Sidonie Squier, Secretary, Human Services Department
Julie Weinberg, Director, Medical Assistance Division, Human Services Department
Diana McWilliams, Director, Behavioral Health Services Division, Human Services Department
Steve McKernan, CEO, UNM Hospitals and Health System Chief Operations Officer
Richard Sanchez, MD, Chief Medical Officer, Molina Healthcare
Katrina Hotrum, Bernalillo County Metropolitan Assessment and Treatment Services Program
Troy Jones, Director, New Mexico Behavioral Health Institute
Rusty Smith, Executive Director, St. Martin's Hospitality Center

ISSUES FOR HEARING
Behavioral Health System:
Opportunities to Improve Services and Address Service Gaps:
Service Provider and HSD Perspectives

Hearing Background

- Although funding for behavioral health increased over the last decade and the Behavioral Health Collaborative was created, improvement in behavioral health outcomes have lagged behind other states or remained stagnant.
- Substance abuse is one of the state's most serious behavioral health problems.
    - Alcohol-attributable death rate was the worst in the country;
    - Drug overdose death rate is the 2nd highest in the nation;
    - Suicide rate per 100,000 people for 2012 was almost double the national rate;
    - Drug withdrawal syndrome in newborns has grown from 1.7 per 1,000 births in 2000 to 6.2 in 2011; and
    - Prescription drug overdose deaths are now more common than illicit drug overdose deaths.
- Expansion of Medicaid under the Affordable Healthcare Act (ACA) for over 130,000 low-income adults currently without health insurance will provide a major boost to the availability of behavioral health services including substance abuse treatment. However, the HSD has not provided behavioral health specific enrollment cost estimates.
- The Department of Health should begin implementing a process to collect income eligibility data so it will be positioned to fully leverage expanded Medicaid revenues in FY14.
- The HSD has not determined the final Medicaid benefit package (including behavioral health benefits) under the expansion for new adults pending final federal guidance. However, the ACA requires the package include mental health and substance use disorder services, including behavioral health treatment.

- A key issue moving forward is the opportunity to reprioritize future general fund appropriations to address behavioral health service gaps given the new availability of Medicaid benefits for adults. The HSD's FY14 budget for the behavioral health services division (BHSD) includes almost $40 million in contracts funded with general fund for behavioral health and substance abuse services. However, some key services are not eligible for Medicaid reimbursement and may be worthy of continued state support, including treatment for undocumented aliens, in-patient substance abuse treatment for adults, treatment for adults in freestanding psychiatric hospitals, transitional living supports, transportation, certain medications, and room and board for clients in supportive housing.
- As part of the HSD's Centennial Care Medicaid plan, behavioral health will be included in the four managed care contracts with Presbyterian, Blue Cross Blue Shield, Molina, and United Healthcare for physical health starting on January 1, 2014. This reflects the view that integration of physical health services with behavioral health services will lead to better patient outcomes. The HSD plans to implement behavioral health homes to provide enhanced care management so that outcomes improve for those with severe behavioral health issues.
- The HSD also proposed to add three behavioral health services to Medicaid coverage that provide additional support services to those being treated for behavioral health issues: recovery services (group peer support), intensive family support, and youth respite.
- The HSD's behavioral health strategic plan placed greater emphasis on intensive out-patient services (IOP) for substance abuse, which is designed to serve individuals needing an intensity of treatment greater than standardized outpatient counseling, but less than what is provided by residential treatment. The IOP services for clients typically lasts 9-10 hours a week for 3-5 months.
- Staff of the LFC followed up on the May performance evaluation on BHSD with a number of site visits with behavioral health providers. There is optimism about Medicaid expansion and providers are confident that they can provide quality evidence-based behavioral services with more emphasis in follow-up care. Key problems remain including a lack of overall strategic direction at the state level, shortages of government and private funding, shortages of behavioral health professionals, and not enough financial support for long-term treatment and related support services.

Behavioral Health Audits

- The behavioral health system in New Mexico is in turmoil with release of behavioral health audit undertaken by the HSD using contractor Public Consulting Group (PCG) earlier this year in-response to concerns about billing and treatment practices. The HSD reports $36 million in overpayments from 2009-2012 have been identified from 15 providers who have about 85 percent of the behavioral health business in New Mexico. These overpayments represent 15 percent of all claims paid. The audit also identified a number of questionable related-party transactions.
- The HSD implemented a pay-hold effective July 1, 2013 for all 15 providers, asserting that a pay-hold was required because of credible allegations of Medicaid fraud. With providers at risk of closing the pay holds have proved very controversial, particularly because federal guidance appears to provide the HSD with ample flexibility to not implement a pay hold (or release a pay hold) if the result would be too damaging to the behavioral health system.
- Of note, the HSD implemented a pay-hold for all 15 providers despite the fact that the allegations varied greatly in severity. The fact that the HSD (with input from the Attorney General) almost immediately lifted the pay hold for a number of providers makes the need for the original pay hold questionable. Also questionable is why the department did not use corrective action procedures contained in the OptumHealth contract with providers as an alternative to pay holds.
- Eight behavioral health providers have filed a lawsuit in state district court seeking an overturn of the payment hold implemented by the Human Services Department on June 24th. In not sharing the results of the audits to allow the providers to respond, they believe the state bypassed the appeal process and are also asking for the state to stop publicizing accusations of wrongdoing until the plaintiffs receive a hearing. The first court hearing on the lawsuit is scheduled for July 17.
- The LFC has requested complete access to the recently released audit report. Without this access, it is not possible to make an evidence-backed assertion that PCG's report is accurate. Ideally, staff of the LFC would have an opportunity to review a sample of PCG's work to validate their audit methodology. Of note, the North Carolina State Auditor was critical of a PCG audit in that state, finding that fraudulent claims in PCG's report were overblown.

- The LFC has encouraged the HSD to be more forthcoming with details of the audit in order to help justify the severe step of pay hold implementation. In addition, the LFC has encouraged the HSD to reinstate funding (with adequate controls) as appropriate to allow providers to stay in business while the fraud allegations are adjudicated.
- The results of the PCG audit demonstrate the HSD and OptumHealth (Optum) exercised inadequate control and oversight over the provision and billing of behavioral health services. The HSD credits OptumHealth with implementing software enhancements that allowed OptumHealth to bring forward creditable allegations of questionable activity in November 2012—3 years after OptumHealth took charge. Anecdotal information from providers is that the results of OptumHealth and HSD billing reviews were typically clean.
- The PCG's own recommendations for "implementation of a comprehensive program integrity effort for behavioral health services" demonstrate the inadequacy of the state oversight. The PCG recommends more technical assistance, implementation of billing "best practices," and improvement to payment systems to prevent overpayments.
- Staff of the LFC will continue to monitor developments in a number of key areas moving forward:

  - Resolution of pay holds for the 15 providers to ensure continuity of services to public;
  - Potential management and/or ownership changes in behavioral health firms accused of wrongdoing and HSD/Attorney General involvement;
  - Progress of the Attorney General and/or other law enforcement investigations;
  - Actions by the HSD to improve BHSD performance
  - Oversight by the HSD over Medicaid funded behavioral health services through four new managed care organizations in 2014.
  - Future role of OptumHealth in managing the HSD behavioral health dollars (non-Medicaid).
  - Future role of the HSD inspector general in investigating Medicaid fraud involving providers (in addition to Medicaid clients).

LFC HEARING BRIEF

AGENCY: Human Services Department representing the Behavioral Health Purchasing Collaborative (BHPC)

DATE: July 17, 2013

PURPOSE OF HEARING: Update on substance abuse trends, behavioral health system changes with Medicaid expansion and Centennial Care and behavioral health initiatives

WITNESSES: Sidone Squier, Secretary, Human Services Department, Julie Weinberg, Director, Human Services Department Medical Assistance Division; Diana McWilliams, Director, Human Services Department Behavioral Health Services Division. Steve McKernan, CEO, UNM Hospitals and Health System Chief Operations Officer; Richard Sanchez, MD, Chief Medical Officer, Molina Healthcare. Katrina Hotrum, Bernalillo County Metropolitan Assessment and Treatment Services Program; Troy Jones, Director, New Mexico Behavioral Health Institute; Rusty Smith, Executive Director, St. Martin's Hospitality Center

PREPARED BY: Greg Geisler, Ruby Ann Esquibel, Pam Galbraith

EXPECTED OUTCOME: To better understand the upcoming changes in the behavioral health system and opportunities to reprioritize state funds to fill service gaps.

New Mexico is at a crossroads in behavioral health. Under the Affordable Care Act (ACA), Medicaid expansion for low-income adults will increase availability of services, but the current system is under great stress due to allegations of behavioral health provider billing fraud and poor quality of services. At the same time, HSD is changing its approach to managing behavioral health managed care to coincide with Medicaid expansion in 2014. This brief will provide updated data on the behavioral health and substance abuse challenges faced by New Mexico, as well as some of the challenges and upcoming opportunities for the behavioral health system.

New Mexico's Behavioral Health and Substance Abuse Crisis—State Demographics. The National Survey on Drug Use and Health (NSDUH) shows that slightly over 4.6 percent of those surveyed in New Mexico had a serious mental illness in the past year and 19 percent reported having a mental illness—close to national averages. However, New Mexico residents have higher rates of drug use, overdoses and suicide.

The NSDUH data indicates adults in New Mexico are using and abusing alcohol and drugs at a rate greater than the national average including pain relievers and illicit drugs. Data also indicate that youth and adults in New Mexico need, but are not receiving, treatment for illicit drug use and alcohol abuse, and many do not access treatment because they feel they don't need it. Yet, New Mexico has over 25 deaths per 100,000 persons due to drug overdoses, whereas the U.S. rate is 10 deaths per 100,000 persons.

In July 2013, the Department of Health provided updated statistical data (Appendix A) regarding the status of substance abuse and behavioral health in New Mexico that indicates:

- Alcohol-attributable death rates are the worst in the country;
- Drug overdose death rates are the second highest in the nation;
- Suicide deaths per 100,000 people for 2012 was almost double the national rate;
- Drug withdrawal syndrome in newborns grew from 1.7 per 1,000 births in 2000 to 6.2 in 2011; and
- Prescription drug overdose deaths are now more common than illicit drug overdose deaths.

New Mexico Behavioral Health Purchasing Collaborative. The key state government entity responsible for behavioral health is the New Mexico Behavioral Health Purchasing Collaborative (BHPC), created by statute in 2004. The collaborative allows state agencies involved in behavioral health prevention, treatment and recovery to work together to improve mental health and substance abuse services in New Mexico. Under the leadership of the Human Services Department's Behavioral Health Services Division (BHSD), the BHPC provides the majority of state-funded substance abuse and mental health services.

However, coordination of a comprehensive, statewide behavioral health system is hampered, in part, because funding is distributed among executive branch agencies, the judiciary and individual

Alcohol-Attributable Death Rates Per 100,000 Persons (2007)	
NM	**53.8**
AK	46.5
WY	42.1
MT	39.3
WV	38.2
US	28.2

Source: DOH Vital Records

Drug Overdose Deaths Per 100,000 Persons (2010)	
WV	28.9
NM	**23.8**
KY	23.6
NV	20.7
OK	19.4
US	12.3

Source: CDC

In 2009, heroin and cocaine were the drugs causing unintentional drug overdose death in New Mexico, followed by oxycodone. In 2011, unspecified drugs and heroin were the drugs responsible for unintentional death, followed by cocaine.

Rio Arriba County has the highest drug overdose rate at over twice the state average. The next worse counties are Mora, Sierra, Catron and Quay.

Prescription opioid drug sales have increased steadily in New Mexico. Counties with the majority of higher-dose opioid prescriptions are Sierra, Grant, Lincoln, Rio Arriba and Otero.

Estimated Costs of Prescription Opioid Abuse and Dependence (NM, 2010)	
Workplace	$410 million
Healthcare	$400 million
Criminal Justice	$80 million
TOTAL	**$890 million**

Source: DOH

counties. Also, the state strategy of contracting behavioral health services to managed care contractors OptumHealth (previously ValueOptions) has shown mixed results—gains in service efficiencies and standardization of care have been offset by problems with provider payments and billings.

Despite eight years of collaboration, significant gaps in service availability remain. And despite good results on BHPC performance measures (such as percent of clients demonstrating improvement), New Mexico ranks near the bottom for per-capita overdose rates, alcohol addiction and suicides. The BHPC has minimal data on outcome-oriented measures, such as the rate of patient relapse.

Currently, the behavioral health system in New Mexico is in turmoil with the release of a behavioral health audit undertaken by the HSD using the contractor Public Consulting Group earlier this year in-response to concerns about billing and treatment practices. The HSD reports $36 million in overpayments from 2009-2012 have been identified from 15 providers who have about 85 percent of state behavioral health business. Pay holds remain in place for the majority of providers and it is possible that the state will step-in with Arizona-based contractors to take over the operations of some providers. Please see bullets for latest information.

Spending for Behavioral Health Services. The BHPC reports 84,847 individuals were served in FY12, with over 83 percent of the services categorized as behavioral health. In the same year, total BHPC spending was reported at $355 million, including $248 million in behavioral health expenditures under the OptumHealth contract are shown in the chart on the next page (excluding administration and block funding), spending for children and adults is broken out in sidebar tables on the next page. Note that 69 percent of the spending is on children and young adults under 21.

It should be noted that Medicaid covers comprehensive behavioral and substance abuse treatment for children and youth, but until 2014 the majority of BHPC-funded adult substance abuse treatment is paid for by state general fund revenues and other federal grants (see sidebar on next page). A few observations:

- Almost 29 percent of total expenditures, or $71 million, was spent on 24-hour residential treatment for children with behavioral health and substance abuse issues. Collaborative staff doubts this level of treatment is warranted; in many cases equivalent outcomes may be achieved with intensive outpatient treatment closer to children's homes.
- The differences among outpatient, intensive outpatient and recovery services are subtle. Substance abuse treatment occurs in each of these service areas, but the level of support services and intensity of treatment is higher in the recovery and intensive out-patient areas than in the outpatient category.
- Limited funding is available for non-Medicaid adult substance abuse treatment through the BHPC—it reports about $23 million in general fund revenues and other federal funds for adult substance abuse treatment.

Isolating substance abuse funding from the total amount spent on behavioral health is a complicated task. Many substance abuse patients have underlying mental health issues, and providers often categorize patient services as behavioral health related, even if there is a substance abuse component.

FY12 Collaborative Spending by Category Children & Young Adults
(in thousands)

Residential	$71,969	43%
Outpatient	$46,328	28%
Recovery	$20,898	13%
Intensive Outpatient	$11,844	7%
Inpatient	$10,667	6%
Other	$3,601	4%
TOTAL	**$165,307**	

Source: OptumHealth

FY12 Collaborative Spending by Category Adults Only
(in thousands)

Outpatient	$41,279	50%
Recovery	$18,037	22%
Inpatient	$10,327	12%
Residential	$7,427	9%
Other	$3,234	4%
Intensive Outpatient	$2,873	3%
TOTAL	**$83,180**	

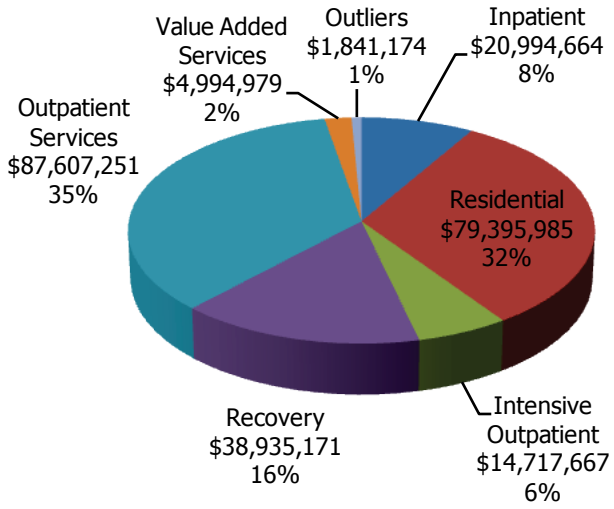
Source: OptumHealth

FY12 Non-Medicaid Collaborative Funding Sources Adult Substance Abuse Treatment
(in thousands)

General Fund	$15,354
Federal SAPT	$5,152
Federal ATR	$2,815
Total	**$23,321**

Source: NM Human Services Department

Allocation of $248 Million in FY12 Behavioral Health Claims



Data Source: OptumHealth NM FY12

NEAR TERM OUTLOOK FOR HSD BEHAVIORAL HEALTH FUNDING

Impact of Medicaid Expansion on Behavioral Health Services. Medicaid expansion under the ACA will likely have a major positive impact on the availability of behavioral health services and substance abuse treatment for over 100 thousand low-income adults starting in 2014.

The HSD has not provided separate cost or enrollment estimates for behavioral health services for newly-eligible adults. The projected per capita cost of the Medicaid benefit package for the newly eligible adults of $5,400 in FY14 is based on the current Medicaid benefit and expenditure history (including physical and behavioral health). The HSD's cost estimates will be adjusted when federal guidance is finalized on which Medicaid clients will be allowed to be in the more limited benchmark benefit package. Also, the HSD's economists and BHSD staff have been discussing use of the BHSD data to tweak the projection for Medicaid behavioral health but this is expected to have limited impact.

Although the HSD has not provided a behavioral health specific cost estimate for Medicaid expansion, some available federal data may provide some clues about potential enrollment. Information from the

Nationwide, the SAMHSA has estimated that about 13.4 million uninsured people who have behavioral health conditions will be eligible through a combination of the ACA's Medicaid expansion (6.6 million people) and state health insurance exchanges (6.8 million people) beginning in 2014 through 2019.

Newly enrolled adults will receive comprehensive behavioral health benefits and the behavioral health benefits will be at parity, meaning those benefits are on par with medical and surgical benefits (similar deductibles, copays, co-insurance and annual/lifetime benefits).

The National Association of State Mental Health Program Directors (NASMHPD) recommends the following services be required as part of a wraparound Medicaid benefit:

- Skills training to address functional impairments resulting from a serious mental disorder and furnished in any appropriate setting, including in the home or on the job (this should include social, daily living, communication, personal care and other skills);
- Peer Support Services;
- Family education, such as Family Psycho-education (an evidence-based practice);
- Integrated treatment for individuals with co-occurring mental illness and substance use disorders, such as Integrated Dual Disorder Treatment (an evidence-based practice);
- Intensive in-home services for children;
- Crisis residential services for adults;
- Therapeutic foster care for children; and
- Outreach, engagement and mobile crisis services for people who are homeless.

Substance Abuse and Mental Health Services Administration (SAMHSA) "Behavioral Health Treatment Needs Assessment Toolkit for States" showed:

- Approximately 176,000 adults with incomes under 138 percent of federal poverty in New Mexico will be newlyeligible for Medicaid in 2014.
- Approximately 4.3 percent of this uninsured group reported receiving outpatient behavioral health services in the past year (about 7,500 of 176,000).
- Approximately 13.5 percent of 99,000 adults with Medicaid coverage and incomes under 139 percent of the federal poverty level received outpatient behavioral health services in the past year (about 13,300 clients).

The Department of Health (DOH) probably serves some of the clients described above in its chemical dependency units and other facilities that provide behavioral health services. However, to date the DOH has not captured data on income levels of its clients, but only collects Medicaid from clients that are currently eligible. The DOH should begin implementing a process to collect income eligibility data so it will be positioned to fully leverage expanded Medicaid revenues in FY14.

The SAMHSA warns their sample sizes may be too small to accurately estimate the numbers of persons receiving specific services but it provides some hints about ranges of service utilization.

Of note, the federal government reported dependence on, or abuse of alcohol or illicit drugs, among persons aged 12 or older was 8.9 percent nationwide in 2009; New Mexico's rate was 10.3 percent, in the bottom five of all states. New Mexico also ranked in the bottom quartile of states for access to treatment for drug use. Applying the addiction percentage to the HSD's enrollment estimate of 149 thousand newly Medicaid-eligible adults, an estimated 15 thousand individuals could be in need of substance abuse treatment and could benefit from Medicaid expansion.

Future of Federal Block Grant Funding. The state receives over $12 million annually in federal block grants targeted for mental health and substance abuse. The federal government has not announced any plans to reduce these grants in the future due to Medicaid expansion, but has provided guidance about how funds should be directed in future grant applications:

1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
2) to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;

The LFC report "*Costs and Outcomes of Selected Behavioral Health Grants and Spending*" released in May 2013 recommends the Legislature should require the HSD to complete a Medicaid eligibility projection for behavioral health, a behavioral health needs and gaps analysis to justify BHSD funding at existing levels, and should consider repurposing at least 50 percent of current state funding levels for BHSD non-Medicaid services to Medicaid by FY16, unless, based on results of needs and gaps study, funding is still needed for BHSD services.

Major findings from the LFC report "*Costs and Outcomes of Selected Behavioral Health Grants and Spending*" released in May 2013 included :

1) The Behavioral Health Collaborative has not maintained an ongoing assessment of system capacity to prepare for major changes in behavioral health delivery,
2) Recent events (i.e. the provider audits) demonstrate the need for a stronger, better coordinated system to monitor program integrity;
3) Despite increased funding, fewer people have received services through BHSD and outcomes still fall short of targets;
4) With the expansion of the Medicaid program, the need for state-funded behavioral health services may decrease; and
5) Evidenced-based practices provide a high-probability that outcomes for consumers will improve and the use of public monies will be more efficient.

3) to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis.

Future of State General Fund Support for Behavioral Health and Substance Abuse. State general fund support for behavioral health programs in the HSD Behavioral Health Services Division (BHSD) is approximately $39 million annually. The vast majority of this funding is to provide services to the uninsured. During the HSD presentation to the LFC on Medicaid expansion in September 2012, the department estimated half of the individuals served by the BHSD would be eligible for Medicaid funded behavioral health services in 2014 (increasing to 75 percent in 2015 and beyond). While noting that some non-Medicaid provided services would be necessary, they projected that up to $17.5 million in funding could be saved by Medicaid covering behavioral health services in FY15 and beyond.

As noted earlier, the HSD has not produced updated estimates on the number of newly-eligible adults who might access behavioral health services. Additionally, the HSD does not have detailed data on the income levels of its BHSD clients receiving services through general fund supported programs because the data was not previously required for treatment. It will probably be challenging for the department to provide reasonable cost and enrollment estimates until after enrollment begins in 2014 for newly eligible adults.

General Fund Dollars May Be Needed to Cover Non-Medicaid Services. Although HSD has not finalized the behavioral health Medicaid benefit package for newly-eligible adults, major changes from the current Medicaid benefit package are not expected. Key services not eligible for Medicaid reimbursement include services for in-patient substance abuse treatment for adults, services for undocumented aliens and treatment for adults in freestanding psychiatric hospitals. The HSD reported spending almost $8 million from the general fund for inpatient and residential behavioral health services in FY12.

Medicaid tends to focus on paying for direct services, so transitional living supports and room and board for clients in supportive housing may need continued general fund support. The HSD reported spending $3.7 million on community support services in FY12. As policymakers consider the FY15 budget request, it will be important to examine the justification for continued general fund support for substance abuse and behavioral health services since Medicaid will begin covering these services for many adults. However, it is likely that options to supplement non-Medicaid funded behavioral services will be on the table because it appears there are underfunded programs in the area of client community supports.

BEHAVIORAL HEALTH SYSTEM INITIATIVES

Centennial Care. As part of the HSD's Centennial Care Medicaid plan, behavioral health will be included in the four contracts for Medicaid-funded managed care for physical health starting on January 1, 2014. This reflects the view that integration of physical health services with behavioral health services will lead to better patient outcomes. However, advocates have raised concerns that behavioral health may not receive as much attention as physical health from the four large managed care companies and services may suffer. In a sense the state is returning to the original managed care system that did not have a behavioral health contractor, with hopes of much better performance.

Also in Centennial Care, the HSD plans to implement behavioral health homes to provide enhanced care management to improve outcomes for those with severe behavioral health issues. The legislature provided a $1.2 million general fund increase in the FY14 appropriation for this program. To address current gaps in Medicaid coverage, the HSD proposed to add three behavioral health services to Medicaid coverage that provide additional support services to those being treated for behavioral health issues: recovery services (group peer support), intensive family support, and youth respite.

The National Association of State Mental Health Program Directors (NASMHPD) notes that delivery and payment innovations introduced by the Affordable Care Act – and through the Medicaid expansion – could facilitate the provision of behavioral health services that are not usually reimbursable, including comprehensive care management, care coordination, social support, transition care, collaborative care, and other evidence-based interventions.

Another example of innovative programming is supported employment programs, which encourages the most severely disabled clients to pursue competitive employment – in other words, employment in jobs that pay at least minimum wage and that are open to anyone in the community – by providing them with support for an unlimited period of time.

Strategic Plan for Substance Abuse. In October 2012, the New Mexico Human Services Department (HSD) released a draft 2013 BHPC substance abuse strategy following completion of a statewide inventory of service providers. Generally, the HSD concludes there is a lack of service providers for intensive outpatient substance abuse services. Travel distance and lack of public transportation are barriers to effective outpatient services for rural areas, and the state lacks facilities to provide intensive outpatient services, particularly in the eastern and central regions.

The May LFC report found that the HSD has funded promising evidence- based approaches included peer support, comprehensive community support services and coordinated service agencies for better care coordination. However, a greater priority needs to be placed on making these services available statewide.

The HSD recommendations to improve substance abuse treatment and a update on status:

- Increase the number of intensive out-patient (IOP) providers by 22. Update: the HSD reports eight new IOP providers have been approved since June 2012.
- Train behavioral health agencies and community workers to ensure standardized support services for substance abuse patients. Update: training is ongoing.
- Increase the use of the evidence-based SBIRT model (Screening, Brief Intervention and Referral to Treatment) in the primary care environment. Update: the HSD applied for a federal grant to support SBIRT.
- Implement a statewide, 24/7 emergency behavioral health line to link individuals to services in their communities. Update: implemented January 2013.

The NASMHPD notes that an array of services must be designed to incorporate the concept of community integration and social inclusion for individuals with behavioral issues.

Community integration ensures that people with behavioral health problems, disabilities and other chronic illnesses have the supports and services they need to live in a home/family/community setting. This includes services to help people live in housing of their choice and to support them in school, work, families and other important relationships, and both paid and unpaid community supports can help achieve these goals.

Innovative Treatment Approaches Can Be Found in New Mexico. One goal of the LFC hearing is to hear from providers about new approaches already implemented that will benefit from reprioritized state and additional federal or insurer support. A few examples from LFC staff site visits in June include:

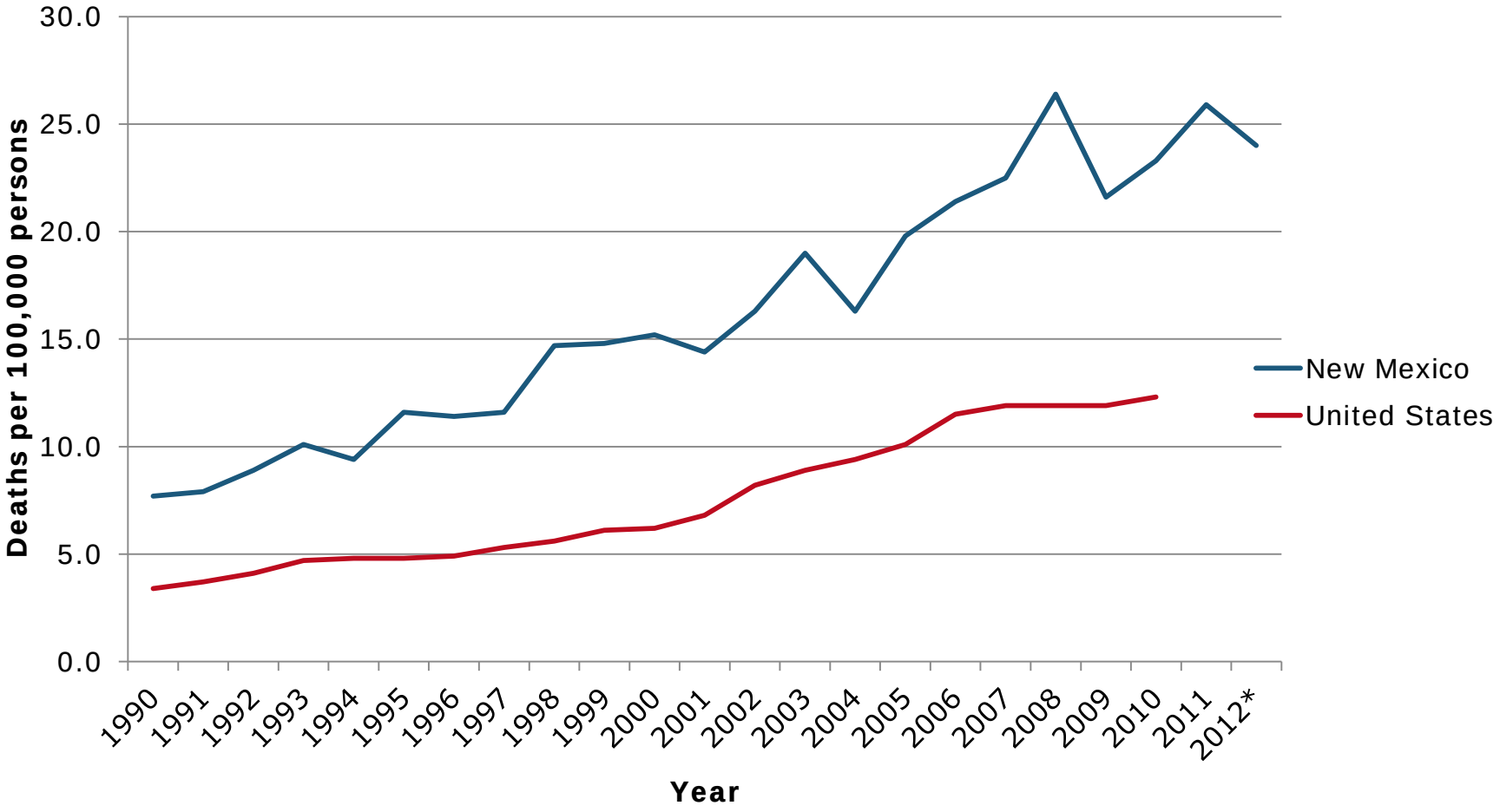
- First Choice Community Health, a large provider of primary care services in the Rio Grande corridor, has implemented behavioral health services in the primary care environment at six locations using the SBIRT model and licensed social workers.
- Project Echo at the University of New Mexico is implementing a community mental health project with support from the GE Foundation. The project will train 16 nurse practitioners and community social workers to diagnose and treat patients with behavioral health conditions at eight federally qualified health centers in rural New Mexico with telemedicine support from UNM. If the model proves successful over three years, replication will begin in other areas.
- Leveraging multiple funding sources including federal, City of Albuquerque, and grant support; St. Martin's Hospitality Center's "Project End Homelessness" has a four step approach to stabilizing homeless clients with day and emergency shelter services, behavioral health services, transitional housing services and employment services.
- Bernalillo County's Community Addiction Program (CAP) provides outpatient substance abuse treatment and support services for clients newly released from jail or referred from the short-term social detox program at the Metropolitan Assessment and Treatment Center (MATS). The CAP served over 2,000 clients in FY12.
- Filling a gap in availability of medical detoxification services for adolescents, the Department of Health will be expanding services at Turquoise Lodge in Albuquerque to provide medical detox services for up to 20 adolescent clients.

Burden of Substance Abuse in New Mexico

Substance Abuse Epidemiology Unit
Injury and Behavioral Epidemiology Bureau
Epidemiology and Response Division
New Mexico Department of Health

July 17, 2013

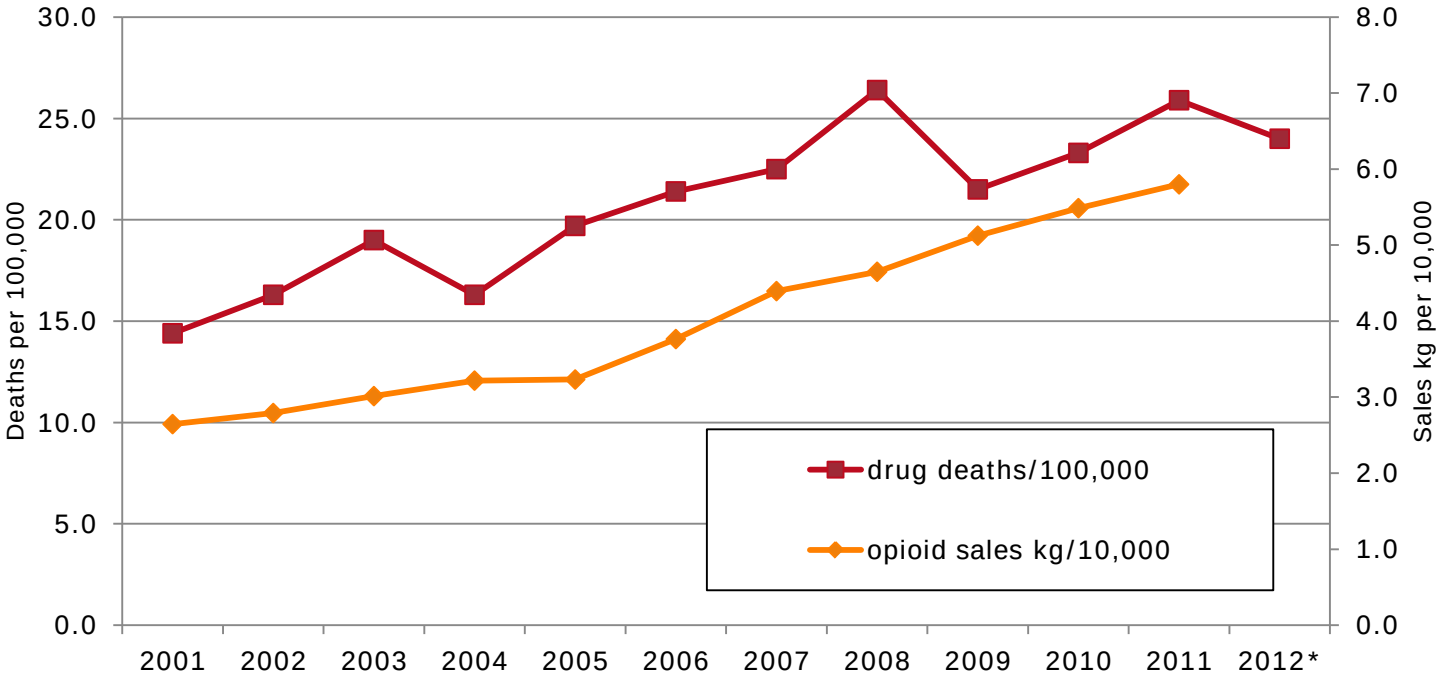
Drug Overdose Death Rates
New Mexico and United States, 1990-2012



* 2012 data are preliminary.

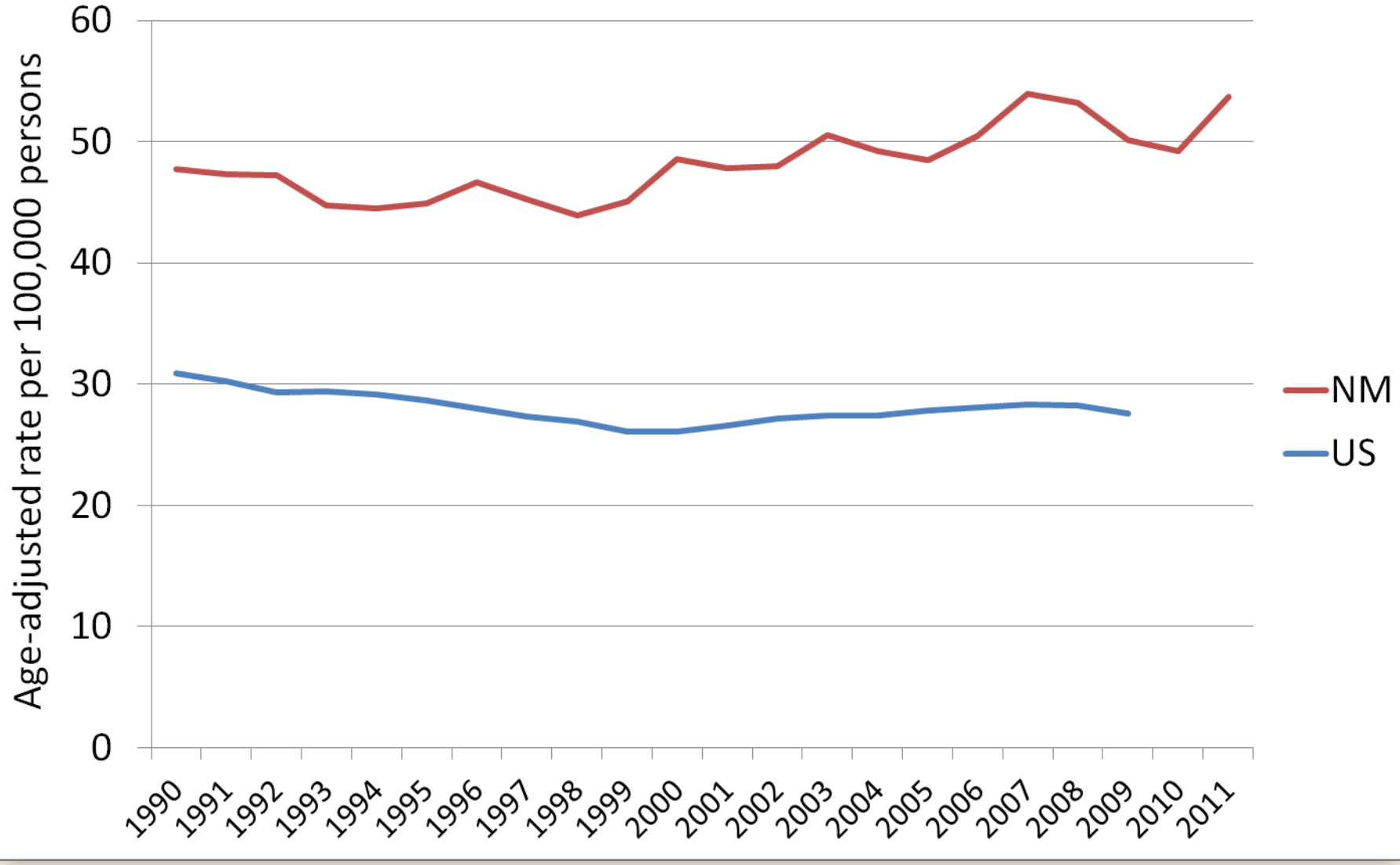
Source: United States (CDC Wonder); New Mexico (NMDOH BVRHS: SAES, 1990-1998, 2012; NM-IBIS, 1999-2011)

Rates of Drug Overdose Deaths and OPR Sales, New Mexico 2001-2012*



* 2012 data are preliminary.
Source: BVRHS, NMDOH; ARCOS, DEA.

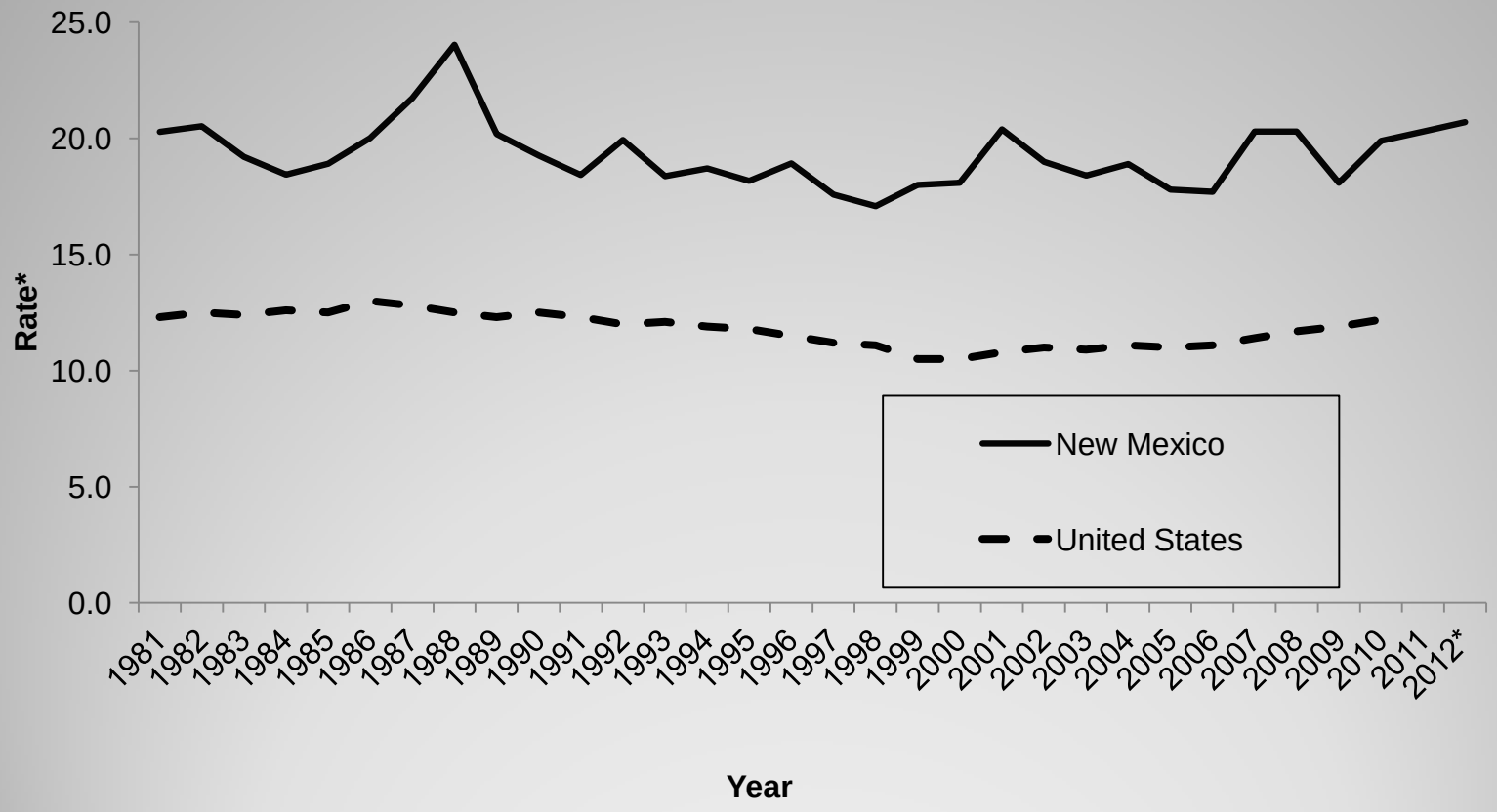
Alcohol-Attributable Death Rates
New Mexico and United States, 1990-2011



Source: NM: BVRHS, UNM-GPS; US: NCHS

Rates are per 100,000, age-adjusted to the US 2000 standard population

Suicide Rates*, New Mexico and United States, 1981-2012



* Rate per 100,000, age-adjusted to the 2000 US standard population

Source: NMDOH BVRHS death files and UNM-GPS population files (NM); CDC Wonder (US)

Performance Report Card
Behavioral Health Collaborative
Third Quarter, Fiscal Year 2013

Performance Overview: The 17-member Behavioral Health Purchasing Collaborative is charged with coordinating a statewide behavioral health system. However, coordination of a comprehensive system is hampered because funding resides in several different agencies. Despite good performance results on collaborative measures, New Mexico ranks near the bottom for per-capita overdose rates, and the Collaborative maintains minimal data on outcome-based measures such as the rate of substance abuse patient relapse. Improving the availability of high quality behavioral health services is essential given the increased demand for services expected in 2014 due to Medicaid expansion for low-income adults. For FY13, an annual measure on the percentage increase in the number of pregnant females with substance abuse disorders receiving treatment from the collaborative is added.

Program		Budget: N/A FTE: N/A	FY11 Actual	FY12 Actual	FY13 Target	Q1	Q2	Q3	Rating
1	Percent of people receiving substance abuse treatment who demonstrate improvement in the drug domains on the addiction severity index (ASI)		70.7%	72%	76%	bi-annual	70.6%	bi-annual	Y
2	Percent of people receiving substance abuse treatment who demonstrate improvement in the alcohol domain on the addiction severity index (ASI)		90.6%	87%	85%	bi-annual	79.5%	bi-annual	Y
3	Percent of youth on probation served by the statewide entity		47.8%	40%	48%	Reported Annually			
4	Percent of individuals discharged from inpatient facilities who receive follow-up services at 7 days		34.8%	36%	38%	33.7%	43.6%	39.5%	G
5	Percent of individuals discharged from inpatient facilities who receive follow-up services at 30 days		53.6%	55%	57%	48.8%	59.3%	60.5%	G
6	Individuals served annually in substance abuse and/or mental health programs administered through the collaborative statewide entity contract		83,605	84,559	83,000	43,090	62,131	84,559	G
7	Number of youth suicides among fifteen to nineteen year olds served by the statewide entity		0	0	3	0	0	0	G
8	Percent increase in the number of pregnant females with substance abuse disorders receiving treatment by the statewide entity.		n/a	n/a	3.5%	Reported Annually			
Program Rating			Y	Y					Y

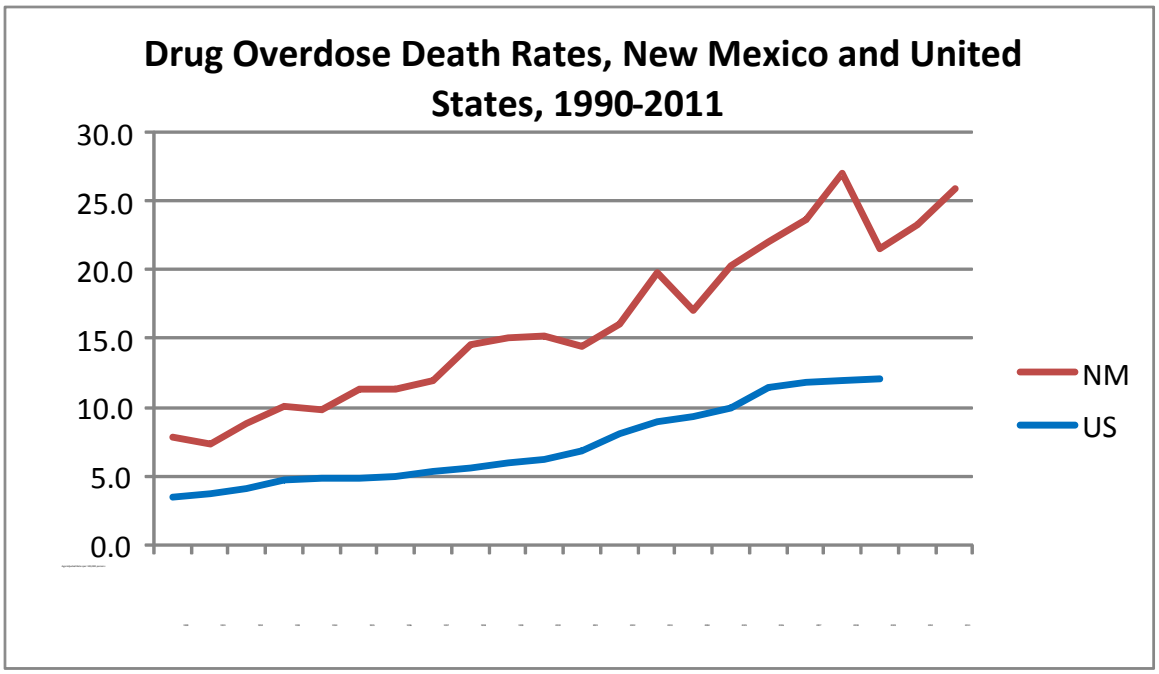
Comments: The overall program rating of yellow reflects concerns about the lack of an overall approach at the state government level to address substance abuse as well as program oversight concerns; the HSD has hired an independent auditor to review behavioral health services contractor billing, recordkeeping and treatment practices statewide. The HSD's examination follows allegations of billing irregularities at Carlsbad Mental Health Services last fall, which led to an Attorney General investigation. Allegations of widespread irregularities are of concern given dual layers of oversight from both the HSD and behavioral health contractor Optum Health.

Key Statewide Data on Substance Abuse Crisis in New Mexico

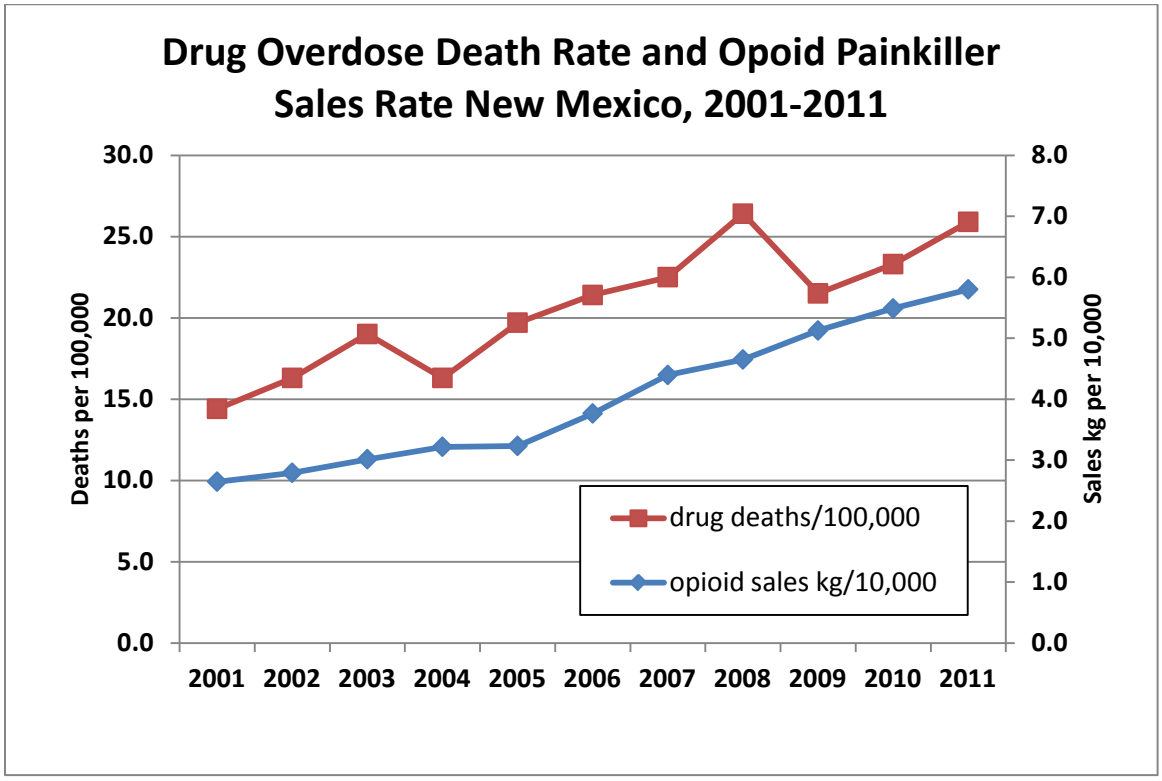
Drug Overdose Deaths Per 100,000 Persons in 2009	
NM	22.4
OK	20.9
Nevada	20.6
Utah	18.7
Alaska	18.1
USA	12.0

Source: CDC

Performance Report Card
Behavioral Health Collaborative
Third Quarter, Fiscal Year 2013



Source: NM DOH presentation



Source: NM DOH

Performance Report Card
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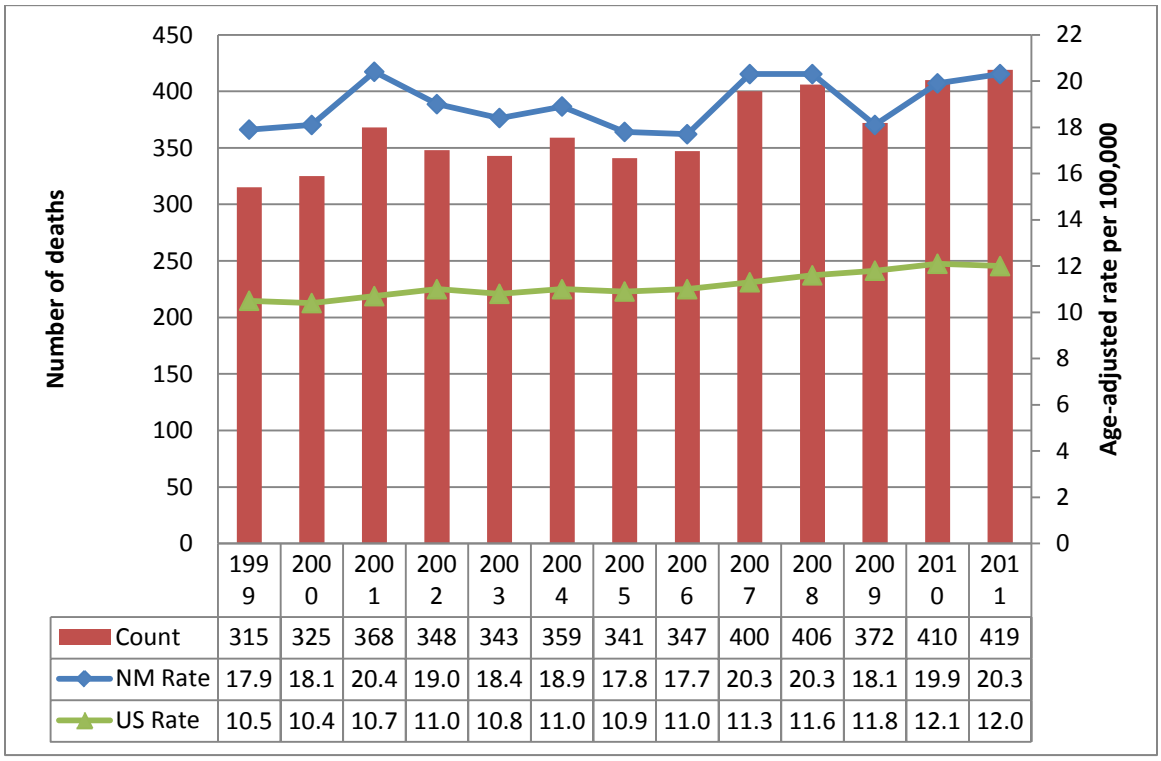
Third Quarter, Fiscal Year 2013

Suicide Deaths and Rates*
NM and U.S., 1999 - 2011



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Count	315	325	368	348	343	359	341	347	400	406	372	410	419
NM Rate	17.9	18.1	20.4	19.0	18.4	18.9	17.8	17.7	20.3	20.3	18.1	19.9	20.3
US Rate	10.5	10.4	10.7	11.0	10.8	11.0	10.9	11.0	11.3	11.6	11.8	12.1	12.0

Source: NM DOH