets eight to twelve hours each week to discuss, monitor, and review the ValueOptions contract and ValueOptions performance.

C. ValueOptions' Proposal to New Mexico

The ValueOptions proposal to the State of New Mexico is more than 1,200 pages in length with an additional three notebooks of appendices. We have not audited the degree to which each initiative has been implemented.

ValueOptions has offices in six locations across New Mexico, including administrative headquarters in Albuquerque and Santa Fe as well as Regional Offices in Farmington, Santa Fe, Albuquerque, Roswell, and Las Cruces. A staff of more than 170 people have been hired to work in New Mexico to support the Collaborative, its customers, families, and providers.

1. Provider Support

To support providers, ValueOptions continued the same reimbursement strategies being used by the Collaborative agencies through at least the end of the first contract year and accept all current network providers for at least the six months. Consequently, ValueOptions took steps to ensure continuity in the provider network.

ValueOptions also established a variety of reimbursement options, including the Ready Pay Payment Plan, which offers providers an upfront payment every month based on the previous year's fee-for-service revenues with reconciliation conducted as providers submit claims. It is designed to ensure a positive cash flow for providers and practitioners.

ValueOptions also proposed to provide administrative and clinical supports to network providers such as on-site technical assistance, training on both administrative and clinical topics, issue provider performance reports, and develop a claims processing unit that is dedicated solely to processing claims for services provided to the Collaborative's consumers.

2. Network Development

ValueOptions proposed several key strategies that guided network development. Some important strategies are as follows:

- Seek the advice of consumers and family members, as well as advocacy organizations and providers in identifying needed services, access-related concerns, quality of care concerns and other issues
- Maintain an open panel and actively recruit all willing and qualified New Mexico behavioral health providers and practitioners
- Expand utilization of peer and family supports and foster the development of consumer-centered and consumer-owned businesses
- Work with current providers to enable them to become contracted to serve consumers in multiple funding streams

3. Support for Local Collaboratives and the Behavioral Health Planning Council

ValueOptions will provide administrative support through the Regional Offices and ensure the involvement of Local Collaboratives by:

- Providing data and staff to support local needs assessment and planning
- Incorporating their review and input into coordination of care protocols that affect local agencies and consumers

- Assisting with the identification of local workforce development opportunities, such as programs for employee recruitment and retention, and opportunities to develop consumer and family-owned/operated businesses
- Providing meeting space and administrative support in the Regional Offices

ValueOptions staff will attend every meeting of Local Collaboratives to which they are invited, and will present data reflecting local service utilization for the review of the members.

Finally, to support the work of the Local Collaboratives and the Behavioral Health Planning Council, ValueOptions will administer technical assistance grants of \$3,000 to each Local Collaborative and \$5,000 to the BHPC.

4. Future Initiatives

The proposal also projected some of the initiatives for the second and third phases. Some key initiatives include a self-directed care initiative, an IT Blueprint Development process, a financial task force to review all potential administrative efficiencies, and task forces to explore a variety of critical issues including workforce development and increasing cultural competency.

D. ValueOptions Compliance with New Mexico Managed Care Regulations

As a condition of its participation in the New Mexico Medicaid Waiver Program, ValueOptions must comply with managed care regulations in the State of New Mexico.

In a comprehensive compliance audit, an External Quality Review Organization (EQRO) for HSD found ValueOptions to be “minimally compliant” for both services and information technology systems. The minimally compliant grade means that ValueOptions was placed into corrective action.

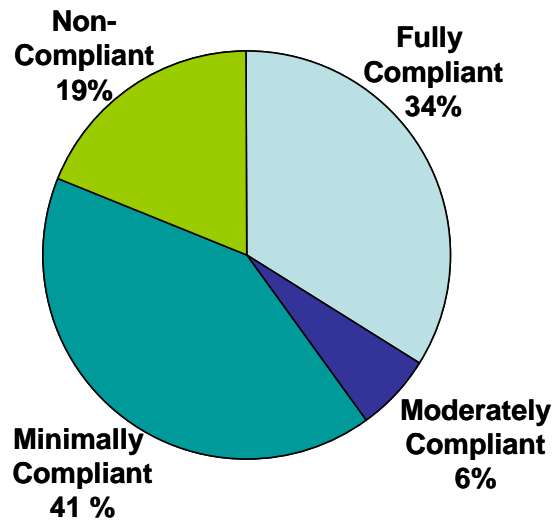
The Department of Health and the Collaborative put the findings of the Compliance Audit into the context of transition during the past year. The Collaborative acknowledges that the period of time in which ValueOptions was required to prepare for and implement the state’s behavioral health programs was short. The period on which the audit was conducted occurred less than one year into the new contract. As a result, the Collaborative and state acknowledges that the findings contained in this report “indicate a good beginning.”²

ValueOptions submitted a Directed Corrective Action Plan (DCAP) related to the compliance audit results. The DCAP identified deficiencies, which were linked to specifically directed actions and interventions as well as specified timeframes for completion. Each deficiency has a defined and required outcome that the contractor must achieve within the specified timeframe for completion. If the DCAP implementation is not effectively implemented, it is basis for imposition of sanctions.

² Pamela S. Hyde, Secretary of HSD and Co-Chair of the Collaborative, and Michelle Lujan Grisham, Secretary DOH and Co-Chair of the Collaborative. <http://www.bhc.state.nm.us/pdf/ComplianceAuditCoverLetter.pdf>

Below Figure 1 shows the number of compliant, moderately compliant, minimally compliant, and non-compliant areas.

Figure 1. Behavioral Health Compliance Audit Results



5. Provider Networks

ValueOptions was reviewed to determine whether a comprehensive provider network was sufficient to serve consumers in compliance with access standards. Consumer and provider handbooks were evaluated for evidence of documentation on how to access various services. The GeoAccess report was evaluated to determine the number of providers, geographic location, and distance of Medicaid members to access providers. Policies and procedures regarding provider recruit and determination were also reviewed. The provider network was determined to be minimally compliant based on MAD regulations. At the time of the audit, a provider directory was not developed nor was a GeoAccess report submitted.

6. Access to Care

The audit reviewed the process a consumer utilizes to access urgent emergency services and all other health care services, as well as policies and procedures and the consumer handbook. The access to care standard was found to be “fully compliant” with MAD regulation.

7. Coordination of Services

Coordination of service policies and procedures were reviewed to determine the coordination of physical and behavioral health services. Policies and procedures relating to the home and community-based waiver programs, school-based services and children’s medical services were reviewed for coordination of services components. Additional policies and procedures focusing on care coordination services within the Juvenile Justice System and Children, Youth and Families Department (CYFD) and a sample behavioral health provider care coordination plan were evaluated. This section included a random sample review of care coordination files for compliance with MAD regulations.

Upon review, this area was found to be minimally compliant with MAD regulations. Training documents for the transition to ValueOptions did not include referrals for care coordination, the sample plan of care did indicate that interventions, community planning, and information sharing occurred between multiple providers, the process for plan of care development and implementation by the case manager was inconsistent, and only half of the random sample of care coordination files met standards.

8. Client Transition of Care

ValueOptions was also evaluated to ensure continuity of care during transition of services. Policies and procedures were reviewed to ensure continuity of care during transition of services. Prior authorizations and provider payment requirements were also analyzed. The Client Transition of Care standard was determined to be fully compliant with MAD regulations.

E. Provider Readiness Assessment

Key components of transitioning to ValueOptions include various strategies for developing the service and infrastructure capacity of its provider network. One aspect of the transformation included increased level of accountability services delivered by providers (e.g. greater emphasis on encounter reporting, fee for service reimbursement). Consequently, the Collaborative commissioned an analysis of provider readiness during the implementation phase to establish a baseline for existing provider competencies and functions in all areas. The results are shown in Figure 2.

Figure 2. Provider Readiness Review Analysis Findings

Readiness Score Range	Percentage of Providers
25% or below	7% of providers
26% - 50%	27% of providers
51% - 75%	49% of providers
Greater than 75%	17% of providers

The assessment finds that only 17 percent of providers are ready to implement the new requirements successfully and that another 49 percent of providers can implement changes with some transitional supports. Using a 50 percent score as a threshold, these data suggest that fully a third of the provider network is poorly prepared to successfully respond to changes in payer requirements, including changes in service requirements, increased reporting requirements, increased fee for service reimbursement, and new service authorization requirements. These providers likely require intensive training and in some cases ongoing mentoring to make the necessary operational changes. Specific areas for technical assistance include psychiatric coverage issues, specific MIS limitations, and limited capacities to support consumers with involvement in provider governance activities.

In addition, the review found that more than half of the behavioral health providers surveyed do not have an information system that can be used to track and manage operations based on

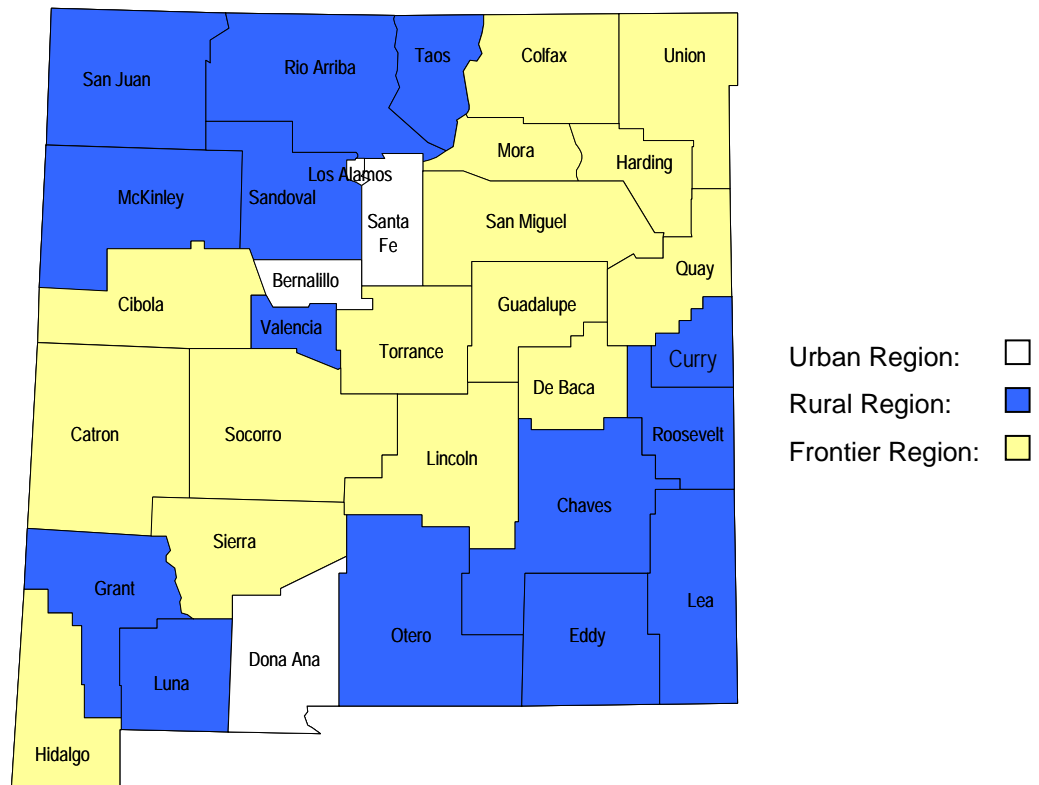
billing and productivity data and generate a HIPAA compliant claim form. This percentage excludes the ValueOptions electronic interface that is available to providers for reporting and billing. The large gap in information system capacity in New Mexico is greater than that found in other states. In Illinois, for example, only 25 to 30 percent of the providers did not have information system capabilities.

F. Network Adequacy

9. GeoAccess Requirements

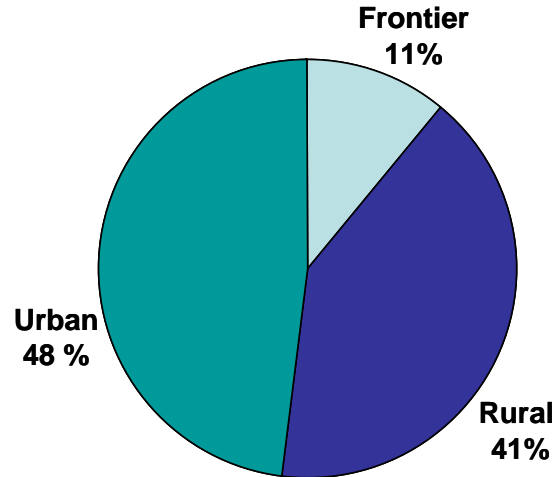
The GeoAccess report was not defined or conducted for the first two quarters of FY2006. Instead of the GeoAccess report, ValueOptions provided the Oversight Management Team with a contracting status report to track the progress of ValueOptions' network development for all participating agencies. There were multiple issues with the source data and cleaning the list in order to capture a realistic base number of providers. ValueOptions has submitted drafts of reports to the Oversight Management Team, who has recommended revisions of data included. ValueOptions is currently revising its GeoAccess report. In addition to the GeoAccess report, ValueOptions also provides a quarterly narrative Network Report that outlines changes that have occurred in the network, including addition of service, providers, and termination of services.

Figure 3. Map of New Mexico Medicaid Regions



It is also helpful to understand the distribution of ValueOptions members in the urban, rural, and frontier counties.

Figure 4: ValueOptions Membership by Medicaid Region



The Collaborative released a Behavioral Health Accessibility Analysis report on April 27, 2006. Although access standards are generally met for urban Medicaid members, rural and frontier Medicaid members are still located considerable distances from providers. For example, the report found that urban Medicaid managed care members had an average of at least one inpatient hospital facility within 6.8 miles, rural Medicaid managed care members can locate one inpatient hospital facility within an average of 15.5 miles, and frontier Medicaid managed care members are able to access an inpatient facility within 25.3 miles. This unequal access to providers occurs across many provider groups, including partial hospital facilities, Indian Health Service and Tribal 638 facilities, psychosocial rehabilitation/intervention facilities, accredited residential treatment centers, and behavioral management services.

The Managed Care Accessibility Analysis dated April 27, 2006 used the following standards to determine whether members had desired access to providers: Urban - 1 provider within 30 miles; Rural - 1 provider within 60 miles; and Frontier - 1 provider within 90 miles. Figure 5 provides more detailed information for several provider groups.

Figure 5. ValueOptions GeoAccess Standards

Provider Group	Member Group	Access Standard	Members with Desired Access
Inpatient Hospital Facilities	Urban	1 Provider within 30 miles	98.5%
	Rural	1 Provider within 60 miles	49.6%
	Frontier	1 Provider within 90 miles	49.5%
Indian Health Service and Tribal 638 Facilities	Urban	1 Provider within 30 miles	59.1%
	Rural	1 Provider within 60 miles	38.8%
	Frontier	1 Provider within 90 miles	33.9%
Accredited Residential Treatment Center Locations	Urban	1 Provider within 30 miles	88.9%
	Rural	1 Provider within 60 miles	9.7%
	Frontier	1 Provider within 90 miles	0.0%
Outpatient Therapy/Clinics/Groups	Urban	1 Provider within 30 miles	98.7%
	Rural	1 Provider within 60 miles	100%
	Frontier	1 Provider within 90 miles	100%
Psychosocial Rehabilitation/Intervention Facilities	Urban	1 Provider within 30 miles	92.5%
	Rural	1 Provider within 60 miles	86.3%
	Frontier	1 Provider within 90 miles	85.4%
Behavioral Management Services	Urban	1 Provider within 30 miles	91.9%
	Rural	1 Provider within 60 miles	89.9%
	Frontier	1 Provider within 90 miles	16.5%
Psychiatrist	Urban	1 Provider within 30 miles	98.7%
	Rural	1 Provider within 60 miles	90.2%
	Frontier	1 Provider within 90 miles	72.3%
Psychologist	Urban	1 Provider within 30 miles	94.9%
	Rural	1 Provider within 60 miles	96.6%
	Frontier	1 Provider within 90 miles	81.3%

Outpatient therapy/clinic/group is one of the few provider groups in which access standards are met. Other provider groups in which the members with desired access is greater than 70% for rural and frontier Medicaid managed care members include psychosocial rehabilitation/intervention facilities, non-accredited residential treatment centers and group home locations, treatment foster care I and II, behavioral management services, enhanced services, psychiatrists, psychologists, and other independent licensed providers.

10. Provider Payment Timeliness

ValueOptions has paid New Mexico providers promptly. Approximately 70,000 claims are received every month. On average, ValueOptions pays 95 percent of clean claims within 30 days of receipt and 99 percent of clean claims within 90 days.

Approximately 11 to 15 percent of claims received by ValueOptions are “unclean,” which means that ValueOptions had to request more information from the provider. Nevertheless, ValueOptions still pays most of the unclean claims within 30 days of initial receipt. ValueOptions’ timely provider payments help to sustain the network and satisfy providers.

G. Selected Reports Submitted by ValueOptions to the Collaborative

11. Customers Served Annually

ValueOptions provides information on whether the number of individuals ValueOptions served in FY2006 was more or less than the number served by other entities in FY2005.

Figure 6. Distinct Customers Served in FY2005 and FY2006 By Category

Category	Distinct Clients	
	FY2006	FY2005
Substance Abuse Community-based Consumers	4,650	1,194
Mental Health Consumers	11,638	8,145
Adults with Co-occurring Mental Health and Substance Use Disorders	4,073	4,756
Native American Customers	1,207	NA
SMI Adult Customers	7,897	1,739
Children/Youth Customers/Families	8,054	14,678
SED Children/Youth Customers	177	NA
Juvenile Justice Involved Children/Youth Customers	635	NA
Children/Youth in Custody of CYFD Customers/Families	337	NA
Adults Leaving Prison and probationers and parolees in the Community Under Supervision of NMCD	5,005	NA
Senior Customers (age 60 and over)	2,599	141

Source: Annual Report, PM#6 Customers Served Annually FY06

The categories that showed an increase in FY2005 to FY2005 were: substance abuse community-based consumers, Mental Health customers, SMI Adult Customers, and senior customers. However, as show in the table above, ValueOptions did not serve a comparable number of customers for the children/youth customers/families. ValueOptions should re-examine its outreach efforts with this population to reach it more effectively.

ValueOptions urges in its report that comparisons between FY2006 and FY2005 be done with caution. Baseline data from FY2005 was taken from a different report (Statewide Diagnostic Categories at Registration-Active). The logic behind each category and in some cases, the data sources were different. The outcome measures will be more accurately measured and reported on in FY2007 when ValueOptions can compare data from FY2006 and FY2007 using categories defined the same, from the same sources of data.

12. Call Statistics

ValueOptions meets the performance standards established by the Collaborative for Phase One. The performance standards dictate that 90% of member services calls must be answered within 30 seconds or less based on the reported average, with no more than a ten percent abandonment rate.

The percentage of calls answered within 30 seconds is consistent throughout FY2006. For the first few months of the year, average percentiles were in the low nineties for English call centers and upper nineties for the remainder of the year. Spanish call centers also answered over 90 percent of calls within 30 seconds, except for August and November.

The call abandonment times for English call centers ranged from 0.3 percent in April 2006 to 6.1 percent in June 2006. In addition, there were only 14 abandoned calls in the Spanish service area for the entire period of August 2006 through June 2006. Both English and Spanish call centers met performance standards.

13. Screening Compliance

In "Performance Measure 7," ValueOptions must provide information on compliance in screenings for adults with mental health and substance abuse disorders. This initial report serves as a baseline for the two performance measures regarding mental health and substance abuse screenings and used as a tool to identify potential areas for quality improvement. Initial outcomes are show in Figure 7 and 8.

Figure 7: Degree to Which Adults Presenting with Psychiatric Issues are Screened for Substance Abuse

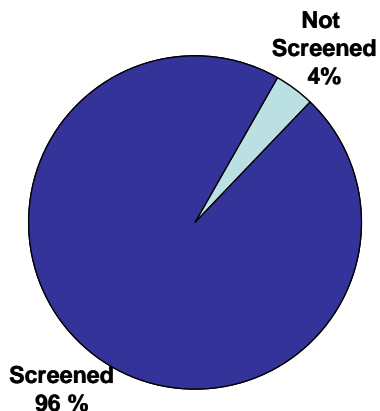
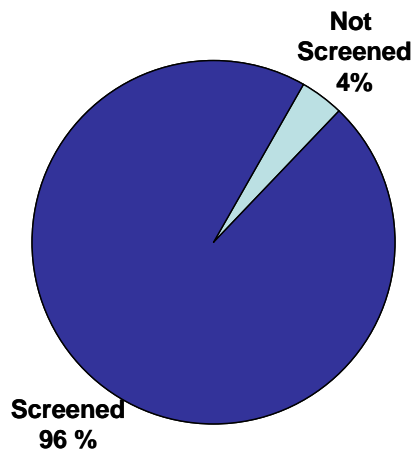


Figure 8: Degree to Which Adults Presenting with Substance Abuse Issues are Screened for Psychiatric Issues



A random sample of charts found that both a high majority of adults presenting with psychiatric issues are screened for substance abuse (Figure 7). Similarly, nearly all adults presenting with substance abuse issues are screened for psychiatric issues (Figure 8). In addition, the report found that a majority of Department of Health providers (94.5%) met and exceeded the compliance standards for these two performance measures based on treatment record reviews conducted in FY2006.

Data are presented by region and facilities in the region, which shows that only three facilities had less than 85 percent of charts with assessment of substance abuse or mental health problems.

After the treatment record review, each agency and provider received a letter that described outcomes of the overall clinical treatment record reviews, a score for each area of the review, as

well as a narrative that includes area of strength and opportunities for improvement. Agencies and providers who did not meet the performance standards were requested to submit a corrective action plan to ValueOptions. These agencies and providers will be reviewed again in six months.

14. Service Denials

Performance measure 13 summarizes Medicaid denial rates for FY2006. For FY2005 and FY2006 comparisons, only the Medicaid managed care trends are comparable. The FY2006 Medicaid managed care rate of denials per 1,000 requests (20.08 denials/1,000 requests) did not increase above the previous year's average, FY2005 (20.29 denials/1,000 requests). Figure 9 summarizes Medicaid Denial Rates by Quarter.

Figure 9. Medicaid Denial Rates by Quarter

	Quarter 1	Quarter 2	Quarter 3	Quarter 4	FY06 Total
Total Requests for Medicaid BH Services	6,939	7,762	9,528	7,748	31,977
Clinical Denials	14	39	86	121	260
Administrative Denials	19	76	166	121	382
Denial Rate per 1,000 service requests	4.8	14.8	26.5	31.2	20.1

The denial rates for both Medicaid fee-for-service and Medicaid managed care increased sharply from Quarter 1 to Quarter 3, and subsequently stabilized in Quarter 4. A similar trend was seen for the number of ValueOptions denials. In the report, ValueOptions asserts that the increase in the early quarters of FY06 correspond to the policy of "do no harm" in which the entity was denying fewer requests in order to sustain the provider network and consumer services during the initial transition period. By the end of Quarter 2 (December of FY2006), ValueOptions began to deny requests that did not have prior authorization (administrative denials) and shortened review periods, which can result in increased clinical denials. The decline in the number of administrative denials from Quarter 3 to Quarter 4 may be partially due to providers becoming accustomed to procedures at ValueOptions regarding authorization of services, and subsequently invoking fewer denials.

The provider satisfaction survey finds providers give a mean rating of 2.6 of five to the appeals process when authorization is denied and to the helpfulness of the Interactive Voice Response System, which is below average. Furthermore, providers rated clear communication of denials also below average (2.6).

Viewed one way, it is important that ValueOptions not simply pay for services a provider may wish to render to a given patient. The necessity and cost-effectiveness of the proposed treatment approach should be closely reviewed. At the same time, it is important that ValueOptions and the provider community achieve a constructive working relationship.

15. Residential Treatment Center Readmission Rates

The performance standard for this measure is that no more than 18% of Medicaid consumers under the age of 21 are readmitted within 30 days post discharge from a residential treatment center (RTC) setting to either the same level or a higher level of care.

In addition to meeting the performance standard for RTC admissions in each quarter of FY2006, ValueOptions compares favorably to average rates reported by Salud! MCOs during FY2005. ValueOptions reported lower readmission rates for each quarter of the year than the MCOs. While ValueOptions continuously strives to improve performance, they currently exceed the expectations for appropriate RTC admissions rates.

H. Summary of Findings

Based on a review of contract requirements, ValueOptions' proposal to New Mexico, compliance with New Mexico regulations, provider readiness, network adequacy, and reports submitted by ValueOptions to the Collaborative, we found that ValueOptions is providing increasing levels of access to Medicaid behavioral health consumers.

Although the new behavioral health system has been recently implemented, the Collaborative and ValueOptions have taken significant steps to ensuring continuity of care through a strong provider network. Even though ValueOptions does not meet all GeoAccess requirements, the health plan continued the same reimbursement strategies being used by the Collaborative agencies and accepted all network providers from the previous system for at least six months. This policy demonstrates ValueOptions' focus on maintaining an extensive provider network.

The new system emphasizes the involvement of local communities, minorities, families, and members. ValueOptions is working with regional organizations, community interests, and Native American and Hispanic minority populations to increase member satisfaction and access to care. Both the contract between the State of New Mexico and ValueOptions and ValueOptions' response to the RFP create high access standards for the new system. According to GeoAccess reports, most members have adequate access to behavioral health providers.

Finally, reports show that ValueOptions is serving a significant majority of the members served by the Medicaid managed care system previously, exceeding performance standards for call centers and screening compliance, and meeting RTC performance goals. As a result, even though ValueOptions does not meet all performance standards reviewed in this document, it is clear that ValueOptions is making progress to meet them and in some cases, already exceeding performance in comparison to prior years.

IV. QUALITY ASSESSMENT

As part of New Mexico's request for a Section 1915(b) Waiver, the State must demonstrate that the quality of services it delivers under the waiver are satisfactory. To assess the quality of services being provided to members, compliance with the State of New Mexico contract, ValueOptions' binding proposal to the State of New Mexico, member satisfaction surveys, provider satisfaction surveys, and compliance with New Mexico managed care regulations will be analyzed.

A. State of New Mexico Contract Requirements

New Mexico's contract with ValueOptions mandates that certain requirements be met regarding quality. The key areas are to establish quality management program, quality improvement programs, a cultural competency plan, and to work with regional organizations in New Mexico.

The contract ensures the creation of a comprehensive system of behavioral health. The contract requires ValueOptions to implement a Quality Management/Quality Improvement program designed to facilitate a smooth transition of care for behavioral health patients and encourages continuous quality improvement. Performance indicators in Phase One focus on transition. In Phase Two (FY2007 and FY2008), these indicators shift to focus on development of the broader system. In the third phase (FY2009), the measures will assess whether ValueOptions has developed a mature system with increased program and service development, increased coordination among local and statewide systems, and increased performance and outcomes.

16. Quality Management Program

New Mexico requires ValueOptions to implement a comprehensive Quality Management (QM) program that contains continuous monitoring and regular evaluation of clinical services, network adequacy, and administrative operations of ValueOptions. The Quality Management program ensures the exchange of information and coordination with customers, family members, advocates, Local Collaboratives, and other stakeholders.

The Collaborative also requires that ValueOptions meet various quality requirements such as provider credentialing, quality management and improvement, incident management, and hiring a medical director.

Some of the key components of the Quality Management program are ongoing monitoring of selected performance indicators and provider performance, regular review of complaints, focused quality improvement studies, and data and analysis of performance indicators to be shared with all stakeholders.

17. Quality Improvement Programs

ValueOptions is also required to have Quality Improvement Programs based on a model of continuous quality improvement. ValueOptions must have a statewide and regional Quality Management/Quality Improvement Program (QM/QI), which encourages quality health care for members.

The contract does not specify exact activities the QM/QI Program must undertake. Instead, it offers general guidelines on the types of programs the contractor should address.

18. Cultural Competency

ValueOptions is also required to demonstrate cultural competency and proficiency through a Cultural Competency Plan. Among others, some of the most important requirements related to cultural competency are as follows:

- Culturally competent and culturally specific services to address the need of ethnically/racially diverse populations,
- Actively recruiting culturally and linguistically fluent providers
- Ensuring that the content of education material provided by ValueOptions be easily understood, available in other languages, and written at not more than a sixth-grade reading level.

19. Work with Regional Organizations

A unique feature of the contract is the requirement to work with regional organizations such as Local Collaboratives (LCs) or the Behavioral Health Planning Council (BHPC). The Collaborative designated Local Collaboratives for each of the thirteen Judicial Districts and for Native American tribes or pueblos. The Local Collaboratives may include schools, faith-based organizations, public health entities, local housing and job organizations, disability-related organizations, and representatives of business community organizations. ValueOptions must disseminate data to the Local Collaboratives, structure committees so that there is optimal Local Collaborative representation, establish formal communications and share information at management levels, and utilize the BHPC for advice and input.

20. Reporting Requirements

ValueOptions is required to submit a wide variety of reports to HSD. Some must be submitted monthly, some quarterly, and some annually. The Collaborative requires ValueOptions to submit a variety of reports on topics ranging from longitudinal data, GeoAccess, claims payment, and critical incidents. Key reports are analyzed throughout this independent assessment.

The contract also outlines potential measures for Phase Two and Phase Three. Relevant reports include customer and provider satisfaction surveys and reviews of treatment plans and treatment attendance.

21. Analysis of Contract Requirements

The requirements set forth by the contract between ValueOptions and the State of New Mexico are extensive. The contract ensures that quality health services are delivered to minority populations. The requirement to develop a comprehensive Cultural Competency Plan and work with regional organizations is also innovative. Since New Mexico has significant Native

American and Hispanic minority populations, the contract makes it more likely that consumers are able to obtain quality services from providers.

Finally, the contract specifies that the Collaborative will retain the services of an external quality review to audit ValueOptions' behavioral health utilization management decisions, including authorizations, reductions, terminations, and denials. This requirement ensures that independent and objective oversight of ValueOptions occurs.

B. ValueOptions' Proposal to New Mexico

New Mexico Interagency Behavioral Health Purchasing Collaborative selected ValueOptions to serve as the Statewide Entity to oversee mental health and substance abuse programs offered by the 15 state agencies that comprise the Collaborative. ValueOptions was selected based upon a binding proposal submitted to the Collaborative.

The response to the request-for-proposal (RFP) proposed a comprehensive organization with New Mexico-based staff performing all required functions with the exception of Pharmacy Operations, which is being conducted at the corporate level.

As a way to complement current customer and family educational and preventative initiatives already under way in New Mexico, ValueOptions will establish a Recovery and Resiliency Department. This Department will provide training for internal ValueOptions staff, provide technical assistance to community organizations, develop educational materials, and assist with the resolution of complaints in order to provide quality health care.

Quality Management committees will include members from existing workgroups of the Collaborative and the Behavioral Health Planning Committee. ValueOptions proposed the following QM Committee Structure:

- Steering Committee
- Customer and Family Member Advisory Committee
- Clinical and Service Advisory Committee
- Regional Advisory Committee comprised of representatives from each Local Collaborative

A core responsibility of all QM committees will be the review of data reflecting the overall functioning of the delivery system and ValueOptions' performance.

Finally, to support local initiatives, ValueOptions proposed that its staff would attend every meeting of Local Collaboratives to which they are invited, and present data reflecting local service utilization for the review of the members. Regular reports also will be provided to the Collaborative and BHPC at the request of the Collaborative. ValueOptions also included technical assistance grants in its administrative budget for \$3,000 to each Local Collaborative and \$5,000 to the BHPC.

C. ValueOptions Compliance with New Mexico Managed Care Regulations

As a condition of its participation in the New Mexico Medicaid Waiver Program, ValueOptions must comply with managed care regulations in the State of New Mexico.

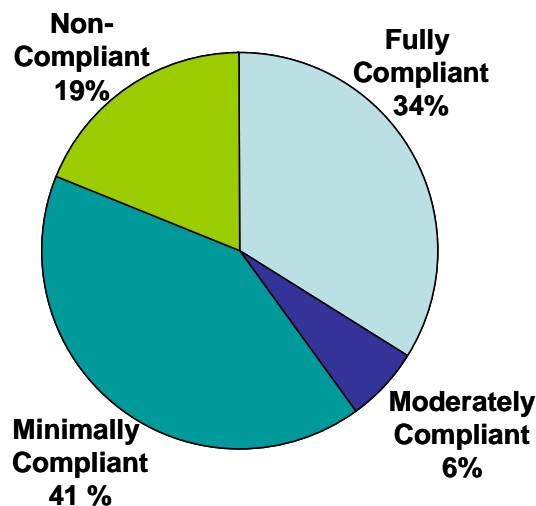
In a comprehensive compliance audit, an External Quality Review Organization (EQRO) for the Collaborative found ValueOptions to be “minimally compliant” for both services and information technology systems. The minimally compliant grade means that ValueOptions was placed into corrective action.

The Collaborative put the findings of the Compliance Audit into the context of transition during the past year. The Collaborative acknowledges that the period of time in which ValueOptions was required to prepare for and implement the state’s behavioral health programs was short. The period on which the audit was conducted occurred less than one year into the new contract. As a result, the Collaborative and state acknowledges that the findings contained in this report “indicate a good beginning.”

ValueOptions submitted a Directed Corrective Action Plan (DCAP) related to the compliance audit results. The DCAP identified deficiencies, which is linked to specifically directed actions and interventions as well as specified timeframes for completion. Each deficiency has a defined and required outcome that the contractor must achieve within the specified timeframe for completion. If the DCAP implementation is not effectively implemented, it is basis for imposition of sanctions.

Below is graph showing the number of compliant, moderately compliant, minimally compliant, and non-compliant areas.

Figure 10. Behavioral Health Compliance Audit Results



22. Quality Management and Improvement

Quality management and improvement structures were evaluated relating to ValueOptions’ Quality Improvement (QI) Program description, QI work plan, committee minutes and other

related documentation. Clinical practice guidelines were reviewed to determine distribution avenues to network providers and the process of involving those providers in developing and adopting these guidelines. Quality of care and over or under utilization file reviews were conducted to assess opportunities for improvement and whether implementation of corrective interventions might be initiated.

Most of the components described above were compliant with state Medical Assistance Division (MAD) guidelines. However, of the five cases submitted for over or under utilization, three were identified as over utilization cases. The over utilization cases did not indicate the implementation of appropriate corrective interventions. Consequently, the compliance audit found quality management and improvement to be moderately compliant based on MAD guidelines.

23. Credentialing and Recredentialing

The audit also reviewed policies and procedures relating to provider participation in the credentialing and recredentialing process. Providers are required to meet applicable federal and state licensing, certification, and accreditation regulations. Policies and procedures were also examined to verify providers had a mechanism for feedback in applying to become a contracted provider and to confirm that a three-year time frame was instituted for the recredentialing process.

This area was found minimally compliant because the process for receiving input from participating providers regarding credentialing and recredentialing is still “under development.” The policy and procedure submitted does not include informed consent or the process to educate providers.

24. Member Grievance System

The member grievance resolution standard was determined to be minimally compliant based on MAD regulations. General requirements for grievance and appeals policies and procedures were met and the Member Handbook addressed consumer filing of grievance or appeal and the resolution process. However, policy and procedures for grievances included inappropriate timeliness requirements and did not include portions of the MAD regulations, policy and procedures for appeals neglected to include critical time frame for consumer notification and did not include portions of the MAD regulations, and the process for expedited appeals included inappropriate timeliness requirement. Finally, a policy and procedure for appeals was not submitted.

25. Reporting Requirements

Although the area of Reporting Requirements was only minimally compliant with MAD regulations, the quality management reports were all compliant with regulations. Reports on staff credentials, denials, prior authorization, critical incidents, and detail denial all met requirements.

26. Client Transition of Care

ValueOptions was also evaluated to ensure continuity of care during transition in services. The Client Transition of Care standard was determined to be fully compliant with MAD regulations. Policies and procedures for member transition of care and files reviewed in relation to transition of care were all fully compliant also.

D. Provider Satisfaction

Although the transformation of the management of behavioral health services to ValueOptions is still in process, results of a Behavioral Health Provider Satisfaction Survey indicate that there are many areas in which satisfaction can be improved.

Providers were asked to rate their satisfaction on a scale from one to five. For the purpose of this analysis, a score of one or two denotes “not satisfied,” a score of three somewhat satisfied, and score of four or five, very satisfied.

Figure 11. Selected Provider Satisfaction Survey Results

Item	Very Satisfied	Somewhat Satisfied	Not Satisfied	Don't Know/Not Applicable	Mean Score
Overall Satisfaction	28%	26%	44%	2%	3.2
Ability to provide high quality health care to consumers	18%	22%	48%	12%	2.5
Process for approval of exceptions to the formulary	11%	5%	2%	81%	2.3
Pays claims promptly	36%	16%	43%	7%	3.1
Helpfulness of provider relations staff	22%	27%	43%	8%	3.3

27. Overall Satisfaction

Providers were divided in their overall assessment of ValueOptions’ management of behavioral health services in New Mexico. Although more than half (54%) of providers are somewhat satisfied or very satisfied with ValueOptions overall, 44 percent are not satisfied.

An important issue to assess for provider satisfaction is ways in which provider practices have been impacted by the transition to ValueOptions. More than one-quarter (27%) of providers feel that there has been a positive impact, while 26 percent feel that there has been a negative one. Providers who feel that there has been a positive impact say it is because they do not have to deal with different plans, ValueOptions is responsive to concerns, and ValueOptions is timely. Those who feel the impact has been negative cite reimbursement issues such as untimely payments and lower reimbursement rates among their main concerns.

Providers were also asked to rate their satisfaction with ValueOptions on several specific attributes such as consumer care, formulary, payment process, and communication. It is important to note that providers who have 45 consumers or more and who are managed by ValueOptions are most likely to be dissatisfied with various aspects of care. For example, 42 percent of these providers convey that the impact of combining behavioral health services under ValueOptions has been negative. This represents a potential area for improvement for ValueOptions.

28. Consumer Care

Behavioral health providers offer ValueOptions an above average rating (3.5 of 5) for the ability to provide high quality behavioral health care to consumers and access to outpatient services. In contrast, they rate ValueOptions below average (2.5 of 5) for the availability of translators for consumers with language needs. This below average rating represents a shortcoming of ValueOptions since the availability of translators is one of the chief components of the cultural competency plan as outlined in the contract with the State of New Mexico.

Providers rate the following attributes related to consumer care an average of three or higher:

- Care coordination for outpatient behavioral health
- Care coordination with primary care physician on consumers' behalf
- Ability to provide behavioral health services to children and adults with special health care needs
- Ease of use of 24-hour clinical call center, and the ability to coordinate emergent hospital admissions when needed

However, providers offer below average ratings for providing materials that address the cultural and language needs of consumers, ease of prescribing medications, care coordination for inpatient behavioral health, availability of case management services, and access to inpatient services.

29. Formulary

Most of the providers surveyed have no experience with prescribing medications under ValueOptions. Among providers with experience, mean ratings were low (between 2.3 and 2.6). For example, ratings were low for the range of drugs available on the formulary, timeliness of updates to the formulary, and process for approval of exceptions to the formulary.

As a result, ValueOptions should possibly revise its process for making updates to the formulary, process for approval of exceptions to the formulary, and the range of drugs covered.

30. Communication

The majority of providers had no experience with ValueOptions' current disease management protocols and the appeals process when authorization is denied. More than one-third of behavioral health providers had no experience with the prior authorization process and explanation of reason in denial letters. Providers who had experience rated ValueOptions

above average (3.6 of 5) for the courteousness and professionalism of clinical case managers. In contrast, the appeals process when authorization is denied and helpfulness of the Interactive Voice Response System were rated below average (2.6 of 5).

31. Analysis of Provider Satisfaction Survey Results

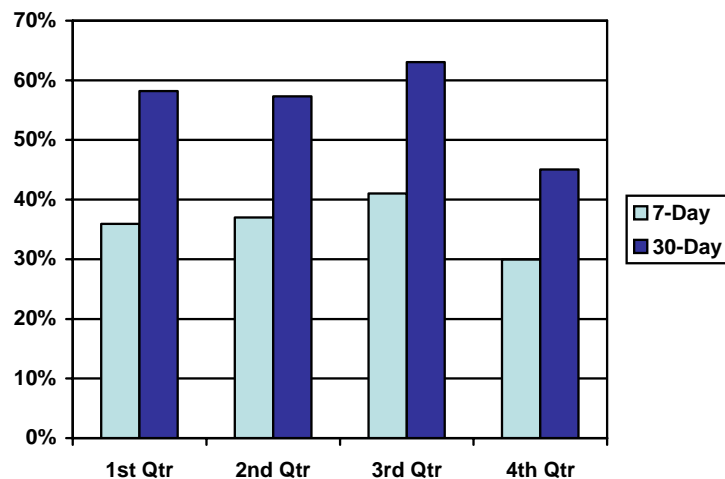
Based on this provider feedback, ValueOptions should focus on developing interventions that target these consumer care concerns. ValueOptions should improve components of ValueOptions' cultural competency plan such as the translation and provision of bilingual materials and availability of translators. In addition, improving ValueOptions relationship with high-volume providers may foster an open relationship and increase communication. Nevertheless, ValueOptions has been responsive to provider concerns and has taken steps in the past to revise policies.

E. Member Satisfaction

32. Performance Measures

ValueOptions collects data on two performance measures: Follow-up after Hospitalization for Mental Illness after 7 days and Follow-up after Hospitalization for Mental Illness after 30 days. The follow-up after hospitalization for mental illness performance measure is used to measure progress towards continuous improvement of follow-up care with consumers who have a mental illness. Appropriate treatment of mental illness has been shown to reduce the duration of disability from mental illness and reduce the likelihood of recurrence.

Figure 12. ValueOptions 7- and 30-Day Follow-Up Care for Hospitalization for Mental Illness, FY2006



A quarterly comparison of 7-day follow-up care rates shows slight improvements from the first quarter (35.9%) to the third quarter (41.1%). A decrease occurred in the fourth quarter (29.3%), for which the reason seems to be claims lag. For 30-day follow-up, the same trend is observed. For the first, second, and third quarters, rates were 58.2 percent, 57.3 percent, and 63.0 percent, respectively. The fourth quarter results were lower (45.1%) for the same reason.

Comparisons with the New Mexico managed care organizations (MCOs) show that for both 7-day and 30-day follow-up care, the ValueOptions rate was higher than or equal to the MCO baseline rate of 21.0 percent and 45.3 percent, respectively. ValueOptions 7-day follow-up care rates compare favorably to the national rates reported by the National Committee on Quality Assurance for similar measures. The national Medicaid 7-day follow-up rates for the past four years ranged from 33.2 percent to 38 percent. ValueOptions' rates ranged from 29.3 percent to 41.1 percent.

33. Mental Health Statistics Improvement Project (MHSIP)

Member satisfaction is an important indicator of how well a health system is serving its consumers. To measure consumer satisfaction on ValueOptions, New Mexico behavioral health consumers and the Collaborative jointly published the 2006 Consumer Satisfaction Survey. The Consumer Satisfaction Project (CSP), which is a joint effort, uses two instruments that are based on the national 28-item Mental Health Statistics Improvement Project (MHSIP), with additional items on substance abuse, housing, and employment. It also includes a section where participants can comment either on specific survey items or about their general perceptions of the programs where they receive services. The survey was made available in English and Spanish. The survey included members from all funding streams and does not provide results specific to the Salud! program.

The survey analyzes information in five key areas, which are referred to as scales:

- *Access:* Services were available at times, amounts, locations, and culturally appropriate to meet the consumer's needs."
- *Appropriateness:* "Service providers included consumers in the treatment decision processes including deciding what treatment options and services would best meet their individual needs."
- *Effectiveness:* "The extent to which services provided to individuals with emotional and behavioral disorders have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery."
- *Satisfaction:* "Overall satisfaction with services provided."
- *Empowerment:* "The perception by consumers that they have more control of their situations, and the available encouragement, support, and techniques offered by the provider."

The first four scales are shared with the national MHSIP survey. The fifth, empowerment, is a combination of items from the other scales. It measures the extent to which participants felt they had a voice in their treatment, and had progressed in their personal recovery process.

Generally, members who completed the Children and Family and Adults Survey indicated well above average levels of satisfaction.

Figure 13. 2006 Member Satisfaction Survey Results

	Access	Appropriateness	Effectiveness	Satisfaction	Empowerment
Children & Families	91%	90%	84%	80%	89%
Adults	87%	88%	80%	85%	89%

Although overall satisfaction was greater among adults, members who completed the Children & Families rated access, appropriateness, and effectiveness higher.

a. Children and Family Consumer Satisfaction

There were no statistically significant differences by region of the state, ethnicity, and the type of service received. People who had services more than a year rated access higher than those having services less than three months. This difference may be a result of the fact that members who have had services more than a year were under the previous system for mental health care services. This difference in satisfaction may be additional evidence that ValueOptions has been successful in improving member satisfaction.

Nevertheless, it is important to mention that although the differences were not statistically significant, Native American respondents provided relatively low ratings. Native Americans rated effectiveness at 67 percent while African Americans and Anglo/Caucasians rated it 99 percent and 78 percent, respectively. Still, 82 percent of Native Americans were overall satisfied with their care. Also, ValueOptions is still a relatively new program that is in the process of creating linkages with minority communities.

Among all of the responses, empowerment scores were very high, ranging from 89 percent to 91 percent. As this is one of the aims of the new system is to offer participants a voice in their treatment, this high response is meaningful.

In addition, a great deal of effort has been invested into bringing consumers into positions to influence both policy and immediate care. However, 41 percent of respondents do not know that consumers are involved in decisions that influence the quality of their care. Another 21 percent say that consumers are not involved in making decisions about services.

Finally, respondents were also asked to rank a group of survey questions. Below in Figure 14 are the top five questions with a positive response and top five questions with the least positive responses.

Figure 14. Responses to Selected MHSIP Items

Five Questions with the Greatest Positive Response		Five Questions with the Least Positive Response	
Our housing situation is important to my child's mental health	98%	Because of the staff's help, my family's housing situation is better	75%
Staff was sensitive to our cultural-ethnic background	97%	My child has reduced his or her abuse of drugs and/or alcohol	74%
Staff respected my wishes about who is, and is not, to be given information about my family's treatment	96%	My child has stopped using drugs and/or alcohol	72%
My family and I were treated with respect and dignity by all the provider's staff	96%	When my family has a housing problem, the staff helps us solve it	71%
Staff members I worked with were competent and knowledgeable	96%	We were encouraged to use consumer-run programs (e.g., support groups, drop-in centers, etc.)	71%

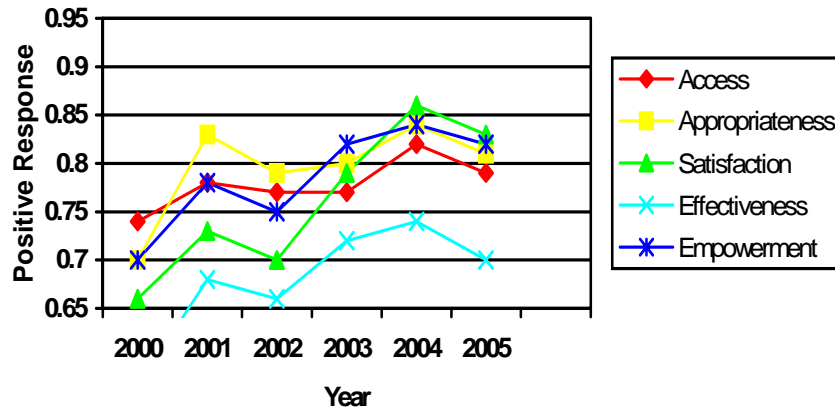
The responses to the questions provide evidence of ValueOptions' commitment to increase member satisfaction and treat any issues that members have, including non-medical matters. For example, a majority of members responded that staff has helped their family solve housing problems. Even the five questions with the least positive responses have ratings above 70 percent.

Ninety-seven percent of respondents thought that the staff were sensitive to their cultural-ethnic background. Prior to the re-organization of mental health services in New Mexico, minorities and ethnic groups were highly dissatisfied with how they were treated. This high rating is additional evidence of ValueOptions and the Collaborative's extensive efforts in this area.

b. Adult Survey

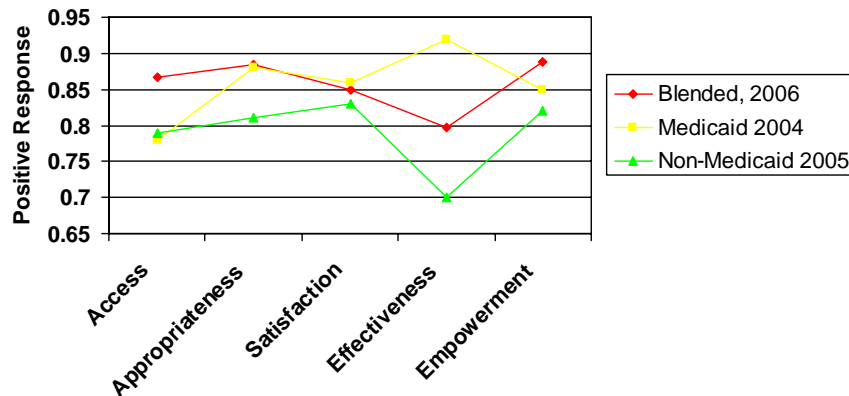
Prior to 2006, Adults were surveyed by funding source. Non-Medicaid funding was assessed using the same five-category method. However, Medicaid funding was assessed using only the first four categories. The three sets of data, (a) blended for 2006, (b) Medicaid funded from the 2004 survey (no survey was conducted in 2005), and (c) non-Medicaid funded from the 2005 survey can be compared to show the gains from blended funding. However, the Medicaid survey does not have exactly the same contents and did not have an Empowerment scale.

Figure 15: Non-Medicaid Funding: Adults



As shown in Figure 15, non-Medicaid funded services showed a consistent upward trend until 2005, which showed decreases in all five scales. Similarly, Medicaid funded services showed a general upward trend, although the years 2001 to 2004 showed little change.

Figure 16: funding Comparison: Adults



An overall improvement is seen with the blended data in Figure 16, which represents the new behavioral health system in New Mexico. Because the survey instruments differ from each other, a strict comparison cannot be made. However, in the future as the same survey is repeated yearly, better insight into adult consumer satisfaction will be gained.

There were statistically significant differences between gender, ethnicity, and length of service. Regarding gender, access and empowerment revealed a statistically higher mean for females than males. Differences in ethnicity were visible in each scale, but a post-hoc test showed that no pair of groups were significantly different from each other. Similar to the Child and Family Survey, Native Americans had the least positive responses for each scale. For example, 67 percent of Native Americans rated effectiveness at 67 percent while African Americans and

Anglo/Caucasians rated it 99 percent and 78 percent, respectively. Still, 82 percent of Native Americans were overall satisfied with their care.

Respondents with differing lengths of service showed significant differences in the access, appropriateness, and empowerment scales. People who had services more than a year rated access higher than those having services less than three months did. This difference may be a result of the fact that members who have had services more than a year were under the previous system for mental health care services. This difference in satisfaction may be additional evidence that ValueOptions has been successful in improving member satisfaction.

Since ValueOptions aims to create a consumer and family drive behavioral health system that is committed to recovery and resilience, the survey also tried to gauge member satisfaction in these areas. In creating a consumer and family-driven system, 92 percent of respondents felt that they participated in their treatment goals. However, only 78 percent were encouraged to use consumer run programs such as support groups or drop-in centers. Yet, a high majority of members are receiving encouragement from staff and providers to seek assistance.

Finally, almost 90 percent of respondents feel that “The staff believes that I can grow, change, or recover,” and 92 percent believe that “The staff encouraged me to take responsibility for how I live my life.” Extremely high responses to both items provide evidence that members are satisfied with the performance of the new behavioral health system.

34. Analysis of Member Satisfaction Results

Both Follow-Up after Hospitalization and MHSIP results were favorable for ValueOptions. Both performance measures scores were above MCO performance and performance in comparison to prior years. In addition, MHSIP shows considerable improvements between ValueOptions and the previous behavioral health system.

The least rated MHSIP scores were rated as favorable by 70 percent or above, which means that a significant majority of consumers are satisfied with the care they are receiving under ValueOptions. The survey also shows that members are receiving assistance with non-medical issues such as housing, which is important since the Collaborative and new system of care was created to implement a multi-disciplinary approach to behavioral health.

Finally, a great deal of effort has been put into bringing consumers into positions to influence both policy and immediate care. The survey results show that members feel that they are “empowered” to make health care decisions.

F. Quality Management Program

The scope of the ValueOptions Quality Management Program is extensive. The program includes the proactive collection, analysis, and reporting of data pertaining to the quality of behavioral health services, along with the development and implementation of systematic improvement efforts, across all components of the various delivery systems.

ValueOptions outlines an internal organizational structure for its Quality Management program. The structure includes clinical operations, provider relations, recovery and resiliency,

and service system relations. In addition, the Vice President of Quality Management and the Chief Medical Officer play important roles in overseeing the program.

The range of the program is far-reaching. Quality management activities include:

- Risk Management: The Clinical Quality Committee monitors high volume services and treatment, high-risk members and treatment, behavioral health rehabilitation services for children and adolescents, critical incident case, and quality of care cases
- Coordination with Primary Health Care: ValueOptions has coordinated with managed care organizations to develop a system of communication and collaboration between primary health care and behavioral healthcare
- Evaluation of the Effectiveness of Services: The Clinical Quality Committee evaluates the effectiveness of services provided to consumers and families by analyzing access to services, authorization and clinical appeal process, treatment outcomes, and clinical quality improvement activities
- Evaluation of the Quality and Effectiveness of Internal Processes: All reports are submitted to the Oversight Management Team, as a means of monitoring progress
- Evaluation of the Quality and Performance of the Provider Network: Provider profiling, coordination with other service agencies, network management, and provider satisfaction survey data are reviewed to evaluate the network
- Training Program: This area provides ongoing training to employees, network providers, and consumers
- Reporting of Suspected/Substantiated Fraud and Abuse: The ValueOptions Policy and Procedure Manual contains policies and procedures regarding reporting requirements for staff and providers, case log, investigation, accountable staff, and definitions for fraud and abuse
- Clinical Records Content, Retention and Storage: The ValueOptions Policy and Procedure Manual contains the State/MAD requirements for clinical records content, retention, and storage. The Quality Management Program outlines the physical and procedural steps taken by ValueOptions to ensure the confidentiality of consumer records
- Assessment of Consumer Satisfaction: ValueOptions has coordinated with the Collaborative agencies to implement the Collaborative's methodology for collecting consumer satisfaction data

The Quality Management Program also details the steps it has taken to ensure the confidentiality of all documentation that is created as a result of the program itself. The overall plan is evaluated quarterly in order to determine the overall effectiveness of the program and reviewed by the Clinical Quality Committee.

Since ValueOptions is still in the process of implementing its programs and policies, it has created a work plan for FY2007. The work plan specifies targeted activities, key measures, responsible persons, and the date that the activity must be completed.

Among others, some major events and accomplishments of the Quality Management Program in FY2006 include:

- Developed and implemented processes for Critical Incidents and Complaints and Grievances
- Completed EQRO audits with the New Mexico Medical Review Association (NMMRA) including one Performance Measure audit, one Compliance audit, and two Denial audits
- Defined Performance measures and critical indicators with the Collaborative Oversight Management Team for performance reporting
- Resolved all grievances within the regulatory timeframe
- Filled three Claims Auditor positions to address the growing need for internal claims process review

ValueOptions also performed an Annual Program Evaluation of its Quality Management program. As a result, ValueOptions has shown commitment throughout FY2006 to improving quality through its Quality Management Program.

G. Selected Reports Submitted by ValueOptions to the Collaborative

35. Grievances

ValueOptions submitted monthly reports to the Collaborative containing information on the number and nature of grievances received (as of FY2007, this information is required to be submitted quarterly only). These reports provide detailed information on the number of consumer and provider grievances received, comparison to MCOs' 2004 baseline data for the same time period, the nature of the complaints, steps taken to resolve the issue, the agency through which the complaint was received, the region the grievance originated in, and finally, detailed information on each grievance.

In comparing the number of grievances received under ValueOptions and by the MCOs in 2004, we found that under ValueOptions in August 2005, September 2005, and October 2005, the number of grievances were over 80 percent higher than the previous year. A majority of the consumer grievances concerned quality of care, whereas providers reported issues with the claims processes. Subsequently, in November and December of 2005, ValueOptions experienced less grievances reported than MCOs did in 2004. However, the number of grievances actually increased by eight in November to 21 total grievances. The MCOs experienced the same pattern for this period.

In January and February of 2006, the number of grievances reported was comparable to baseline data. However, the number of grievances received by ValueOptions increased by 40 percent from February to March. This level was also high in comparison to baseline data. Although the reports do not attribute the increase to any particular source, an examination of complaints reveals that a majority of complaints concerned a specific employee of Mental Health Resources.

Overall, although the number of grievances compared to baseline data was high, the fluctuations and overall decrease in the number of grievances shows that ValueOptions is

responsive to consumer and provider grievances. For example, a consistent grievance was unreturned phone calls to the Claims department. An initial response to the issue in November, the ValueOptions CEO mandated a policy that requires all staff to return telephone calls to providers and consumers within 24 hours from the time of the receipt to address the issue. ValueOptions also changed its system to allow providers the ability to route calls about claims questions directly to the Claims Department and began its provider training in December 2005. As a result, the number of grievances received concerning this specific issue was zero by March 2006.

To improve performance in this area, ValueOptions Quality Management Department is analyzing individual grievances as well as patterns of grievances based on first year data for trends to determine needed follow-up or improvement activities. Specifically, the Claims Department has hired and trained four claims/customer service representatives, who answer claims, status, benefits, and eligibility calls.

36. Critical Incidents

ValueOptions provides information on critical incidents quarterly and annually. Critical incidents are occurrences that represent actual or potential serious harm to the well being of a ValueOptions consumer, or to others by a ValueOptions consumer who is in active behavioral health treatment, or has been recently discharged from behavioral health treatment. In FY2006, there were 848 critical incidents. ValueOptions reported 214, 148, 195, and 291 critical incidents for the first through fourth quarters, respectively. The increase in incidents from the second to the fourth quarter is largely attributed to ValueOptions provider education efforts to develop procedures to facilitate consistency in handling critical incidents.

Figure 17. Critical Incidents by Type, FY2006

Critical Incident Type	Number of Incidents	% of Incidents
Injuries/Emergency Services	215	25.4%
Elopement	153	18.0%
Violent or Assaultive Behaviors: Non-lethal intent	91	10.7%
Other Deaths	76	9.0%
Detentions for Alleged Criminal Activity	55	6.5%
Sexual Behaviors	42	5.0%
Self-Injuries Behaviors: Non-lethal intent	27	3.2%
Attempted Suicides	22	2.6%
Detentions for Protective Custody	12	1.4%
Damage to Property/Environmental Hazard	8	0.9%
Suicides	8	0.9%
Medication or Treatment Errors	7	0.8%
Financial Exploitation	3	0.4%
Homicides	1	0.1%
Other Incidents	128	15.1%
TOTAL	848	100%

The top three types of critical incidents for each quarter differed slightly:

- 1st Quarter: Violent/Assaultive Behavior, Other Incidents, Injuries/Emergency Services
- 2nd Quarter: Injuries/Emergency Services, Elopements, Other (non-homicidal) Deaths
- 3rd Quarter: Injuries/Emergency Services, Elopements, Detentions for Criminal Behavior
- 4th Quarter: Injuries/Emergency Services, Other Incidents, Elopements

It is unclear the reason why the number of incidents classified as injuries/emergency services increased after the first quarter.

ValueOptions also reports that consumers under 21 without a special diagnosis were the highest population associated with a critical incident. Severely Disabled Mentally Ill patients comprised the second highest population.

To improve its performance in this area, ValueOptions developed a standard reporting form for providers, implemented procedures to facilitate consistency in handling critical incidents, educated providers on the reporting process, and use baseline study and on-going data monitoring to address quality of care issues related to specific providers.

H. Performance Measurement and Improvement

37. Performance Measurement Standards

The State of New Mexico requires ValueOptions to meet performance measurement standards. Components of the performance measurement include periodic data tracking and implementation of a Continuous Quality Improvement (CQI) program. The EQRO performed a required annual audit of the periodic data tracking system and the CQI program.

The periodic data tracking section received the maximum score possible (25 of 25). However, the CQI program only received 37.5 points out of a possible 75 points. Consequently, the overall performance measurement program review received a rating of 63 percent, which means it is in minimal compliance with its contract. Specifically, ValueOptions at the time of the audit, did not develop or initiate effective interventions to decrease readmission within 30 days or demonstrate documented reassessment of improvements through its QI Program. As a result, ValueOptions was required to submit a Directed Corrective Action Plan (DCAP) related to the Performance Measurement Standards. The DCAP identified deficiencies, which are linked to specifically directed actions and interventions as well as specified timeframes for completion. If the DCAP is not effectively implemented, it is basis for imposition of sanctions.

Nevertheless, since the period of time in which ValueOptions was required to prepare for and implement the state's behavioral health programs was short, ValueOptions can be expected to meet performance standards during the next review.

38. Performance and Accountability Metrics

As a component of the Comprehensive Behavioral Health Plan, the Collaborative has set metrics to measure the new system's performance. For example, Goal 4 of the "Healthy New Mexico" statewide initiative is to improve behavioral health through an interagency and collaborative model. Underneath this goal, there are four tasks specified:

1. Reduce suicide among youth and high-risk individuals
2. Improve access, quality, and value of mental health and substance abuse services
3. Provide enhanced services for high-risk and high-need individuals
4. Increase rural, frontier, and border access to behavioral health services

Under each of these tasks, specific measures are identified to measure progress. For each measure, the ValueOptions FY2007 contract reference, data sources, definition, whether the measure is used anywhere else (i.e. HEDIS, CDC national survey, DOH Strategic Plan, etc.), numerator, denominator, technical specifications, baseline, and targets for FY2006 and FY2007 are identified.

The Collaborative's table of metrics for its goal is highly advanced and technical. Establishing and collecting measures from the outset of the program allows for sufficient program evaluation.

39. Performance Improvement Projects

ValueOptions is required to conduct performance improvement projects (PIPs) related to clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and consumer satisfaction. The PIPs must include the following:

- Measurement of performance using objective quality indicators
- Implementation of system interventions to achieve improvement in quality
- Evaluation of the effectiveness of interventions
- Initiation of activities for increasing or sustaining improvement

The audit reviewed two PIPs that were evaluated for compliance with the contract and CMS regulations. The first focused on improving turnaround time for utilization management decision making. In this area, ValueOptions received a rating of 73 percent, which is minimally compliant. Measures that ValueOptions scored low in were intervention strategies, data analysis, re-evaluation processes, sustained improvement, and its measurement method.

The second PIP reviewed was improving the identification of individuals with special health care needs and other high-risk populations through development of clinical criteria. This PIP received a rating of 44 percent, which is non-compliant. ValueOptions scored low in the following measures: measurement objective, measurement population, measurement method,

data tracking procedure, intervention strategies, data analysis, re-evaluation processes, and sustained improvement.

The audit suggested that ValueOptions implement a variety of recommendations to meet regulations. Among these recommendations, the most important are to identify or develop a quality measurement tool to document performance improvement projects and to assess whether improvements are sustained over measurement periods.

Based on this audit of performance measurement programs and PIPs, HSD was informed that ValueOptions met CMS standards with significant deficits or did not meet them and require corrective action. As a result, ValueOptions was required to submit a Directed Corrective Action Plan (DCAP) related to the Performance Measurement Standards. The DCAP identified deficiencies, which are linked to specifically directed actions and interventions as well as specified timeframes for completion. If the DCAP is not effectively implemented, it is basis for imposition of sanctions.

I. Summary of Findings

As a result of the Collaborative's efforts, the behavioral health program is structured to promote and deliver quality health care to its members. The requirements set forth by the State are comprehensive, which ensure that ValueOptions is providing quality care to its members and fostering a comprehensive behavioral health system.

Providers are somewhat divided in their overall assessment of ValueOptions' management of behavioral services. More than two-fifths (40%) of providers are not satisfied with ValueOptions, one-quarter had mixed feelings, and the remaining were satisfied with ValueOptions. Providers who have 45 consumers or more and are managed by ValueOptions were most likely to be dissatisfied with various aspects of care. This represents a demographic for ValueOptions to improve satisfaction and relations.

ValueOptions' performance in measures reviewed compare favorably to the National Committee for Quality Assurance (NCQA) rates and the MCOs. The ValueOptions rate was higher than or equal to the MCO baseline and performance measures improved each quarter. However, there are still areas for significant improvement.

MHSIP scores show considerable improvements between ValueOptions and the previous behavioral health system. The least rated MHSIP scores were rated as favorable by 70 percent or above, which means that a significant majority of consumers are satisfied with their care.

ValueOptions' Quality Management Program is comprehensive as it includes procedures for data collection, performance improvement, risk management, and evaluation of ValueOptions' quality processes. Since ValueOptions is still in the process of implementing its program and policies, it has created a detailed work plan, which specifies targeted activities, key measures, responsible persons, and deadlines.

Although ValueOptions has not met each of the performance standards reviewed in this analysis, it has taken steps to improve its performance. For example, it submitted a corrective

action plan describing steps that ValueOptions would take in the coming months to improve quality.

The State of New Mexico set specific requirements for performance, which ValueOptions has already met or is making significant progress towards. Thus, New Mexico's behavioral health system meets CMS guidelines and requirements in terms of quality.

V. COST EFFECTIVENESS

The “cost-effectiveness” of New Mexico’s behavioral health initiative is extremely difficult to assess for several reasons. First, by many accounts there was an under-utilization of services under Salud! which prompted the switch to a behavioral health carve-out model. Against this baseline, Medicaid behavioral health care costs were presumed to *need* to increase. Second, additional services were added in the Value Options contract that were not covered under Salud!, which creates commensurate cost increases. Third, the program is in its first year of implementation. It is far too early to obtain sound data on the impacts of the newly redesigned system, and the carve-out approach requires years to evolve (rather than months) before its true impacts can be discerned.

Figure 18 presents the State’s estimated Medicaid behavioral health costs during FY05 (under Salud!) and during FY06 under the carve-out initiative implemented by ValueOptions. These figures estimate that behavioral health costs increased by 26 percent in total dollars, and by 33.6 percent on a PMPM basis from FY05-FY06. This is clearly a large-scale, intentional increase designed to strengthen the behavioral health services delivery system and improve patient outcomes. It is not yet possible to make a determination as to whether these investments will prove to be “cost-effective,” although aspects of this report have shown short-term improvements in the service delivery under the carve-out program.

Figure 18. Behavioral Health Cost Comparisons, FY05 versus FY06

	Membermonths	MCO Behavioral Health Expenditures	Costs Including 15% Administration Allocation
SFY05 Total Dollars, MCOs, FY05 PMPM, MCOs, FY06	3,139,978	\$131,693,246 \$41.94	\$151,447,233 \$48.23
SFY06 Total Dollars, Value Options, FY06 PMPM, Value Options, FY06	2,967,182	\$166,312,611 \$56.05	\$191,259,502 \$64.46

Three final observations are made relative to the costs of the behavioral health initiative. First, it is important to emphasize that the ValueOptions contract was awarded competitively, with several experienced entities submitting bids. The State’s procurement process created strong technical and price competition for a large-scale contract. Given those circumstances, the State likely procured the most favorable “deal” it could obtain in the initial contract year.

Second, the Lewin Group’s Salud! cost-effectiveness assessment included both behavioral health and physical health experience. That analysis led to an estimated overall savings of 3 percent to 5 percent in FY2006. New Mexico’s cost trends closely matched national norms throughout the 1999-2004 timeframe, and PMPM capitation cost increases from 2003-2006 (including behavioral health services) averaged 8.6 percent annually – also closely in line with national Medicaid per capita cost escalation norms. The total percentage increase in FY06 costs versus 2005, 10.8 percent, is a relatively high rate of increase but the collective increase of 8.6% from 2003-2006 includes the relatively high 2006 year. Given that New Mexico substantially

invested in its behavioral health care system to implement the carve-out initiative and since program-wide cost escalation (even with the relatively large increase in behavioral health expenditures in 2006) has been held directly in line with national norms over time, we do not see the “spike” in 2006 behavioral health costs depicted in Figure 18 as problematic.

Lastly, the State is keenly aware of the sensitivities associated with its behavioral health initiative, and the new program is, appropriately, operating under scrutiny. The State has a strong monitoring structure in place, and the carve-out initiative’s financial and clinical results are being closely assessed. Behavioral carve-out programs inherently create “grey areas” between what the physical health and mental health systems are responsible for. Thus, the potential for each at-risk entity to aggressively manage only its own costs and push the patient towards the “other system” will warrant particularly close monitoring going forward.