Report
to
The LEGISLATIVE FINANCE COMMITTEE

Review of the Interagency Behavioral Health Purchasing Collaborative
November 15, 2006

Report # 06-35

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DAVID ABBEY
DIRECTOR

November 15, 2006

Pamela Hyde, Co-Chair
Interagency Behavioral Health Purchasing Collaborative
Cabinet Secretary - Human Services Department
2009 South Pacheco, Pollon Plaza
Santa Fe, New Mexico 87504

Dear Secretary Hyde:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the Review of the Interagency Behavioral Health Purchasing Collaborative (Collaborative).

The review team evaluated the effectiveness and efficiency of the Collaborative oversight structure and its ability to ensure New Mexicans can access cost-effective high quality behavioral health care services through the Value Options' network. The report will be presented to the Committee on November 15, 2006. An exit conference was conducted on November 6, 2006 to discuss the contents of the report with you and your respective Collaborative co-chairs.

I believe this report addresses issues the Committee asked us to review and hope the Collaborative benefits from our efforts. We very much appreciate the cooperation and assistance we received from you and from Collaborative agencies' staff.

Sincerely,

David Abbey
Director

cc: Representative Luciano "Lucky" Varela, LFC Chairman
Dorian Dodson, Secretary-Designate, Children, Youth and Families Department
Michelle Lujan Grisham, Secretary, Department of Health

DA:CS/csd

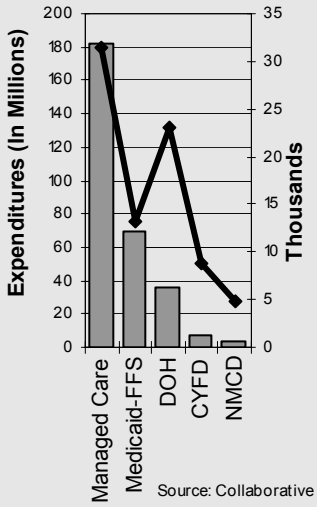
Table of Contents

Page No.

EXECUTIVE SUMMARY

Historically, the behavioral health system has provided insufficient access to evidence-based care.

Behavioral Health: People Served & Spending - FY06



Source: Collaborative

In FY06, the Collaborative spent about $300 million on services for about 70,000 New Mexicans.

In 2004, the Legislature created an Interagency Behavioral Health Purchasing Collaborative (Collaborative), consisting of 21 agencies, to develop and coordinate a single statewide behavioral health care system. The legislation was consistent with Governor Richardson's direction that these agencies streamline the delivery and oversight of services. Recent extensive studies, such as the Behavioral Health Needs and Gap Analysis in 2002, summarized what many people who use behavioral health services (consumers) and their families already knew – that the behavioral health system too often:

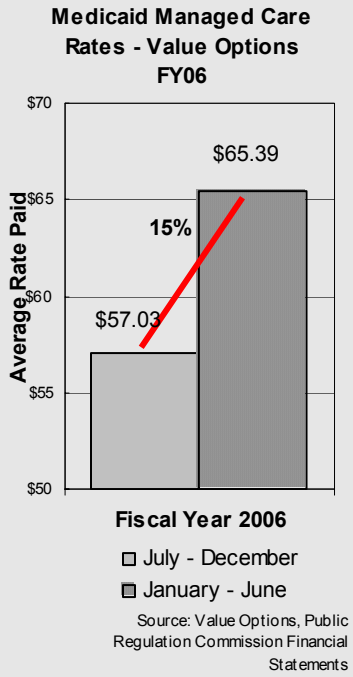
- provides insufficient access to evidence-based care;
- delivers services through a confusing array of uncoordinated public and private agencies and providers; and
- focuses on "managing" people's problems rather than helping them adapt and lead productive lives.

The Collaborative aims to ameliorate these issues through, among other strategies, a contract with ValueOptions to manage a single statewide provider network. The review assessed progress made to develop a single statewide behavioral health system; the efficiency and effectiveness of the Collaborative oversight structure; and its ability to ensure access to high quality cost effective services.

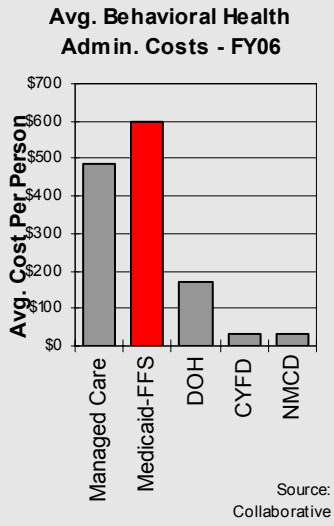
Overall, the promises of behavioral health reform are great, though the results of the Collaborative's first two years are mixed. The Collaborative has generally met its goals to transition the state's behavioral health programs to ValueOptions. In FY06, the Collaborative spent approximately $300 million on services for about 70,000 New Mexicans. The Collaborative needs to continue developing a concrete and comprehensive approach to oversee and ensure the state provides sufficient access to high quality services.

Improvements in three key areas, ***authority***, ***administration***, and ***accountability***, are needed to fulfill the promise of New Mexico's behavioral health reform efforts. The Collaborative lacks clear authority to efficiently streamline rules governing access and quality of care standards. Administering about $300 million in funding through a "virtual department" may prove ineffective over time. And, finally, appropriations and performance measures remain spread across multiple agencies, limiting the executive's accountability to the Legislature.

The findings and recommendations in this report are intended to build on the Collaborative's initial innovations and better position the Legislature to assist in the long-term sustainability of the state's behavioral health reforms.



The $11 million increase in Medicaid funding appears unrelated to ValueOptions performance.



Significant Findings.

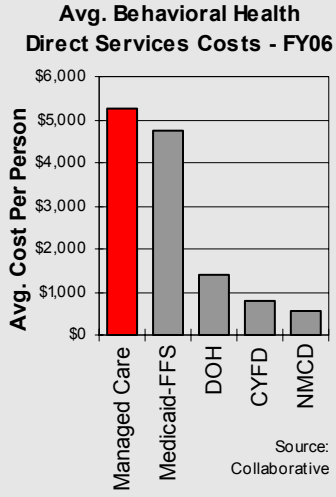
The Collaborative could still improve on its key statutory duties necessary to ensure a well planned and functioning behavioral health system. Almost two years have passed since the inception of the Collaborative without a clear behavioral health system strategic plan. Strategic planning provides the basis for organizations to define goals, identify specific strategies to accomplish the goals, and performance measures to determine success.

The Collaborative's financial oversight of ValueOptions needs improvement to ensure sound business practices.

- *The Collaborative provided ValueOptions with a year end FY06 Medicaid managed care funding increase of $11 million, which appears unrelated to its performance under the contract.* The appropriation for this increase remains unclear, though it appears that the Collaborative moved part of this expenditure into the FY07 budget. This approach circumvents the Legislature's appropriations authority by allowing agency to expand its budget beyond its appropriation.
- *The increased Medicaid funding resolved ValueOptions' regulatory non-compliance with Insurance Division risk-based capital requirements, according to its own auditor.*
- *Providing funding increases, unrelated to performance, for an "at-risk" program defeats the purpose of contracting with a managed care organization, and raises questions about the viability of ValueOptions initial cost proposals.*
- *Pre-payments to ValueOptions for Medicaid-FFS program resulted in overpayment to the company, based on the rate of claims submitted through September 2006. However, at the time of this report HSD was in the process of recouping the overpayments.*
- *In FY07, the Collaborative approved an arrangement to pre-pay ValueOptions for services not yet rendered, which appears contrary to best practice.*
- *Pre-paying ValueOptions costs the state between 3.73 percent and 5.84 percent in earned income on Collaborative funding.*
- *The Collaborative lacks efficiency measures to regularly assess the cost-effectiveness of services and administration.*

The Collaborative lacks rulemaking authority needed to streamline regulations common to all behavioral health programs and improve access to quality services. The behavioral health system does not operate under common regulations for important standards such as access and quality of care.

Aligning agencies' rules through multiple and separate processes complicates effective public participation in critical decisions regarding quality of behavioral health services.



Behavioral health only accounts for 10 percent of the overall Medicaid budget, forcing it to compete for resources from a host of other Medicaid services.

The Collaborative does not have a clear and consistent process to make policy and include and inform the public of its decisions.

- *The Collaborative has made significant efforts to include the public in its deliberations and provide information via its website.* However, it has not adopted a policy governing its decision-making process, including how it will notify, seek or allow public participation.
- *Aligning agencies' rules through multiple and separate processes is inefficient, and complicates effective public participation in critical decisions regarding quality of behavioral health services.*
- *Using the contract process to make or align policy is not contemplated by state law and puts the public at a disadvantage to effectively participate in the process.* For example, the Collaborative negotiates the contract, some of which is behind closed doors and not subject to Public Meetings Act requirements.

New Mexico still lacks a unified behavioral health budget. Behavioral health outcome measures cannot be tied to individual agency's appropriations, limiting the Collaborative's accountability to the Legislature and New Mexico taxpayers.

- *The Legislature appropriates 80 percent of the Collaborative's funding to programs where behavioral health services makes up only a portion of the overall program appropriation.* For example, behavioral health services only accounts for about 10 percent of the overall Medicaid budget, forcing the program to compete for resources from a host of other service-types. However, Medicaid behavioral health services account for about 76 percent of the Collaborative's contract with ValueOptions in FY07.
- *The executive's proposal to transfer the Behavioral Health Services Division (BHSD) from the Department of Health to the Human Services Department provides the Legislature with a good opportunity to review the need to further streamline behavioral health administration.*
- *The Collaborative has adopted outcome measures that cross agency funding streams, making, in some cases, existing program performance measures obsolete or inappropriate.*

Consumers and families lack access to information on the quality and performance of ValueOptions and its network providers. A consumer-driven system allows people who use the services to make an informed decision about which providers and organizations to receive services, in addition to participating in treatment decisions.

Significant Recommendations.

The Collaborative should implement the following.

- Report performance measure and other outcome data to the Legislative Finance Committee as a Collaborative.
- Move the comprehensive behavioral health plan to a strategic plan no later than June 1, 2007.
- Report annually to the Legislature and public on progress made to transform the system.
- Ensure future contract amendments to increase funding to the single entity are clearly tied to performance, change in scope of the contractor's work or need adjustment due to an unsound actuarial rate structure.
- Phase out the use of pre-payment arrangements to ValueOptions in FY07 for CYFD and Corrections Department funding, and DOH by the end of FY08.
- Require external quality audits to review all services funded by the Collaborative, not just Medicaid managed care.
- Finalize Geo-access report standards, and begin reporting publicly, no later than January 1, 2007. Use the reports to measure progress made over time in expanding the state's behavioral health network as part of the Collaborative's strategic plan.
- Publish ValueOptions' quality assessment results compared to evidence-based standards.

The Legislature could consider the following changes over the next two years. Build on the executive proposal to consolidate behavioral health administrative functions by streamlining behavioral health authority and accountability, in addition to administration. Consider the following.

- *Create a unified behavioral health services budget using FY07 Collaborative-ValueOptions contract amounts and programs.* The Legislature could appropriate the funds to the Collaborative, which would be administratively attached to HSD.
- *Select Collaborative developed outcome measures for use as performance measures in the General Appropriations Act.*
- *Provide the Collaborative with rulemaking authority over delivery of behavioral health services, including access and quality of care standards common to most services provided by the single entity.*

In 2004, the Legislature created the Interagency Behavioral Health Purchasing Collaborative (Collaborative) to develop and coordinate a single statewide behavioral health care system. The legislation was consistent with Governor Richardson's direction that all agencies involved in the delivery, funding, or oversight of behavioral health care services in New Mexico collaborate in the creation of this new system. The legislation also consolidated multiple advisory bodies through creation of the Behavioral Health Planning Council.

The *statutory duties* (Section 9-1-7.6 NMSA 1978) of the Collaborative are to:

- identify behavioral health needs statewide and develop a comprehensive statewide behavioral health plan; and
- give special attention to regional differences, including cultural, rural, frontier, urban and border issues;
- inventory all expenditures for mental health and substance abuse services;
- plan, design and direct a statewide behavioral health system and
- contract with one or more behavioral health entities to ensure availability of services throughout the state (the collaborative chose one – ValueOptions).

FAST FACTS

New Mexicans with Behavioral Health Issues. An estimated 500,000 people in New Mexico have substance abuse/dependence or mental health disorder, based on estimates in 2002. About a third needs services from the publicly funded behavioral health system. Nearly 90,000 adults and children have serious mental illnesses or emotional disturbances.

Behavioral Health Funding. The Collaborative has contracted with ValueOptions New Mexico, Inc. to manage a single statewide provider network, using state and federally funded mental health and substance abuse program funds. Funding totals between $300 million in FY06 to over $360 million in FY07.

Customers Served. In FY06, the Collaborative served about 70,000 people through the ValueOptions network, based on billings through September 2006.

Provider Network. ValueOptions ensures services are delivered through contracts with about 230 agencies and facilities, and 674 individual practitioners.

HISTORY OF MAJOR EVENTS

1999	Mental Health: A Report from the Surgeon General. Provides the scientific basis for transforming mental health delivery system.
2001	New Mexico Medicaid Behavioral Health Advisory Committee issues report on managed behavioral health care options and improved cross-agency coordination of services. The Committee made system-wide proposals considered essential to the effective functioning of any behavioral health model for the state, including topics related to access, quality, financing, and treatment of consumers and interagency coordination.
2002	President George W. Bush establishes President's New Freedom Commission on Mental Health and directs it to identify policy changes needed to maximize resources, improve coordination and promote community integration for people with serious mental illness.
	The New Mexico Behavioral Health Needs Assessment and Gap Analysis Project commissioned by the Legislature completed.
2003	New Freedom Commission issues report Achieving the Promise: Transforming Mental Health Care in America which establishes comprehensive recommendations for transforming the mental health system.
	Governor Bill Richardson directed all agencies tasked with the delivery, funding or oversight of behavioral health care services; including, mental health and substance abuse services and treatment, in New Mexico to work collaboratively to create a single behavioral health service delivery system throughout the State.
2004	The New Mexico Legislature passes House Bill 271, establishing the Interagency Behavioral Health Purchasing Collaborative and Behavioral Health Planning Council.
2005	The Behavioral Health Collaborative selects ValueOptions New Mexico, Inc. as the single statewide entity to manage mental health and substance abuse programs and funding from 6 separate state agencies.

SYSTEM TRANSFORMATION

Recent extensive studies, cited above, at the federal and state level summarized what many people who use behavioral health services (consumers) and their families already knew – the behavioral health system too often provides insufficient access to evidence-based care, delivers services through a confusing array of uncoordinated public and private agencies and providers, and focuses on "managing" people's problems rather than helping them adapt and lead productive lives. The Collaborative was created to address these and other problems plaguing New Mexico's behavioral health system, in particular its "fragmented and uncoordinated array of services via multiple funding streams [that] offer varying degrees of accessibility and quality of service delivery."

According to the Collaborative, the following specific problems frustrate New Mexico's behavioral health system, necessitating a comprehensive transformation of how the system is operated and overseen.

- Often insufficient and inappropriate services, especially a lack of attention to evidence-based and promising practices.
- Lack of common agreement about goals and outcomes.
- Not maximizing resources across funding streams.
- Multiple disconnected advisory groups.
- Fragmentation, i.e. multiple service delivery approaches, plans, service definitions, billing processes, and reporting requirements for similar or related services.
- Duplication of effort and infrastructures at state and local levels.
- Higher administrative costs for providers due to multiple contracting entities.
- Insufficient or duplicative oversight of providers and services.

Table 1.
Membership: Behavioral Health Collaborative

Statutory Members

- *Aging and Long-Term Services Department*
- *Administrative Office of the Courts*
- *Children, Youth and Families Department, Co-chair*
- *Corrections Department*
- *Department of Finance and Administration*
- *Department of Health, Co-chair*
- *Labor Department*
- *Department of Transportation*
- *Developmental Disabilities Planning Council*
- *Division of Vocational Rehabilitation*
- *Governor's Commission on Disability*
- *Governor's Health Policy Coordinator*
- *Health Policy Commission*
- *Human Services Department, Co-chair*
- *Indian Affairs Department*
- *Mortgage Finance Authority*
- *Public Education Department*

Non-Statutory Members

- *Children's Cabinet Coordinator*
- *Higher Education Department*
- *Office of Workforce Training and Development*
- *State Public Defender's Office*
- *Veterans Services Department*

Source: Collaborative

ORGANIZATION

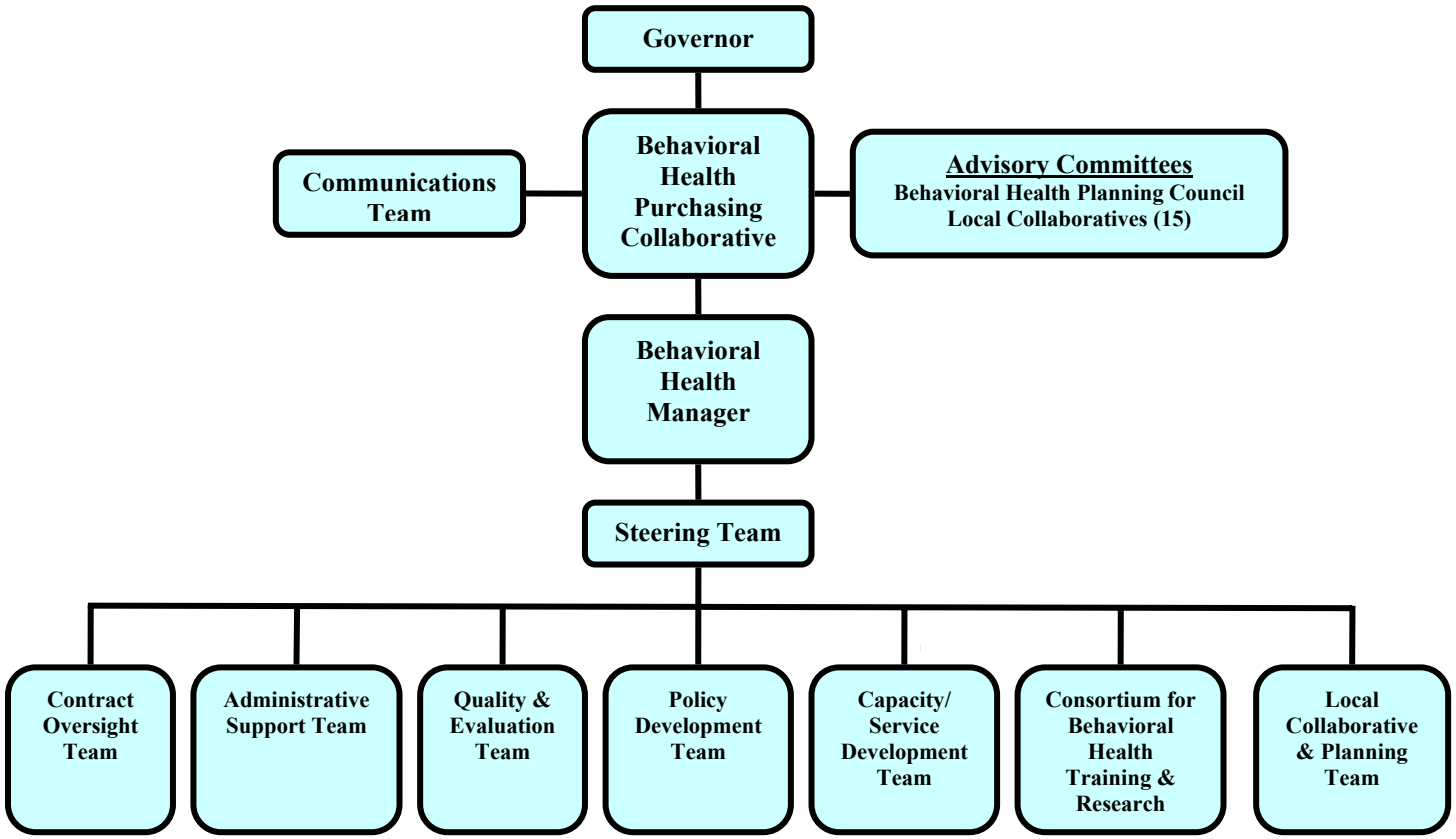
Policy, Planning and Advisory Bodies. Three primary entities guide the strategic planning and oversight of behavioral health services in New Mexico.

Behavioral Health Collaborative. Collaborative members represent 21 state agencies, offices, or programs involved in the direct or indirect delivery of behavioral health services, advocacy, health policy and research, or that significantly impact consumers. The collaborative consists of 17 statutory voting members and five additional ex-officio members, shown in Table 1. The Secretary of the Human Services Department (HSD) permanently co-chairs the collaborative, with the Secretaries of the Children, Youth and Families Department (CYFD) and Department of Health (DOH) rotating annually as the other co-chair. For FY07, the Secretary of the Department of Health acts as co-chair.

Behavioral Health Planning Council. The Behavioral Health Planning Council (council) was established as a single statewide advisory group to the governor and the Legislature. The council replaced multiple behavioral or mental health advisory councils. The council conducts planning, advisory and advocacy duties. The council members are appointed and serve at the pleasure of the Governor. Membership consists of consumers, providers, advocates and state agency representatives. Consumers must account for 51 percent of members. The council has 44 appointed members, and 12 members representing state agencies.

Local Collaboratives. The collaborative has approved 15 local collaboratives (LC) to assess local needs, help develop resources, and serve as formal local advisory organizations in designing the new behavioral health system in New Mexico. The LCs represent 13 geographic areas based on state judicial districts. Two LCs represent the state's sovereign tribes and pueblos. Each local collaborative consists of consumers, families, providers, advocates, and other system representatives.

Behavioral Health Collaborative
Organizational Chart - September 13, 2006



Source: Collaborative

Operations. The collaborative has created a virtual department made up of staff from multiple agencies and guided by the Behavioral Health Manager and an Interagency Steering Team. They provide appropriate cross-agency leadership, staff support, and partnership with the council and the SE to ensure the successful implementation of the Collaborative's goals.

In this virtual department there are a total of nine (9) Cross Agency Teams (CATS) and subcommittees with staff and collaborative leads. These teams focus on each phase; transition, development and implementation with perspectives to their responsibilities. The teams and their responsibilities include:

Cross Agency Coordinating Team (Steering Group) - assures all efforts are coordinated and consistent, troubleshoot, oversee T-SIG grant and identify possible new fund sources.

SE Contract Oversight Team – contract development, contract negotiation, and contract management (performance measures, quality compliance, etc.)

Administrative Support Team – provider capacity survey, technical assistance for increasing provider administrative capacity, development of data warehouse to report measures, grants management, fund mapping for outcome tracking, rate/payment schedule.

Local Collaboratives and Planning Team – roles and responsibilities of LC's, memberships, comprehensive planning process, templates for planning, top priorities from LC's for Legislative Session, legislative requests, identify and distribute available fund sources to LC's, implement guidelines for consumers/family members, development of data reports for LC's with ValueOptions, community reinvestment process and guidelines.

Policy Development Team – definitions of consumer/family with recommended guidelines for use, legislative process to coordinate review and approval of legislative initiative affecting behavioral health, outpatient commitment law revisions and public meeting, identify areas needing collaborative policy (children's code changes, provider licensure and certification, etc.)

Capacity/Service Development – immediate priority for capacity buildings (housing, residential services, IOP and substance abuse, etc), longer term priorities for service system development (early childhood mental health, veteran's issues, jail and prison re-entry, etc.), activities underway to improve cross agency coordination (advance directives implementation, suicide prevention, gambling, etc.)

Consortium for Behavioral Health Training and Research – development of advisory group, infrastructure proposal, inventory current research efforts, hire and set up academic leader, state behavioral health research agenda, training and workforce development plan, workforce recommendation, telehealth capacity, research projects of interest, and statewide provider training.

Quality and Evaluation Team – calculations and data sources for performance measures, help to develop warehouse and funds mapping tied to performance measures, monitor and implement evaluation contracts, work with ValueOptions on CQM/OI activities, implement T-SIG evaluation as required by SAMHSA grant.

Communications Team – develop common message for performance measures, hire communications and website staff, develop and set up website, produce newsletter with ValueOptions, one pagers for legislators, talking points for key collaborative issues, plan and manage events, media relations.

Single Entity. The Collaborative has contracted with ValueOptions of New Mexico to carry out the functions of the single behavioral health entity (SE). ValueOptions is a subsidiary of FHC Health Systems out of Virginia.

The SE operates as both a managed care organization for the at-risk portion of Medicaid and an administrator of other publicly funded behavioral health programs. The SE performs the following functions to help the Collaborative achieve a more streamlined and improved behavioral health system.

- Establishes and monitors a network of providers, including assuming billing and claims functions, and credentialing of providers for multiple state agencies.
- Conducts utilization review and management, quality assurance and care coordination.
- Coordinates with consumers, families and local collaboratives.
- Collects, manages and reports data.

Phases of System Change. The textbox, *Behavioral Health Transformation*, shows the planned system changes outlined by the Collaborative. The Collaborative anticipates a full ten years will be needed to truly transform the system.

Behavioral Health Transformation

Pre-planning and Transition
September 2003–July 1, 2005

- Designing, Planning, Public participation, Federal approvals sought, Local systems of care criteria determined and, Selecting Statewide Entity finalists, final selection and contracting of SE, Transition to implementation of the program.

Operational - Phase One
July 1, 2005 – June 30, 2006

- Services provided; providers paid; data reported, Transition continued, Expectations refined, Data systems refined, Identification of ways to maximize funding, Local collaboratives developed, Implement statewide plan, Establish goals for Phase Two.

Phase Two
July 1, 2006 – June 30, 2008

- Establish greater blending ("braiding") and flexibility of funding, Additional funding streams established, Local systems of care refined, Development of additional evidence-based and promising best practices, Additional consumer/family operated services, Performance expectations and consumer/family outcomes refined, measured and reported, Additional resources sought (e.g., grants), Establish goals for Phase Three.

Phase Three
July 1, 2008 – Forward

- System maturation, Increased program and service development, Improved performance and outcomes, Increased coordination among local, and statewide systems, development begun, Releasing RFP

Source: Collaborative

FUNDING

Chart 1 provides a breakdown by agency of the approximately $300 million in estimated funding included in the FY06 contract between the Collaborative and ValueOptions. The original contract did not include specific funding levels by program, or projected funding for the Medicaid programs. However, according to Collaborative staff, HSD programs account for, by far, the largest portion of funds in the contract and consist of Temporary Assistance for Needy Families substance abuse funding of $800 thousand, Medicaid Managed Care (Medicaid – MC) at $183.1 million and the Medicaid Coordinated Fee-for-Service program (Medicaid FFS) accounts for $69.2 million.

Chart 2 provides a breakdown by agency of the estimated $320 million in funding included in the FY07 contract between the Collaborative and ValueOptions. Federal funds account for about $199 million, or 62 percent, and state funds total about $121 million, or 48 percent, of total contract costs.

HSD accounts for the largest portion of funding, which consists of TANF at $800 thousand, Medicaid-MC at $186 million and Medicaid FFS at $58.5 million. This amount is not inclusive of all funding that ValueOptions may receive in FY07, and may change depending on Medicaid costs, and decisions regarding State operated facilities. For example, at the time of this publication, projected Medicaid FFS costs increased to an estimated $65.5 million. In addition, the estimated amount in Chart 2 does not include potential funding for State operated facilities at DOH, totaling $30 - $42 million.

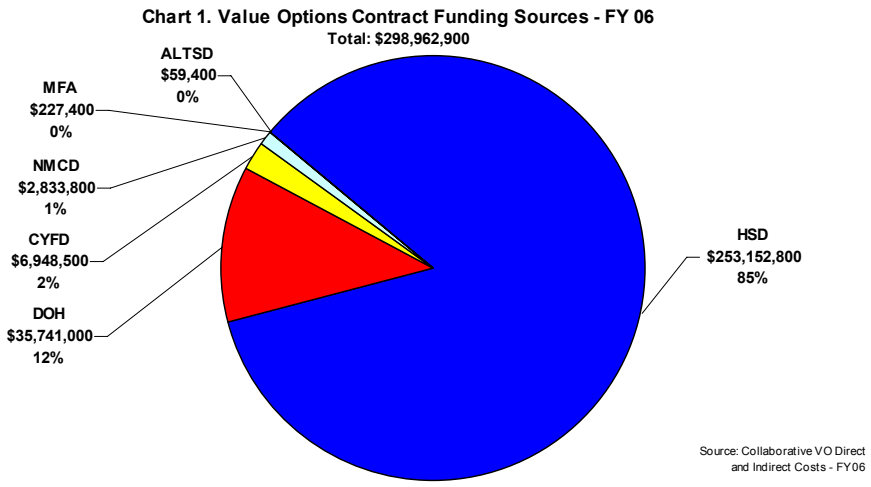


Chart 1. Value Options Contract Funding Sources - FY 06
Total: $298,962,900
ALTSD
$59,400
0%
MFA
$227,400
0%
NMCD
$2,833,800
1%
CYFD
$6,948,500
2%
DOH
$35,741,000
12%
HSD
$253,152,800
85%
Source: Collaborative VO Direct and Indirect Costs - FY06

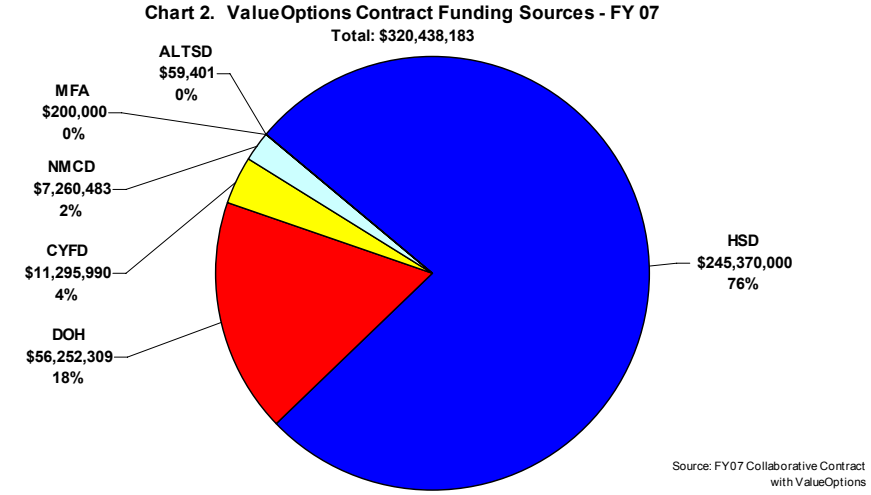


Chart 2. ValueOptions Contract Funding Sources - FY 07
Total: $320,438,183
ALTSD
$59,401
0%
MFA
$200,000
0%
NMCD
$7,260,483
2%
CYFD
$11,295,990
4%
DOH
$56,252,309
18%
HSD
$245,370,000
76%
Source: FY07 Collaborative Contract with ValueOptions

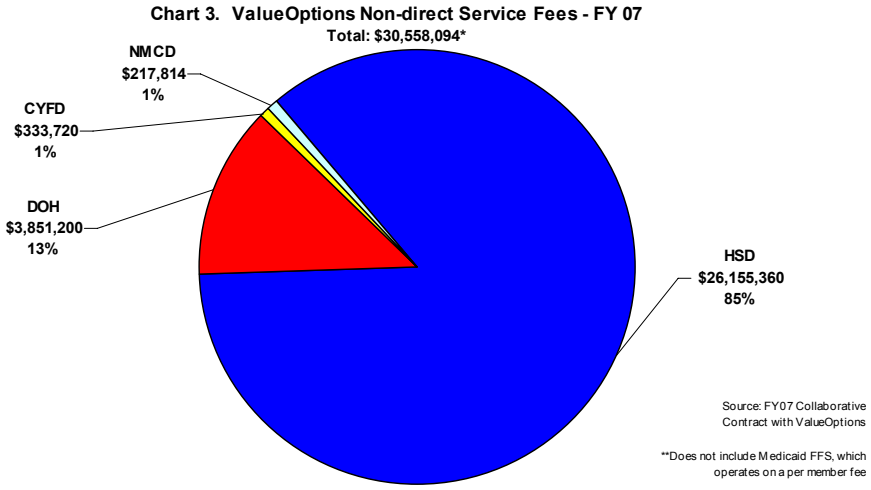


Chart 3. ValueOptions Non-direct Service Fees - FY 07
Total: $30,558,094*
NMCD
$217,814
1%
CYFD
$333,720
1%
DOH
$3,851,200
13%
HSD
$26,155,360
85%
Source: FY07 Collaborative Contract with ValueOptions
**Does not include Medicaid FFS, which operates on a per member fee

Chart 3 provides estimated non-direct services funding included in the FY07 contract. Non-direct services costs include ValueOptions' administrative overhead costs, training, evaluations and company profit. Each agency except MFA and ALTSD pays a percentage ranging from 3-14 percent for non-direct services to ValueOptions. The Medicaid FFS program pays a per-member per-month administrative fee to ValueOptions. The contract does not provide a breakdown of total administrative fees it expects to pay during FY07 for the Medicaid FFS program, however subsequent projections by HSD indicate that ValueOptions may earn up to $7 million in administrative fees for this program. For FY06 these fees amounted to about $7 million or 10 percent of the nearly $70 million total projected expenses for the Medicaid FFS program. Depending on enrollment growth, the fees paid to ValueOptions may change.

Review Objectives.

- Assess the effectiveness and efficiency of the Collaborative oversight structure, including the use of planning councils and local collaboratives.
- Review the implementation status of the transition towards a single behavioral health care system and use of a Statewide Entity.
- Evaluate performance criteria used to ensure access to high quality care, ease of administration, and cost-effective services.

Objective and Scope. The review period included data from FY04 through FY08. The review was conducted to assess the effectiveness and efficiency of the Collaborative oversight structure, the implementation of a single behavioral health care system, and performance criteria used to ensure access to high quality care. The following specific tests were performed.

- Identify all behavioral health programs.
- Identify organizational structures of Collaborative
- Determine if data is being collected to report performance measures,
- Determine total dollars appropriated and how funding is disbursed,
- Determine if clients are being served and how many,
- Determine administrative costs associated with behavioral health,
- Determine if the SE is meeting the requirements set out in the RFP and Contract,
- Identify efficiencies gained from collaboration.

Procedures. The following review procedures were conducted.

- Review the Collaborative program requirements.
- Obtain behavioral health financial information from Oversight Team and VO to analyze for statewide allocation, administrative costs and direct program cost distribution.
- Visit with department Secretaries, local collaboratives, and stakeholders.
- Review RFP, contracts, laws, meeting minutes, policies and procedures.
- Review studies conducted, audits, evaluations, meeting minutes and all monitoring reports.

Review Authority. The Committee has authority under Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political sub-divisions, the effect of laws on the proper functioning of these government units, and the policies and costs of government. Pursuant to its statutory authority, the Committee may conduct performance reviews and inquiries into specific transactions affecting the operating policies and costs of governmental units and their compliance with state law.

Review Team.
Manu Patel, Deputy Director for Performance Audit
Charles Sallee, Performance Auditor
Consuelo Mondragon, Performance Auditor

Exit Conference. The contents of this report were discussed with Secretary Pamela Hyde and staff, Human Services Department; Secretary-Designate Dorian Dodson, Children, Youth and Families Department; Secretary Michele Lujan-Grisham, Department of Health; and Pamela Galbraith, Chief Executive Officer, ValueOptions New Mexico on November 6, 2006.

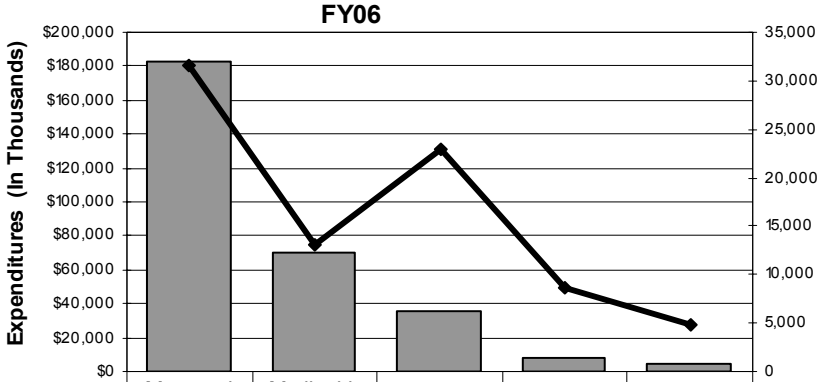
Report Distribution. This report is intended for the information of the Office of the Governor, the Interagency Behavioral Health Purchasing Collaborative, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report which is a matter of public record.

Manu Patel
Deputy Director for Performance Audit

THE PROMISE OF BEHAVIORAL HEALTH REFORMS ARE GREAT, THOUGH THE RESULTS OF THE COLLABORATIVE'S FIRST TWO YEARS ARE MIXED.

In FY06, the Collaborative, through ValueOptions, has spent approximately $300 million on behavioral health services for about 70,000 New Mexicans. Chart 4 provides a breakdown of spending and people served by agency through ValueOptions' network in FY06. The total number, 81,241, may include duplicate counts as people may receive services through more than one agency. However, the agency/program specific figures for people served include a non-duplicate count of New Mexicans receiving services through ValueOptions.

Chart 4: Behavioral Health: People Served & Spending FY06



	Managed Care	Medicaid-FFS	DOH	CYFD	NMCD
Total Expenditures	$182,406,23	$69,900,000	$35,741,663	$7,520,529	$4,170,092
People Served	31,522	13,149	22,985	8,724	4,843

Source: Collaborative

The Collaborative has indicated the need for expanded home and community based behavioral health services for individuals, children and families as the preferred method of delivering services. Historically, the system has over-relied on costly out-of-home and residential based services. According to the Collaborative, past state efforts have failed to fulfill "the promise of an array of community and home-based as alternatives to institutional care to the full extent that the state would have liked."

Medicaid-MC accounted for about 61 percent of all Collaborative funded behavioral health expenditures in FY06. Of the $182 million spent on Medicaid-MC, about 91 percent, or $167 million was spent on direct services by ValueOptions. Medicaid-MC's largest expenditure was for out-of-home or residential services to children under 18. Chart 5 indicates that out-of-home/residential expenses account for 57 percent of direct service expenditures. Chart 6 shows that Medicaid-MC spent over $113 million on services for children under 18 in FY06.

Chart 5: Medicaid Managed Care
Direct Behavioral Health Costs - FY06

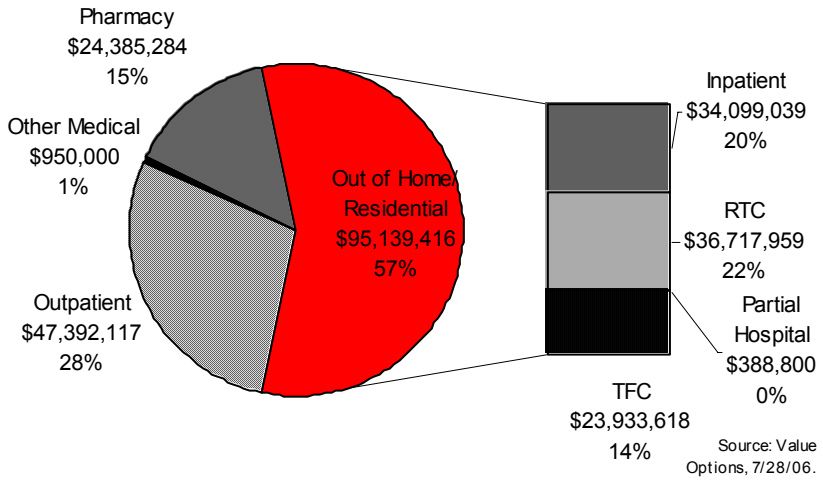
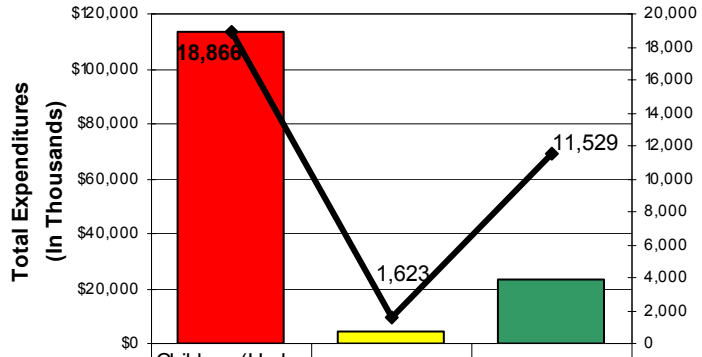


Chart 6: Medicaid Managed Care
Direct Behavioral Health Services Costs
FY06

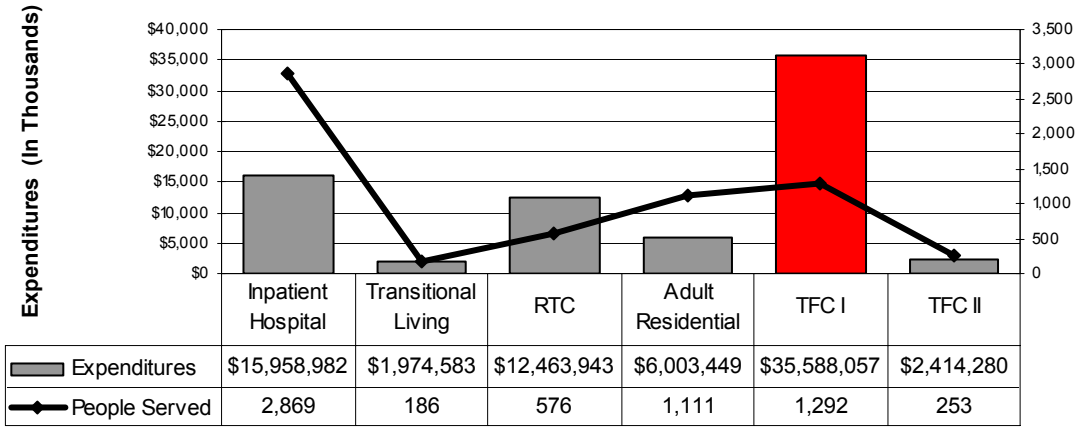


	Children (Under 18)	Youth (18-20)	Adult (21 +)
Direct Costs	$113,388.9	$4,662.8	$23,161.5
People Served	18,866	1,623	11,529

Source:
Collaborative

ValueOptions spent considerable resources on out-of-home/residential services across all funding streams in FY06. Chart 7 shows treatment foster care (TFC) expenditures accounted for over $35 million, according to Collaborative reports. Outpatient therapy services dominate community-based expenditures, which serve many New Mexicans at relatively little cost.

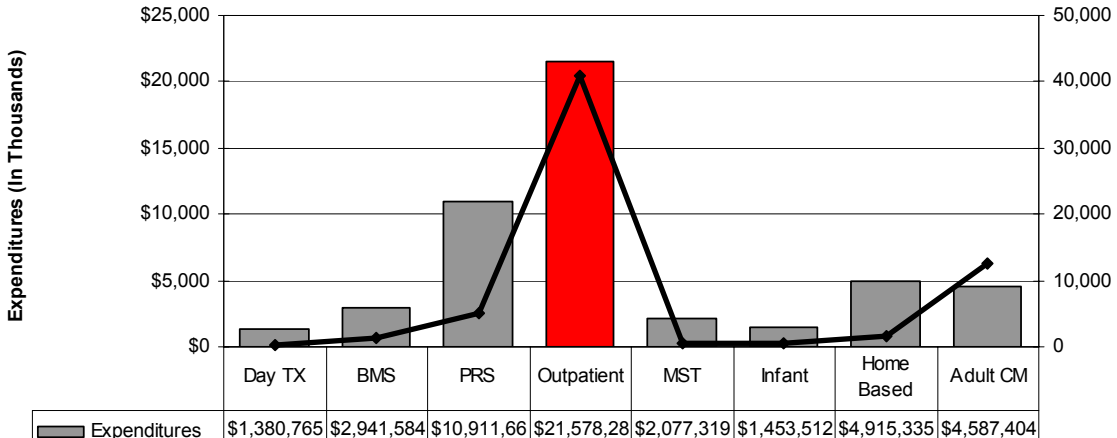
Chart 7: Out-of-Home/Residential Service Behavioral Health Expenses - FY06



	Inpatient Hospital	Transitional Living	RTC	Adult Residential	TFC I	TFC II
Expenditures	$15,958,982	$1,974,583	$12,463,943	$6,003,449	$35,588,057	$2,414,280
People Served	2,869	186	576	1,111	1,292	253

Source: Collaborative. Based on claims as of 9/22/06

Chart 8: Community-Based Behavioral Health Services - FY06



	Day TX	BMS	PRS	Outpatient	MST	Infant	Home Based	Adult CM
Expenditures	$1,380,765	$2,941,584	$10,911,66	$21,578,28	$2,077,319	$1,453,512	$4,915,335	$4,587,404
People Served	337	1,245	4,982	40,883	409	534	1,550	12,629

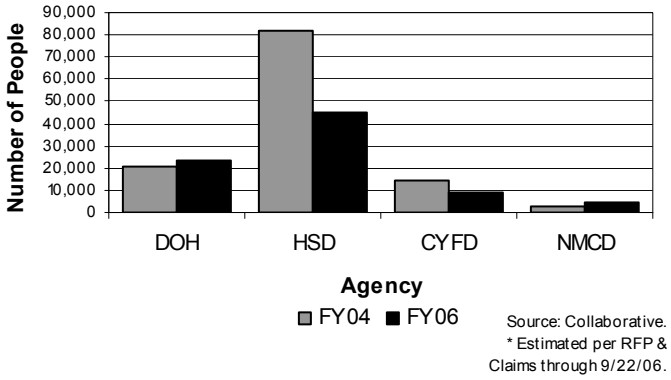
Source: Collaborative. Based on claims as of 9/22/06

The Collaborative should be commended for transitioning the behavioral health system to a single entity, though more performance information would be useful. In 2004, the Collaborative set out to solicit and contract with a single behavioral health entity within one year, and then transition services to the entity during FY06. The Collaborative successfully transitioned approximately $300 million to the single entity at the beginning of FY06, though the first year of implementation has been difficult to evaluate. The Collaborative set four main goals for the FY06 transition to a single entity:

1. People continue to get served;
2. Providers continue to get paid;
3. Data continues to get collected and reported; and
4. Performance standards continue to be met.

People Get Served. The Collaborative did not publicly set minimum targets for the number of people it expected to serve through ValueOptions during FY06. As a result, evaluating whether the Collaborative met its own goal proves difficult. The Collaborative's RFP did set estimated targets using FY04 data. Chart 9, *People Served*, shows ValueOptions has not served comparable numbers of people for HSD and CYFD programs, but has for DOH and Corrections based on FY04 and FY06 estimates. The reasons for discrepancies in Medicaid services are unclear, but could include: decreasing enrollment in Medicaid program, over-estimate of number of people served by Medicaid in FY04, or ValueOptions missed the mark and did not serve a comparable number of people from one year to the next. The RFP suggested HSD Medicaid programs would serve about 82,000 individuals in FY04. ValueOptions reported a total of 44,671 individuals receiving Medicaid services during FY06, about 37,500 less than estimated FY04 amounts.

Chart 9: People Served*
FY04 & FY06

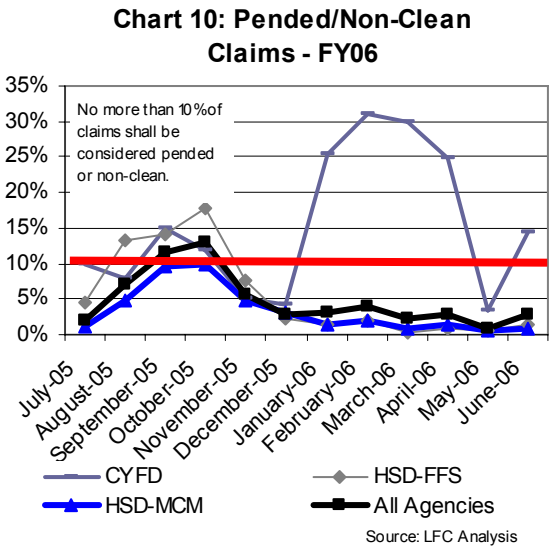


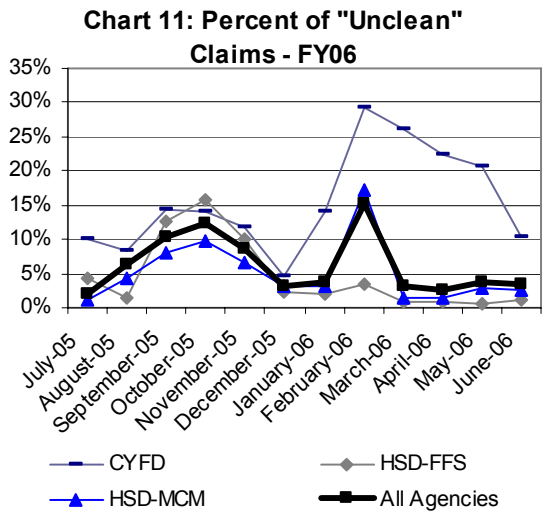
Source: Collaborative.
* Estimated per RFP & Claims through 9/22/06.

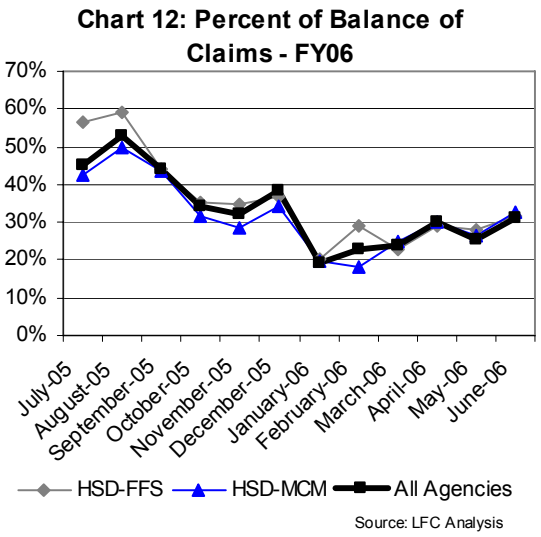
Providers Get Paid. ValueOptions received more than 630,000 claims in FY06. About 45 percent of claims were paper-based, which complicates efficient processing. The FY06 contract requires ValueOptions to pay 90 percent of clean claims within 30 days. ValueOptions generally meets this performance standard each month. Again, the Collaborative did not set a clear benchmark or target to allow the public to easily assess whether ValueOptions met the "providers get paid" goal for FY06. Committee evaluated ValueOptions performance in paying providers timely, rates of "unclean" claims, and rates of pended claims. We did not test ValueOptions data for its reliability or accuracy.

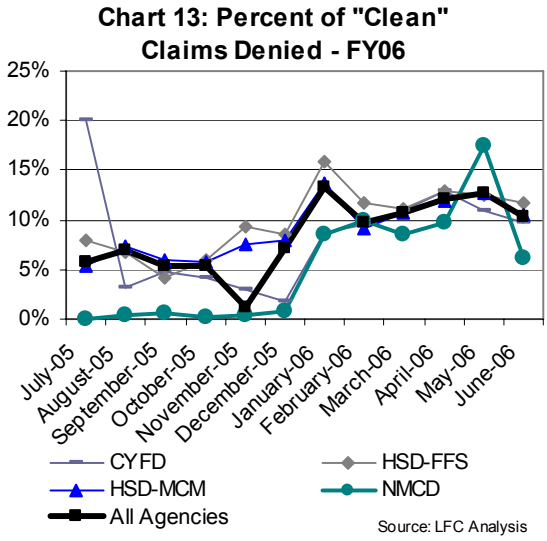
Committee staff assessed ValueOptions performance of ensuring that no more than 10 percent of claims were pended or considered non-clean each month. Large percentages of pending or unclean claims may indicate the provider network needs improvements in submitting clean claims. ValueOptions showed significant improvements in this area as the fiscal year progressed as shown in the Chart 10, *Pended/Non-clean claims*.

Committee staff also analyzed the balance of claims left unpaid at the end of each month as an indicator related to timely processing. The balance of claims each month decreased from 45 percent in July 2005 to 31 percent in June 2006.









The percentage of unclean claims fluctuated for the entire year. For all agencies, there was a peak of over 10 percent in September 2005 and October 2005 and another peak of 15 percent for the month of February 2006. CYFD providers appeared to have problems submitting clean claims. From July 2005 thru December 2005, unclean claims for CYFD were below 15 percent but increased up to 30 percent later in the fiscal year.

The percentage of clean claims denied increased significantly after the six month "hold-harmless" period ended in January 2006. Medicaid-FFS, over the course of the fiscal year, experienced the highest rates of clean claim denials. The increase, overall, in the percentage of clean claims denied raises questions about the ValueOptions network billing and payment practices. Presumably, as the year progressed providers should have improved their billing practices to ensure they bill for allowable services, but data indicate otherwise. Also, clean claim denials do not affect ValueOptions performance measure for timely payments of clean claims.

Data Gets Reported & Performance Standards Met. The Collaborative experienced problems obtaining and reporting data through part of FY06. The following list includes some of the problems the Collaborative has experienced collecting and reporting data:

- No reports on contractual performance measures to the Collaborative or public as of October 2006.
- HSD did not begin accepting encounter data until April 2006. As a result, the first years' encounter data for Medicaid managed care does not appear to have been reviewed for accuracy by the external Medicaid auditor.
- As of January 2006, the Collaborative was not receiving any claims data needed to effectively oversee the terms of the contract.
- The Collaborative lacked data for most of the year regarding claims payments and encounters, making it difficult to determine which providers were getting paid for what services.
- The Collaborative lacked spending and services information needed to respond to policy-makers during the Legislative session in 2006.
- During the review the oversight team was receiving some reports used to oversee the contract, but had yet to finalize a master list of all required reports for across all programs and funding agencies.

The Collaborative was collecting baseline data during FY06 for new outcome measures resulting in limited performance measure information or reports to the Committee and public throughout the year. The Collaborative has reported initial outcome measure baselines during the production of this report as anticipated. As a result, policy makers and the public lack the information needed to evaluate and hold the Collaborative and ValueOptions accountable for the results of spending approximately $300 million in tax-payer funded behavioral health services.

The Collaborative could still improve on its key statutory duties necessary to ensure a well planned and functioning behavioral health system. State law requires the collaborative to do the following (Section 9-7-6.4 (B) NMSA 1978):

1. Identify behavioral health needs statewide [using the DOH "gap analysis" as baseline], and develop a master plan for statewide delivery of services;
2. give special attention to regional differences, including cultural, rural, frontier, urban and border issues;
3. inventory all expenditures for behavioral health;
4. plan, design and direct a statewide behavioral health system; and
   contract for the operation of one or more behavioral health entities to ensure availability of services throughout the state.

Almost two years have passed since the inception of the Collaborative without a clear behavioral health system strategic plan. State law does not provide a specific deadline for completing the needs assessment, inventory of resources or adoption of a plan. The Collaborative has forwarded a plan to the federal government, but is still working to enhance the contents.

According to Section 9-7-6.4 (C) NMSA 1978, this plan should guide the delivery of services, address the needs of specific populations, such as children and address workforce development needs and quality improvement. Statutory construction suggests a logic order of events should take place: 1) needs assessment; 2) create a master (strategic) plan for the delivery of services; 3)

contract with one or more entities for the delivery of services. The Collaborative appears to have implemented its duties in reverse, with planning coming last.

Strategic planning provides the basis for organizations to define goals, identify specific strategies to accomplish the goals, and performance measures to determine success. According to the U.S. General Accounting Office (GAO), "there is no more important element in results-oriented management than an agency's strategic planning effort."

The GAO explains that effective organizations set strategic goals to explain what results to expect from the agency's major functions and when to expect those results. The Collaborative has implemented a short-term work plan to guide its cross-agency teams. The work plan does not appear to have received formal discussion or extensive public input as needed for an effective plan. According to GAO, three key practices are needed for effective strategic planning: "organizations must (1) involve their stakeholders; (2) assess their internal and external environments; and (3) align their activities, core processes, and resources to support mission-related outcomes." While the work plan is commendable, without a comprehensive strategic plan the state may use resources in way that does not support long-term objectives for transforming the behavioral health system. The work plan aligns state activities and staffing resources, but not clearly around a publicly adopted strategic plan.

Recommendations. Report performance measure and other outcome data to the Legislative Finance Committee as a Collaborative.

Move the behavioral health plan to a comprehensive strategic plan no later than June 1, 2007. Ensure the plan's goals include clear objectives, outcome measures, and funding amounts appropriated or needed to accomplish goals. The plan should address both long-term strategic goals and short-term benchmarks to assess the Collaborative's progress at achieving an improved behavioral health system.

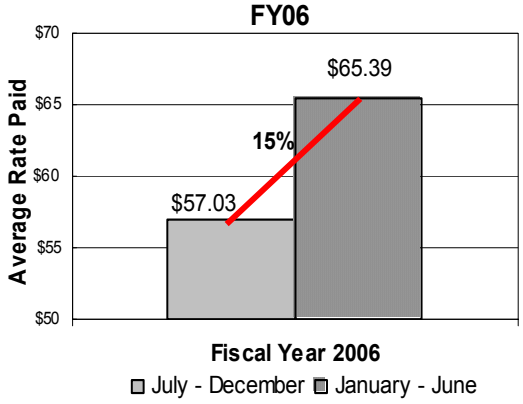
Report annually, no later than September 1, to the Legislature and public on progress made to transform the behavioral health system. Ensure the report, at a minimum, includes specific information on the Collaborative's progress achieving the behavioral health strategic plan's goals and objectives, performance information and data on the number people receiving services, expenditures by service type, and claims information.

THE COLLABORATIVE'S FINANCIAL OVERSIGHT OF VALUEOPTIONS NEEDS IMPROVEMENT TO ENSURE SOUND BUSINESS PRACTICES.

The Collaborative provided ValueOptions with a year end FY06 Medicaid-MC funding increase of $11 million, which appears unrelated to its performance under the contract. At the March 30, 2006 public meeting, the Collaborative authorized the Co-Chairs to execute a FY06 contract amendment and include Medicaid-FFS administrative amounts in the amendment. The meeting minutes do not reflect any discussion or approval for increasing the Medicaid-MC rates or portion of the contract. The contract amendment was executed in June 2006. The Collaborative posted the amendment on its website, however, HSD does not publicly disclose the detailed rate sheets used to pay to ValueOptions, or any managed care organization, under the Medicaid-MC program. As such, the public may not have known the Collaborative increased the Medicaid – MC rates as a result of the June amendment. Committee staff identified the increase through other publicly available documents, but was not allowed by HSD to view the detailed rate sheets.

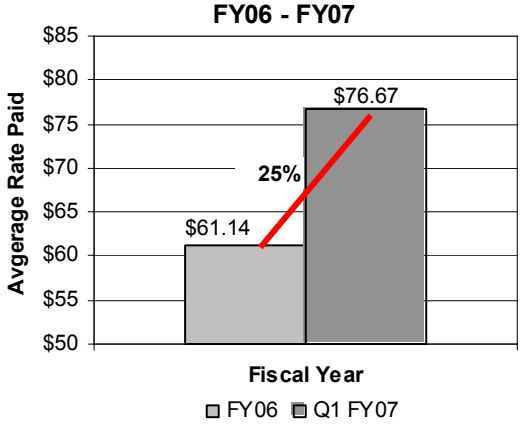
The approval appears unrelated to ValueOptions performance under the contract as performance measure information has not been finalized as of October 2006, well after the execution of the amendment. The Collaborative and ValueOptions also experienced problems throughout the year with obtaining and reporting data and performance information.

Chart 14: Medicaid Managed Care Rates - Value Options FY06



Source: Value Options, Public Regulation Commission Financial Statements

Chart 15: Medicaid Managed Care Rates - Value Options FY06 - FY07



Source: Human Services Department

The Collaborative increased Medicaid-MC rates paid to ValueOptions by an estimated 15 percent, which generated about $11 million in additional funding. Medicaid-MC rates paid to ValueOptions have increased nearly 35 percent from the beginning of FY06 through the first quarter of FY07. The Chart 14 estimates are based on publicly available financial reports showing the number of member months and premiums earned by ValueOptions for periods covering FY06. Chart 15 includes estimates provided by HSD. During the production of this report, HSD provided additional, but conflicting data, indicating the rate increases of only about 6 percent in FY06 and about 1.1 percent from the beginning of FY06 through the end of the first quarter in FY07.

We were not provided access to portions of the contract containing rate information, as HSD considers that information confidential. As a result, we could only rely on publicly available information and HSD to estimate contractual changes. However, HSD agrees the rate changes generated about $11 million in additional funding for Value Options at the end of FY06.

The increased Medicaid funding resolved ValueOptions' regulatory non-compliance with Insurance Division risk-based capital requirements. As of December 31, 2005, ValueOptions was not in compliance with national and state standards for the amount of capital needed to cover the risk assumed. According to ValueOptions' audited financial statements the June 2006 contract amendment "includes a rate increase to the Medicaid at-risk and FFS ASO [administrative services organization] population which provided sufficient additional funding to remedy the aforementioned non-compliance." Committee staff was not provided access to Medicaid-FFS rate sheets to verify whether the Collaborative also provided a rate increase to ValueOptions for the Medicaid-FFS program. ValueOptions' parent company has infused the New Mexico subsidiary with a significant capital investment, though based on its audit, the company appears to have relied on state funding increases to meet some of its risk-based capital requirements.

Providing funding increases, unrelated to performance, for an "at-risk" program defeats the purpose of contracting with a managed care organization, and raises questions about the viability of ValueOptions initial cost proposals. The state uses a managed care arrangement to provide more certainty in Medicaid costs and shield it from cost spikes by shifting the per-person risk to an HMO. The rates paid to the insurance company should cover losses, administrative overhead and if the company performs well, profit. The managed care company, however, is "at-risk" for having cost overruns, which are not reimbursed by the state.

The Collaborative, in its request for proposal, indicated that the acceptance of negotiated Medicaid-MC capitation rates indicates those rates "are sufficient to assure the financial stability of the SE." In addition, the Collaborative made clear that, in this case ValueOptions, should not "accept capitation rates if the offerer cannot perform the duties and requirements set forth in the contract."

Pre-payments to ValueOptions for Medicaid-FFS program resulted in overpayment to the company, based on the rate of claims submitted through September 2006. However, at the time of this report HSD was in the process of recouping the overpayments. HSD staff indicated they attempted to create an "at-risk" payment structure to ValueOptions for FY06, but the federal Center for Medicare and Medicaid Services (CMS) disallowed the payment structure mid-year. While HSD would not allow Committee to examine the rate structure paid to ValueOptions under this agreement, it included a pre-payment component, or fixed amount, similar to managed care arrangements. ValueOptions would pay claims out of this pre-paid pool of funding, which differs from the traditional approach to paying vendors after services are delivered under the program.

The disallowed arrangement required HSD to recalculate how much ValueOptions should earn in administrative fees and reimbursement for direct services under the traditional fee for service program. HSD paid ValueOptions about $64 million in Medicaid-FFS payments, which included both direct service and administrative fees. ValueOptions has only encountered about 69 percent or $48 million of the total projected expenditures for Medicaid – FFS behavioral

health services ($69.8 million) as of September 22, 2006. This expenditure rate is much lower than other comparable Medicaid FFS service categories. This indicates that the original "at-risk" payment structure could have been more costly to the taxpayer should ValueOptions not demonstrate it encountered about $23 million in HSD estimated outstanding claims. The Committee should monitor the process to recoup overpayments and subsequent payments of claims incurred in FY06 but paid in FY07.

Appropriations amounts to support year end funding increases and the administrative fees to ValueOptions remain unclear. Moving expenditures from one fiscal year into the next circumvents the Legislature's appropriations authority. This approach allows an executive agency to, in effect, expand its own appropriation. For example, the Medicaid-MC funding increase to ValueOptions appears to have contributed to a projected Medicaid program shortfall as the amendment was being signed at the end of FY06. Subsequently, HSD appears to have shifted about $8.6 million of FY06 Medicaid expenditures to the FY07 budget, resolving the potential shortfall. The changes also appear to have contributed to a projected Medicaid shortfall for the FY07 Medicaid operating budget.

In FY07, the Collaborative approved an arrangement to pre-pay ValueOptions for services not yet rendered, which appears contrary to best practice. The Collaborative's FY07 contract with ValueOptions requires CYFD and Corrections to modify their payment process from a traditional reimbursement for services to a pre-payment arrangement by making monthly payments based on $1/12^{th}$ of each programs' appropriations. This approach mirrored a poor business practice historically executed by DOH.

The Procurement Code (Section 13-1-158 NMSA 1978) requires agencies to not pay for services until it certifies that the contractor has provided the services. The ValueOptions' pre-payment arrangements for DOH, CYFD and Corrections and in FY06 possibly Medicaid-FFS payments appears contrary to the Procurement Code standard. This requirement ensures that the state receives purchased services in the manner required under the contract before making payment. Pre-payment arrangements reduce a purchaser's leverage to require the contractor to perform adequately and demonstrate that it actually incurred costs needing reimbursement.

The Collaborative's general counsel has asserted that the Collaborative is exempt from Procurement Code requirements; even though the RFP and contracts clearly state that the ValueOptions-Collaborative contract is subject to the Procurement Code. The RFP, FY06 and FY07 contracts provide that all services provided under the contract with the SE are subject to the Procurement Code, unless specified otherwise. However, the contracts do not claim any exemptions from the Procurement Code.

Section 13-1-98.1 (b) exempts state agencies from provisions of the Procurement Code for specific services, including agreements to create a network of health care providers. Specifically, the statute allows an exemption *if* "the state purchasing agent or a central purchasing office makes a determination that the arrangement will or is likely to reduce health care costs, improve quality of care or improve access to care." Again, the contract does not assert this exemption.

The Collaborative has paid about $2.7 million in CYFD funds, but the amounts actually earned by ValueOptions will not fully be known until December 2006. Assuming no delays, the claims system has at least a 120 day lag time built in before ValueOptions will pay providers for services rendered. Providers have 90 days to bill ValueOptions, which then has 30 days to a pay clean claim. This "lag factor," combined with pre-payments to ValueOptions, puts agencies, like CYFD, in a poor position to determine expenditure levels until one or two quarters after making the payment to ValueOptions.

The Collaborative is at-risk of paying for services not-rendered. CYFD indicates that it will reconcile payments with ValueOptions each quarter to ensure funds are being expended. However, CYFD providers experience high rates of unclean and denied claims. This makes assessing whether services aren't being provided, or just not being paid, difficult should large balances exist at the end of each quarter. ValueOptions' payments to providers could continue, or not, well into the following fiscal year but the Collaborative will have little authority to recoup the payments.

Pre-payment arrangements may allow the Collaborative to redirect unspent funds for other purposes outside the appropriations process. Unexpended funds should revert to the state general fund. However, the Collaborative will have already spent its appropriations by the time it would discover funds unused by ValueOptions. The contract contemplates a process of the Collaborative identifying other uses for unexpended funds each quarter. If this process continues into the following fiscal year, the Collaborative would, in effect, appropriate itself unexpended balances for use as it sees fit. This arrangement directly usurps the Legislature's appropriations power.

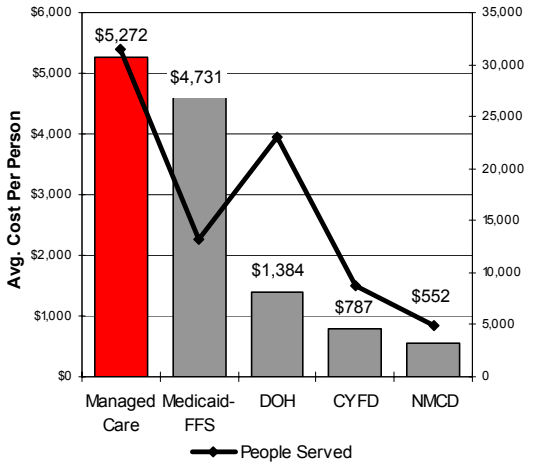
Pre-paying ValueOptions costs the state between 3.73 percent and 5.84 percent in earned income on Collaborative funding. Pre-payments to ValueOptions transfers interest income earnings from the State of New Mexico directly to ValueOptions. Again, the time between service delivery and payment creates a period of inactivity in spending appropriated amounts from the general fund. During these periods the state invests this money.

The Collaborative lacks efficiency measures to regularly assess the cost-effectiveness of behavioral health services and administrative funding. Average cost information allows the public and policy makers to evaluate the relative efficiency of services and programs. The ValueOptions contract and the Collaborative's new accountability contract with the Governor lack any efficiency measures to help explain the cost-effectiveness of behavioral health services. Likewise, the General Appropriations Act does not include any efficiency measures related to cost of services.

Out-of-home/residential placements account for considerable costs to the system, both on an aggregate and per-person basis. The charts above show a breakdown of average cost per person served based on service type. Treatment foster care and residential treatment centers are the two most expensive behavioral health services according to Collaborative figures. People can receive more than one service throughout the year, making it difficult to accurately compute an overall cost per person. For example, one child could experience an acute psychiatric episode and receive services from an acute inpatient hospital for stabilization, then from a residential treatment facility, and a treatment foster care placement before returning home and receiving in-home behavior management services. But, the figures are useful for assessing costs by service.

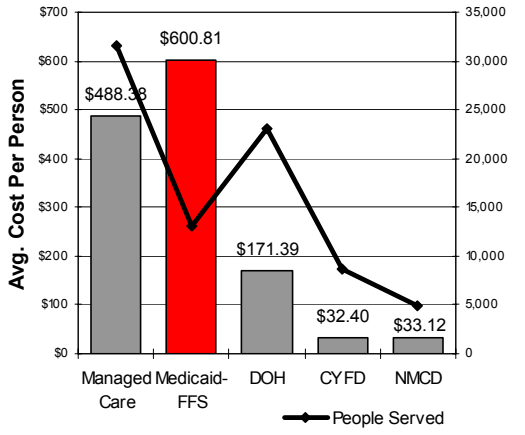
Efficiency measures could be useful for evaluating ValueOptions administration of behavioral health services. The chart, *Average Behavioral Health Administrative Costs*, shows that the ValueOptions spends more per person receiving Medicaid FFS program services than other agencies' programs. HSD paid ValueOptions a $5 fee per member of the Medicaid FFS program, regardless of the number of people using behavioral health services for FY06. Either the Medicaid FFS behavioral health program is extremely expensive to administer or HSD may need to review its fee levels to bring them in line with comparable programs, such as Medicaid MC. The Committee should monitor these fee amounts, and possibly compare the amounts to pre-ValueOptions levels.

Chart 16: Avgerage Behavioral Health Direct Services Costs - FY06



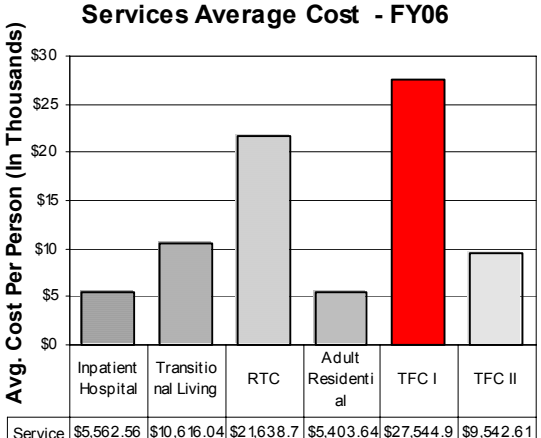
Source: Collaborative

Chart 17: Average Behavioral Health Administrative Costs - FY06



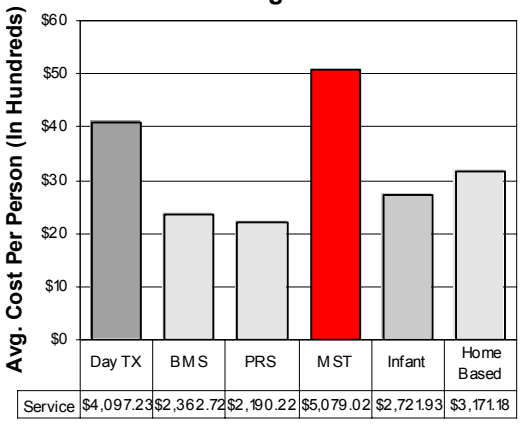
Source: Collaborative

Chart 18: Out-of-Home/Residential Services Average Cost - FY06



Source: Collaborative.
Based on claims as of 9/22/06

Chart 19: Community Based Services Average Cost - FY06



Source: Collaborative.
Based on claims as of 9/22/06

Recommendations. Ensure future contract amendments to increase funding to the single entity are clearly tied to performance, change in scope of the contractor's work or need adjustment due to an unsound actuarial rate structure.

The Collaborative should adopt a policy for approving contract amendments that includes, at a minimum, a final vote by the Collaborative *after* staff finalizes the amendment language and any rate changes. The official meeting minutes should reflect, in detail, the areas authorized by the Collaborative for staff to negotiate in the amendment.

The Collaborative should phase out the use of pre-payment arrangements to ValueOptions. For the remaining FY07 contract year transition to a standard reimbursement payment process, at a minimum, for CYFD and Corrections Department funding. Continue efforts to transition DOH funding to ValueOptions based on standard reimbursement payment process, but complete the transition no later than the end of FY08. Reconcile pre-payments monthly, rather than quarterly. During the transition, work to establish a standard billing process to ensure timely payment of ValueOptions after the company reimburses providers.

Develop and monitor standard efficiency measures to assess the cost-effectiveness of behavioral health services and administration. Publish results in the Collaborative's annual report.

THE COLLABORATIVE'S UNCLEAR AUTHORITY HAMPERS EFFECTIVE PUBLIC PARTICIPATION AND DEVELOPMENT OF A STATEWIDE BEHAVIORAL HEALTH SYSTEM.

The Collaborative lacks rulemaking authority needed to streamline regulations common to all behavioral health programs and improve access to quality services. The Collaborative claims it makes state policy governing behavioral health services. The State Rules Act and the Administrative Procedure Act govern the making and publication of state policy. According to the State Rules Act, Section 14-4-2 (C) NMSA 1978, a rule means "any rule, regulation, order, standard, statement of policy" promulgated by an agency and that affects people and/or agencies outside the agency issuing the rule. Rules are a special category of law made by agencies meant to clarify or support a statute enacted by the legislature. The Administrative Procedure Act only applies to agencies specifically made subject to this law, and provides for a specific process to adopt rules, including public notification and comment.

Section 9-7-6.4 NMSA 1978 directs the Collaborative to create a statewide behavioral health system and contract with one or more administrative entities to implement the system. Creating a statewide system of care and contracting with an entity presumably will require changes to the way the state administers its behavioral health programs. These changes clearly will, and hopefully in a positive way, affect thousands of New Mexicans receiving, and organizations providing, services.

The behavioral health system does not operate under common regulations for important standards such as quality of care. Most programs have common elements, such as quality, access to services, and utilization review standards, but different technical regulations governing each element. For example, HSD and DOH each have detailed quality, clinical care, utilization and access to service standards for their respective programs.

The Collaborative's statutory duty to create a statewide system of care will require it to reconcile these differences. For example, HSD Medicaid-MC and DOH each have rules governing the use of clinical practice guidelines, though HSD's rules are the only ones incorporated into the FY07 contract. Both are similar in nature, but differ in one important aspect – the role of the state in approving the use of the guidelines. DOH rules provide the agency with a role in approving which guidelines the network will use.

The statute does not provide the Collaborative with rulemaking authority over the behavioral health system. Instead HB 271 required each agency participating in funding the system to comply with the Collaborative's master behavioral health plan.

Aligning agencies' rules through multiple and separate processes is inefficient, and complicates effective public participation in critical decisions regarding quality of behavioral health services. To streamline regulations governing the system, each agency has to go through a separate rulemaking process, presumably at the direction of the Collaborative. Without changes to rules agencies would simply ignore enforcement rules already adopted, that could lead to public confusion.

Using the contract process to *make* or align policy is not contemplated by state law and puts the public at a disadvantage to effectively participate in the process. For example, the Collaborative negotiates the contract, some of which is behind closed doors and not subject to Public Meetings Act requirements. The Collaborative did seek public comment period, but this process is not legally required to continue in future years. The comment period also occurred before negotiations with ValueOptions. The size (nearly 140 pages) and complexity of the contract may not afford effective public participation within a short-time frame. A narrower focus of key issues across agencies may provide a better framework for allowing the public to effectively participate in the governing of behavioral health services.

The Collaborative does not have a clear and consistent process to make policy and include and inform the public of its decision. The Administrative Procedures Act (APA) creates a standard process for making agency policy, and has procedures in place to protect the public's interest in participating in decisions of the government. The public has recourse, through judicial review, to over turn rules not adopted according to the APA. The State Rules Act provides a uniform way for agencies to notify the public of pending and final policy decision. State law does not require the Collaborative to follow either of these Acts.

The Collaborative has not adopted a policy governing its decision-making process, including how it will notify, seek or allow the public participation. The Collaborative has, however, made efforts to include the public in its deliberations and on occasion used its web site for public notice and to seek comments prior to adoption of the ValueOptions contract and other policies. Without any requirements to follow a standard process the Collaborative could continually change its approach to working with the public. In addition, without any formal compiling of its decisions the public is at a disadvantage for knowing what policies and rules the Collaborative has adopted.

The Collaborative has made efforts to include the public in its deliberations and provide information via its website. Before the Collaborative became effective in law, the associated agencies were already seeking input into the design of the new behavioral health changes. For

example, staff from a cross agency steering team released a series of concept papers on designing the system in April of 2004, and traveled across the state seeking public input. In addition, shortly after the Collaborative formed, the public's comments were sought on a draft implementation plan that helped form the basis for the single entity request for proposal.

The Collaborative indicates it follows the requirements of the New Mexico Open Meetings Act, which establishes the public's right to observe and participate in formation of public policy and conduct of government business. The Collaborative provides seven days notice to the public of its meetings, and a meeting agenda 24 hours in advance of its deliberations. The public notices provide general topic areas for consideration, but generally lack specifics on decision items. Considering the public's interest in the Collaborative's proceedings, and the fast paced nature of its decisions, a mere 24 hour agenda notice may not provide the public with sufficient opportunity to make informed comments on decision items.

The Collaborative's behavioral health outcome measures cannot be tied to individual agency's appropriations, limiting its accountability to the Legislature and New Mexico taxpayers. The lack of a unified budget and associated performance measure makes the executive agencies less accountable to the Legislature. The General Appropriations Act (GAA) provides a format for the Legislature to set expectations for agency performance and outcomes as a result of the executive's spending of taxpayer money. Governor Richardson has joined this effort through the use of accountability contracts for agencies under his authority and has charged the Collaborative with improving behavioral health services.

New Mexico still lacks a unified behavioral health budget. Often, behavioral health services are part of a larger budget program, such as Medicaid, TANF and CYFD's Family Services program. Separate behavioral health budgets within the GAA makes behavioral health services compete for funding priorities within each agency and across the executive.

The Legislature appropriates 80 percent of the Collaborative's funding to programs where behavioral health services makes up only a portion of the overall program appropriation. For example, behavioral health services only accounts for about 10 percent of the overall Medicaid budget, forcing the program to compete for resources from a host of other service-types. However, Medicaid behavioral health services account for about 76 percent of the Collaborative's contract with ValueOptions in FY07.

The Collaborative has adopted outcome measures that cross agency funding streams, making existing program performance measures obsolete or inappropriate, in some cases. For example, HB 2 includes a list of measures attached to the Behavioral Health Services Division (BHSD) at DOH that reflect some of the Collaborative outcome measures. The programs funded at BHSD are one, among many, that may contribute to improving Collaborative outcomes. Holding the Collaborative accountable for its own outcome measures is appropriate. However, holding BHSD accountable for those same measures, as is contemplated in FY06 GAA, may not continue to be appropriate.

The Collaborative outcome measures were also adopted as part of the Governor's accountability contracts with executive agencies. The Governor holds the entire Collaborative accountable for these results. The Legislature does not have a similar accountability structure through the appropriations process.

The proposal to transfer the Behavioral Health Services Division (BHSD) to HSD provides the Legislature with a good opportunity to review the need to further streamline behavioral health administration. The executive branch does not have authority to move the division, and must seek Legislative approval through statutory and budget changes.

In July 2006, HSD and DOH formulated a proposal to move administrative authority over programs operated at BHSD to a new division within HSD. Both agencies have included this change in their respective budget requests. This proposal was not generated by the Collaborative. The proposal does not appear to go far enough to meet the legislative goals of creating a Collaborative-led single statewide behavioral system. Specifically, the proposal:

- would increase HSD's, not the Collaborative's, administrative and regulatory power, without enhancing accountability;
- lacks any performance measures associated with about $60 million in BHSD funding;
- lacks any Collaborative measures, though HSD asserts BHSD would carry out the Collaborative's administrative duties;
- maintains fragmented administrative functions through a separate division by not including CYFD, Corrections or other behavioral health contractual functions; and
- does not consolidate staff within HSD that perform similar functions, such as contract oversight, from the Medical Assistance Division.

Continuing to administer over $320 million through a "virtual" department approach over the long-term may prove difficult. While the Collaborative has established a staff work plan, it still lacks common operational policies, financial and performance reports, a full-time centralized oversight staff reporting to the Behavioral Health manager. Currently, cross-agency oversight team members may sit on multiple teams and have more than one supervisor (their parent agency and CAT team leaders).

Recommendations. With some additional changes, the Legislature could build on HSD's proposal to transfer BHSD by further streamlining administration, authority and accountability over the next two years. The following enhancements to the HSD proposal would help move the state towards a single behavioral health system. The following recommendations would require Legislative action.

- *Create a unified behavioral health services budget using FY07 Collaborative-ValueOptions contract amounts and programs.* The Legislature could appropriate the funds to the Collaborative, which would be administratively attached to HSD. This approach would also better position the state to flow non-Medicaid funding to its single entity contractor more quickly, in a similar approach as the Medicaid-FFS program.
- *Select Collaborative developed outcome measures for use as performance measures in the General Appropriations Act.* The Collaborative would be a key quarterly reporting agency.
- *Clarify state law to provide the Collaborative with oversight authority of the BHSD, including the authority to recommend to the Governor a Behavioral Health Director to manage the division.* The division would be administratively attached to HSD for financial, human resource and other indirect services. Consider transferring select FTE's and funding from MAD and CYFD that perform behavioral health contract and

administrative functions. Other Collaborative program staff should remain at their respective agencies to continue the collaborative effort.

- *Provide the Collaborative with rulemaking authority over delivery of behavioral health services.* The authority would allow the Collaborative to establish statewide standards for the delivery of behavioral health services, including quality management and improvement, performance measures, accessibility and availability of services, utilization management, credentialing, rights and responsibilities of consumers and providers, preventive services, clinical treatment and evaluation and the documentation and confidentiality of client records.

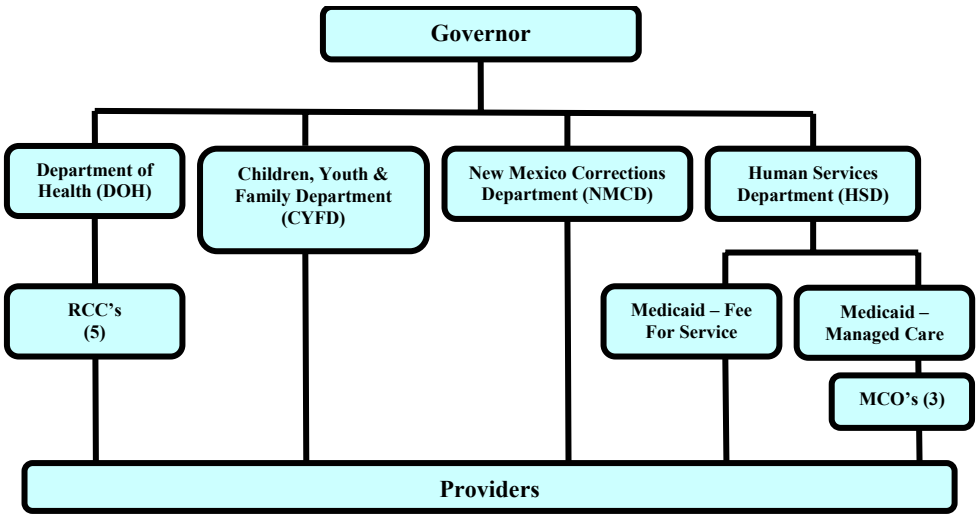
THE COLLABORATIVE NEEDS A MORE COMPREHENSIVE APPROACH TO ENSURE NEW MEXICANS HAVE ACCESS TO HIGH-QUALITY BEHAVIORAL HEALTH CARE.

The creation of a single entity has streamlined the administration and utilization review functions of New Mexico's behavioral health system, and has the potential to improve access to high quality care. According to the National Academy of Sciences, the behavioral health system generally lacks "the infrastructure needed to measure, analyze, publicly report, and improve the quality" of care. New Mexico has the potential to ameliorate these issues.

Before the creation of the single entity, the State delivered services through a fragmented array of public-privately operated networks, including using 3 Medicaid managed care organizations (that subcontracted behavioral health network operations), five DOH sponsored regional care coordination organizations, CYFD-run network, and Corrections Department network. This approach resulted in ten separate networks, with separate rules governing treatment, billing, utilization review, etc.

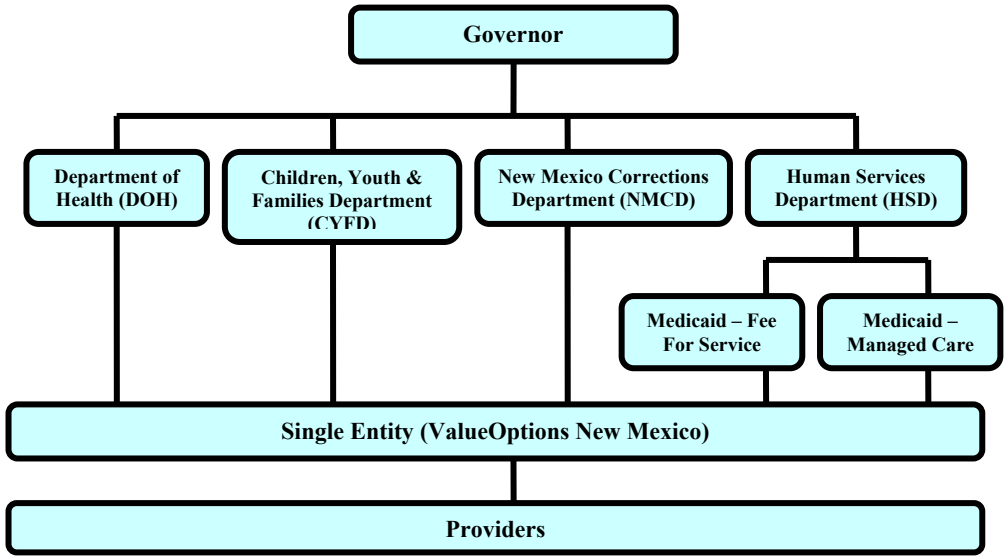
Creating a single entity, while streamlining administrative functions for the state, has the potential to improve the quality of clinical services delivered as well. The lack of comprehensive statewide community resource information, according to ValueOptions, "affects the clinical decision regarding where the consumer will receive aftercare services appropriate to their clinical needs." For example, "a consumer who resides in Clayton may seek residential service in Albuquerque. The Albuquerque provider is unfamiliar with services in the Clayton area and there may be limited services in Clayton to develop a sound clinical discharge plan." The single entity, theoretically, could improve clinical outcomes by ensuring, in this example, expanding community-based resources in Clayton and ensuring Albuquerque providers know about services available in rural and frontier counties.

New Mexico Behavioral Health Administration
2004



Source: Collaborative

New Mexico Behavioral Health Administration
2006



Source: Collaborative

Inconsistent use of evidenced-based clinical practice guidelines reduces quality of care and effective treatment of mental illness and substance abuse conditions. Nationally, research indicates a substantial discrepancy between what is known as effective care and what is actually delivered. The use of a standard set of evidenced based clinical treatment guidelines has the potential to improve the quality of behavioral health care provided to New Mexicans. According to ValueOptions, diagnosis-related treatment guidelines incorporate the latest in evidence-based practices based on expert consensus. Clinical treatment guidelines can provide a powerful tool to improve the quality of care delivered to New Mexicans, but effective oversight, and possible approval authority, may be needed by the Collaborative to ensure they are not used to unnecessarily restrict care – particularly if ValueOptions develops its own propriety guidelines.

Health networks can use clinical treatment guidelines as recommended treatment strategies for providers, as a basis for authorizing or paying for services, or as monitoring tools to evaluate providers' treatment practices. All three uses have advantages and, in some, cases disadvantages. Without buy-in from clinical practitioners and other providers, the guidelines could be viewed as a way to restrict or depress certain service levels, particularly for guidelines developed internally by a health insurance company. The effects of treatment guidelines in the physical health arena are limited due to the multiple networks' competing guidelines that a doctor may be subject to.

During FY06 ValueOptions collected baseline data to determine which diagnosis groups have the highest utilization rates for inpatient and residential treatment centers. Based on data reported to the Collaborative, mood disorders were the most common diagnosis and account for the highest utilization rates for in-patient care. ValueOptions is using this information to target its education process regarding clinical treatment guidelines.

The Collaborative generally ensures contractual compliance, but needs to continue developing a comprehensive approach to oversee the quality of ValueOptions' network administration and utilization review functions. The Collaborative monitors quality of care through the following methods.

- Contract compliance oversight to ensure ValueOptions implements certain quality plans, policies and procedures.
- External quality review organization audits, conducted under contract with HSD by the New Mexico Medical Review Association, to review implementation of Medicaid managed care regulations and evaluate clinical decisions for timeliness and accuracy.
- Regular ValueOptions reports on service denials (prior-authorization, etc), complaints/grievances, appeals and critical incidents, such as suicides.
- Customer satisfaction surveys of both people using services and providers.

We reviewed a sample of 28 contract deliverables/requirements related to quality and access to care issues to determine whether or not the Collaborative ensured ValueOptions compliance. The Collaborative demonstrated it ensured compliance on 50 percent, or 14, of the contract deliverables/requirements. The Collaborative did not focus on ensuring compliance or could not provide supporting documentation for 25 percent, or 7, items reviewed. For example, the contract required ValueOptions to develop specialty programs related for such programs areas as corrections and juvenile justice, but Collaborative staff indicated this was not a focus of oversight during the first contract year and could not supply compliance documentation. We could not clearly determine whether the Collaborative ensured compliance with the remaining 25 percent (7) of items reviewed due to incomplete or the unclear relationship of documentation provided. For example, the contract requires submission of on-site provider audits and schedules to the Collaborative. The Collaborative only supplied committee staff with a template for the audit, making it difficult to determine whether the oversight team monitored the results of ValueOptions provider audits.

The system still lacks a comprehensive set of quality and utilization review regulations to evaluate the single entity overall. The Collaborative lacks a comprehensive approach to ensuring compliance with quality standards, in part due to the continued fragmentation of policy governing the multiple behavioral health programs administered by ValueOptions. The contract requires ValueOptions to comply with a multitude of agencies regulations governing all the separate programs and funding streams. The main tool used to ensure compliance, according to the contract, with quality standards is through the use of an external quality review organization (EQRO). HSD contracts with the New Mexico Medical Review Association (NMMRA) serves as the EQRO. However this external review only focuses on compliance with Medicaid manage care regulations.

Denial audits are another method to monitor and improve the quality of ValueOptions utilization management review performance. However, the audits do not include a review of decisions made across agency programs and funding streams, and instead only review Medicaid managed care consumers. As a result, ValueOptions decisions regarding CYFD, DOH and Corrections programs appear to lack external review.

The Collaborative has not taken up a deliberative policy-making process, or review, to determine what policies should govern the system. The FY06 and FY07 contracts include extensive reference to quality management and improvement requirements, which may or may not align with state regulations. The FY07 contract improves in clarity, and appears to reflect many Medicaid-MC regulations related to quality. Simply using Medicaid managed care regulations may not be appropriate in some cases, particularly since they were written for a system using competing companies. Oddly, some quality requirements, such as accreditation through the National Committee for Quality Assurance (NCQA), apply to the managed care organizations, but exempt ValueOptions. The contract indicates the Collaborative will use NCQA standards, and does require certain NCQA reports, but could not provide evidence to Committee staff of other areas. NCQA specifically accredits behavioral health organizations, including some ValueOptions companies in other states.

External quality reviews found ValueOptions quality and utilization review functions generally compliant with Medicaid regulations, however improvements are needed in certain areas. Medicaid regulations require a comprehensive compliance audit. The Collaborative instituted an external quality review process to assess ValueOptions concerning authorizations, reductions, terminations and denial of care clinical decisions. These audits help the Collaborative determine whether authorized service levels are appropriate. The external reviews are specifically tied to Medicaid's quality standards.

Overall Compliance. The external quality review gave ValueOptions a rating of "moderate compliance" for its overall assessment of the company's adherence to Medicaid utilization management rules. The company received moderate to high marks in critical to quality of care, including access to care, utilization management, and quality improvement.

However, the compliance review found ValueOptions “minimally compliant” with certain Medicaid managed care regulations. Though other areas, such as compliance with grievance system requirements, coordination of care, and services to individuals with special health needs, were rated as minimally compliant, and raise concerns.

Interestingly, ValueOptions was found non-compliant with preventive health services regulations. These requirements do not appear totally applicable to a purely behavioral health company and may require revision. This further indicates the need for a more comprehensive approach to regulations for the single entity as simply using traditional Medicaid managed care rules may not suffice.

Timely-Decisions. Medicaid managed care rules require that ValueOptions make decisions regarding the utilization of services within certain time frames. These timeliness requirements help ensure the managed care organization accommodates the clinical urgency of the situation and do not disrupt the provision of behavioral health services. For example, Medicaid rules require ValueOptions to make prior authorizations decisions within 72 hours. These rules contribute to both quality and access to care.

ValueOptions achieved a 79 percent, or "moderate compliance," rating in the external quality review organization's audit of the company's case files for the second quarter of FY06. Of specific concern was ValueOptions non-compliance rating on making its clinical decisions within prescribed time frames in only 64 percent of the cases reviewed.

In the third quarter of FY06, ValueOptions continued to receive a rating of "moderate compliance on its case review audit. The company achieved a notable improvement in making timely utilization management decisions by meeting the target in 83 percent of the cases reviewed.

Accurate-Decisions. ValueOptions appears to appropriately deny service requests, achieving a 91 percent agreement rate with the external quality review organization audit during the second quarter of FY06. The external quality review organization agreed with 88 percent of the company's utilization review decisions during the third quarter.

ValueOptions appears to resolve grievances in a timely manner, though the number of consumer grievances has increased compared to FY05 levels. Tracking of consumer and provider grievances provides another method for the Collaborative to monitor quality of care issues. The Collaborative receives monthly reports on the number and type of grievances received by ValueOptions. According to an annual ValueOptions report, timeliness does not appear problematic as the company has resolved all of its grievances within the 30 day regulatory time frame. Although, according to the external quality audit, ValueOptions had inappropriate timeliness policies and procedures for its grievance system.

Table 2, on the next page, provides a breakdown of the type of grievances received from consumers and providers. Quality of care issues top the list as concerns for consumers, and claims issues accounted for the major of provider grievances. Almost 84 percent of the grievances came from HSD fund sources. According to ValueOptions, in FY05, about 42 percent of all grievances were filed by or on behalf of consumers, this rate increased to 59 percent in FY06 under ValueOptions.

Table 2. ValueOptions Grievances
FY 2006

Consumer Grievances	1st Q	2nd Q	3rd Q	4th Q	Total	
	Number	Number	Number	Number	Number	%
Quality of Care	11	12	14	19	56	54.4%
Pharmacy Formulary/Prior Auth	13	2	4	2	21	20.4%
Claims Issues	0	2	0	0	2	1.9%
Access to Care	11	2	4	1	18	17.5%
Consumer Services	2	1	1	0	4	3.9%
Other	0	0	0	2	2	1.9%
Total # of Consumer Grievances	***37***	***19***	***23***	***24***	**103**	**100.0%**
Provider Grievances	1st Q	2nd Q	3rd Q	4th Q	Total	
	Number	Number	Number	Number	Number	%
Claims issues	11	15	10	5	41	57.7%
Pharmacy Formulary/Prior Auth	16	3	1	0	20	28.2%
Utilization Review	1	2	0	1	4	5.6%
Consumer Services	0	1	1	0	2	2.8%
Quality of Care	1	0	0	1	2	2.8%
Access to Care	0	0	1	0	1	1.4%
Other	0	1	0	0	1	1.4%
Total # of Provider Grievances	**29**	**22**	**13**	**7**	**71**	**100.0%**

Source: ValueOptions,
Quality Management Annual Program Evaluation, 7/28/06.

Consumers and families lack access to information on the quality and performance of ValueOptions and its network providers. A National Academy of Sciences report on quality of mental health and substance abuse services recommends providing consumers with increased amount of information to assist in choosing service-providers. The report indicates the health system, in general, needs more transparency to ensure consumers have access to performance information on safety, evidenced based practice and customer satisfaction.

A consumer-driven system allows people who use the services to make an informed decision about which providers and organizations to receive services, in addition to participating in treatment decisions. However, consumers and their families have little to no comparative information about quality of care given by practitioners and organizations in New Mexico. In addition, the creation of a single behavioral health entity eliminates previous choices that people had among competing managed care plans under Medicaid. Limiting consumer choice among behavioral health plans increases the need for public oversight of ValueOptions operations and for transparency on spending, services and outcomes.

The Collaborative's web site could become a powerful tool for providing cost and quality information both on ValueOptions' and providers' performance. For example, the web site could provide provider specific information by combining clinical practice outcomes from ValueOptions, licensing and regulation ratings/reports, length of treatment, and cost information. The Collaborative could begin with high risk-high cost services such as inpatient acute hospitals, residential treatment centers and treatment foster care providers. As indicated in other parts of this report, the Collaborative and ValueOptions have struggled to provide the public with up to date and accurate data and other information. These initial transitional issues should not prevent

the state from building on its collaborative efforts across agencies from providing improved access to public information. Efforts to improve the public's access to this type of information would support the Collaborative's goal of making the system more consumer and family driven.

Recommendations. Amend the ValueOptions contract to require Collaborative approval of the single entities' use of specific clinical treatment guidelines. The Collaborative should not be engaged in development of guidelines, only approving their use. The Collaborative could use an advisory committee of experts to review ValueOptions proposed clinical treatment guidelines. Special consideration should be given on sustainability of using the guidelines if ValueOptions does not continue as the single entity in future years. For example, if ValueOptions uses company specific and proprietary guidelines then will the system have to adopt different guidelines if ValueOptions leaves New Mexico.

Require external quality audits to include a review of all services funded by the Collaborative, not just Medicaid managed care.

In next single entity RFP, consider requiring it to obtain national accreditation as a behavioral health company. Consider working with the National Committee for Quality Assurance to help develop a comprehensive accrediting process.

Publish results of ValueOptions quality assessment of its provider network. This information would provide the public and the provider network with the information needed to determine how the system delivers care when assessed against evidence-based clinical practices. The Collaborative should also publish specific information on in-patient and residential providers' utilization rates, length of stay, average cost, and performance outcomes. Consideration should be given on whether, initially, to publish provider specific information. At a minimum, system-wide information should be published and compared to evidence-based standards.

The Collaborative should also make available, on its website, licensing information about individual providers, including complaints, surveys and other regulatory information to assist the public in determining providers' regulatory outcomes.

EFFECTIVE OVERSIGHT OF ACCESS TO CARE AND SUFFICIENCY OF VALUEOPTIONS' NETWORK OF PROVIDERS IS LACKING.

The Collaborative has attempted to use standard tools to monitor access to care issues. Determining whether health care networks provide sufficient access to care is difficult. In particular, the public already knows that certain areas lack access to certain behavioral health services as evidenced in the Gap Analysis report. However, the collaborative has used typical network performance measures to oversee ValueOptions; Geo-access distance to provider standards and call-waiting standards. Other standards, that apply more to providers, such as appointment waiting times, are used, but do not appear measured.

The FY06 contract requires ValueOptions to "develop statewide behavioral health provider access based upon geo-access standards, including appropriate and timely access to out-of-network providers."

Geo-access reports are useful for mapping a health care organizations network and determining how far consumers have to travel. The FY06 contract requires ValueOptions to provide 90 percent of consumers with access to an appropriate behavioral health provider within certain distances from their homes. The following driving distances apply for consumers living in different areas of the state: Urban, 30 miles; Rural 60 miles; Frontier, 90 miles. The Collaborative was supposed to use monthly Geo-Access reports, which map the geographic distribution of providers by provider type.

The Collaborative's external quality review audit also review ValueOptions compliance with Medicaid managed care regulations, including those related to access to care. Again, this was not a comprehensive review of the company's performance as the audit only focused on compliance with Medicaid managed care regulations. However, ValueOptions was found fully compliant with access to care requirements and contract management, received moderately compliant marks for reimbursement and fell just short in its compliance with provider network requirements. Specifically, ValueOptions was found minimally compliant with provider network regulations due to lack of provider directory and Geo Access reports.

The Collaborative's Geo-access Behavioral Health Accessibility Analysis report does not provide a comprehensive analysis of the ValueOptions network or consumers served. Instead the report focuses on Medicaid managed care portion of the program. In addition, the report lacks specific information on the number of New Mexican's actually receiving some type of behavioral health service through managed care. Without this information the Collaborative cannot tell whether the ValueOptions network is sufficient to provide a comprehensive array of behavioral health services to New Mexicans.

The current method to assess access to behavioral health services through ValueOptions lacks key information needed to successfully evaluate the adequate disbursement of the provider network. For example, according to oversight reports, only 9.7 percent of rural Medicaid managed care members have desired access to accredited residential treatment centers. The report does not distinguish between adult and child members and whether those members use behavioral health services. Without this information the Collaborative cannot effectively assess accessibility of residential treatment centers for children living in rural New Mexico.

About 89 percent of rural Medicaid members appear to have desired access to non-accredited residential treatment centers and group homes indicating a possible difference in the accessibility to higher quality services.

The access report indicates that 92 percent of members in urban areas have desired access to children's case management services. Again, the access report appears to include the total number (both adult and child) Salud! membership when measuring accessibility for a child only service. As a result, this report does not provide an accurate description of whether Salud! children have desired access to services. The same issue is present for measure accessibility for adult case management services.

Co-mingling all Medicaid members into services that are only delivered to children could understate the accessibility of ValueOptions' network as well. About 71 percent of all members in frontier counties live within 90 miles of a treatment foster care provider. However, this report

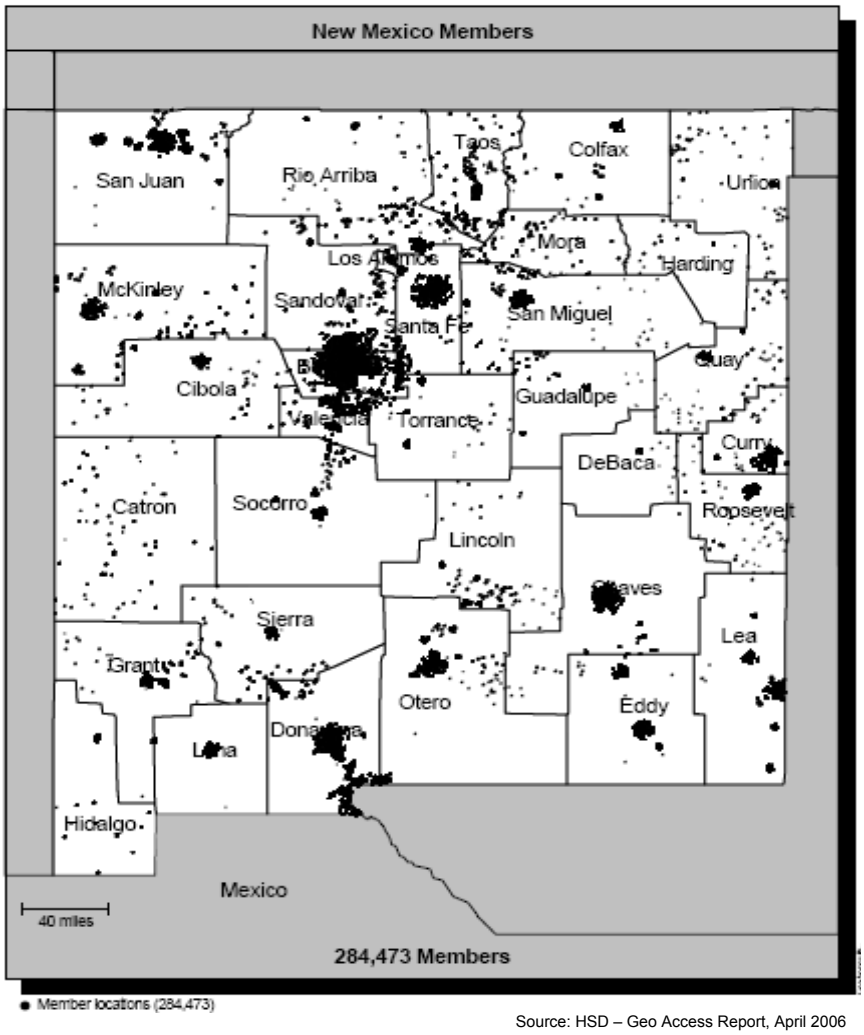
does not identify the number of child members with desired access, which presumably could be more, or less than the 71 percent reported.

The Collaborative has struggled to develop an effective way to determine sufficient accessibility to services within the ValueOptions network. An entire year has passed since ValueOptions began operations, yet the Collaborative has not established a useful reporting mechanism to ensure consumers have sufficient access to services.

As of July 2006, ValueOptions and the Collaborative had not yet finalized reporting parameters for the Geo-access reports, and ValueOptions has struggled with data errors. Instead, ValueOptions reported on the number of contractors within its network, about 230 agencies/facilities and about 670 individual practitioners.

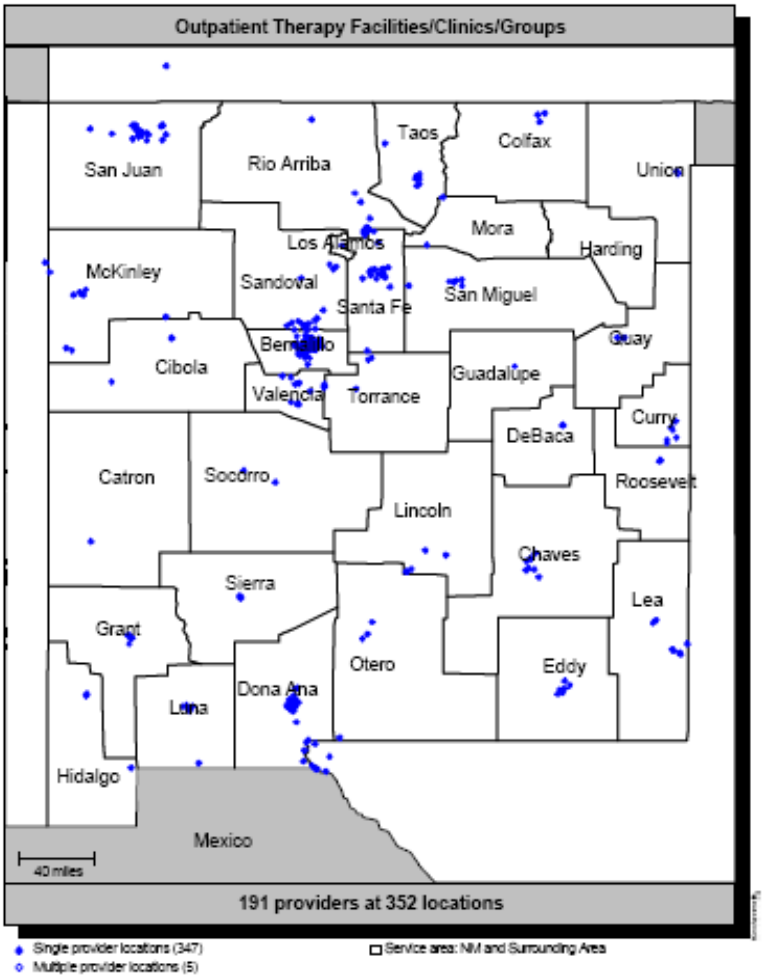
The Collaborative did provide one Geo-access report. The following data and maps illustrate the potential usefulness of this type of reporting, should proper reporting parameters be agreed upon.

ValueOptions Medicaid – Managed Care Members
April 2006



Source: HSD – Geo Access Report, April 2006

ValueOptions Medicaid – Managed Care
Outpatient Therapy Network
April 2006



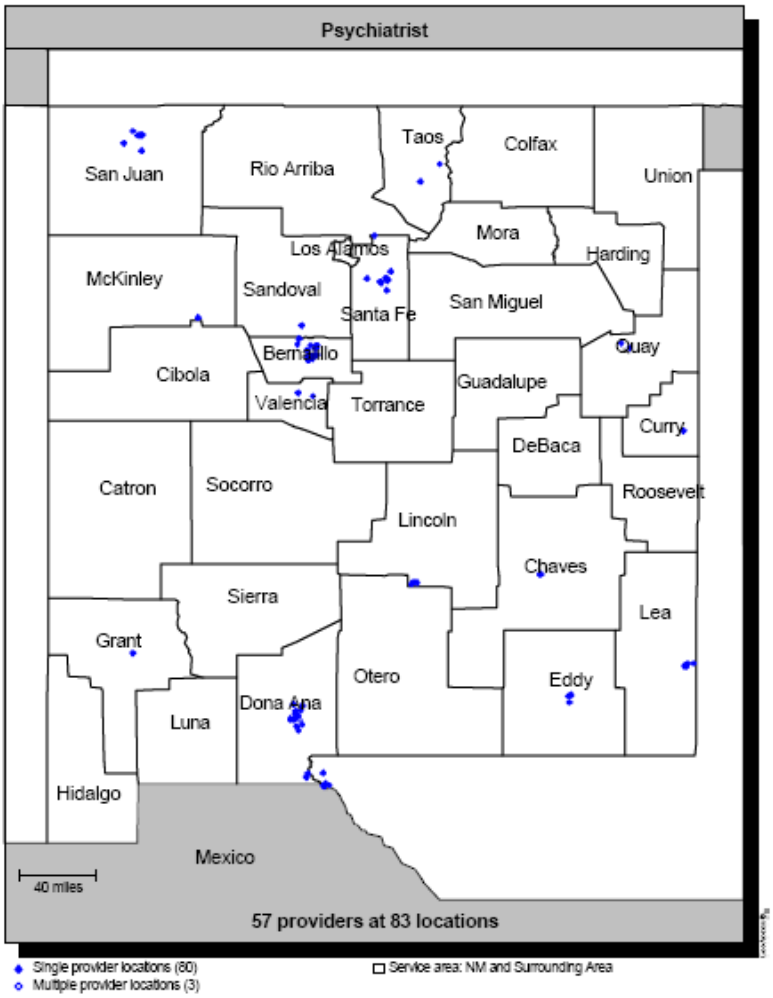
Source: HSD – Geo Access Report, April 2006

Table 3. Access to Outpatient Therapy
ValueOptions – Medicaid Managed Care Members
April 2006

Area of State	Members	Percent Members with Desired Access
Urban	138,542	98.6% (136,595)
Rural	109,995	100.0% (109,995)
Frontier	35,936	100.0% (35,936)

Source: HSD – Geo Access Report, April 2006

ValueOptions Medicaid – Managed Care
Psychiatrist Network
April 2006



Source: HSD – Geo Access Report, April 2006

Table 4. Access to Psychiatrists
ValueOptions – Medicaid Managed Care Members
April 2006

Area of State	Members	Percent Members with Desired Access
Urban	138,542	98.7 % (136,745)
Rural	109,995	90.2 % (99,164)
Frontier	35,936	72.3% (25,981)

Source: HSD – Geo Access Report, April 2006

ValueOptions receives generally positive marks from providers on access to care, though other areas indicate potential problems. About 44 percent of providers have indicated general satisfaction with ValueOptions' overall performance, but are sharply divided over the impact of combining funding into one behavioral health company. A Collaborative sponsored provider satisfaction survey indicates that 26 percent of providers feel the creation of a single network has had a negative impact, while about 27 have positive views of the change. According to survey results, providers rating the transition positively have felt that combining health plans/processes has had a positive impact on services. Those with negative views tend to blame reimbursement issues. In addition, the survey indicates that large providers serving 45 people or more, and providers located in Santa Fe consistently expressed the most dissatisfaction with ValueOptions across multiple aspects of care.

The survey indicates low satisfaction with reimbursement rates, with almost half of providers, or 47 percent, giving ValueOptions low marks in this area.

Most providers (53 percent) indicate similar services levels under ValueOptions as prior years under SALUD!, however about 23 percent indicated a decrease in the number of consumers served under ValueOptions.

According to providers, ValueOptions appears to need improvements in certain areas of consumer care, in particular coordination and access to inpatient behavioral health and availability of case management services and translators for people with special language needs. Furthermore, providers indicate dissatisfaction with ValueOptions drug formulary. Providers expressed satisfaction with access to outpatient care.

The Collaborative has not released its survey of people using behavioral health services during review period. Therefore we could not determine whether New Mexicans using behavioral health services have similar concerns of consumer care as providers.

Recommendations. Finalize Geo-access report standards, and begin reporting publicly, no later than January 1, 2007. The reports should include comprehensive data including all providers in ValueOptions' network. The Collaborative should assess, at least quarterly, whether New Mexicans *receiving* behavioral health services live within appropriate distances from providers. The Collaborative should set specific targets for improving regional access to services most in need or services the Collaborative is trying to expand to more New Mexicans. Use the reports to measure progress made over time in expanding the state's behavioral health network as part of the Collaborative's strategic plan.

The Collaborative should periodically audit ValueOptions' to ensure the accuracy of provider lists used to assess the sufficiency of the company's network.

Ensure external quality audits review access to care issues for all programs funded by the Collaborative. Consider reducing ValueOptions administrative fees, require participating agencies to help fund, or request additional funding to expand scope of external audits.

M E M O R A N D U M

TO: Charles Sallee, LFC Performance Auditor

CC: David Abbey, Executive Director, LFC
Manu Patel, Deputy Director for Audits, LFC
Michelle Welby, Governor's Senior Health Policy Advisor
James Jimenez, Governor's Chief of Staff
Pamela Galbraith, CEO, ValueOptions New Mexico

FROM: Pamela S. Hyde, Secretary HSD & Co-Chair, BH Collaborative
Michelle Lujan Grisham, Secretary DOH & Co-Chair, BH Collaborative FY07
Dorian Dodson, Secretary-Designate CYFD & Co-Chair, BH Collaborative FY06
as authorized by

RE: Response to the LFC Audit Report of the Review of the Behavioral Health Purchasing Collaborative dated 11-15-06

DATE: November 15, 2006

Thank you for the opportunity to comment on the LFC Report on the Review of the Behavioral Health Purchasing Collaborative. We also appreciate your willingness to present the report to the full Collaborative at its December or January meetings. Other members of the Collaborative may have additional comments upon seeing the Report or hearing the presentation of the report. This memorandum will serve to provide the comments of the Co-Chairs, as informed by ValueOptions New Mexico (the statewide entity) and key cross agency team staff leads regarding the findings and recommendations found in the draft report.

GENERAL COMMENTS

First, a general comment is that while the report acknowledges the phases of this transformation, it only briefly describes what we expect to accomplish in each of the phases. There are some activities or data that would not have been expected at this point in the 10 year evolution of this process. This audit began during or just after the end of the first full year of the contract with ValueOptions. We indicated when the audit began that much of the data LFC might want would not be available until near the end of the audit timeframe. We also indicated that activities such as developing performance measures, doing planning and improving the contract oversight process would not likely be accomplished until Phase Two or FY 2007 & FY 2008. We believe we are right on target with our process. The report might be thought of as a baseline with which

future reviews would compare, rather than expecting current status to be a point at which any aspect of the transformation would be completed.

This Behavioral Health Purchasing Collaborative passed into law in 2004 is a *massive* systems change. No other state has attempted a transformation of this magnitude or of this type. This process holds great promise to make our state's use of funds and our service delivery system more efficient and effective for the people of our state. However, it is a multi-year (at least 7-10 year) process, as indicated in the report, and results will not be seen quickly. The report should be viewed in this context, reflecting challenges and accomplishments early in the change process.

Secondly, the report does not acknowledge the complexity and the "mess" the multiple departments handed VONM, nor the requirement that VONM not change much during at least the first six months of the first fiscal year. This required VONM to clean up provider contracts, implement consistent billing practices, train providers and new VONM staff on new billing rules, and identify all the unique contractual arrangements and multiplicity of rates that had been put in place over the prior decade by multiple payer sources (MCOs, RCCs, state agencies, etc.) State staff, VONM staff and providers all worked hard to implement new service definitions, become familiar with new ways of billing for services and accounting for funds, and new ways of compiling and reviewing performance data and reports. The fact that the Collaborative has the performance reports we have and the encounter and expenditure data we do, not to mention the emerging performance data as promised, is an incredible feat that will serve as a baseline from which this process of transformation can continue to evolve.

Third, the report does not acknowledge that the Collaborative has done all the transition of this effort without one new state dollar for infrastructure, oversight or evaluation. While it is appropriate that staff tasks shift from prior activities to new activities under this new arrangement, the fact is there are multiple new requirements and tasks that must be done, significant demands for information and data that did not exist before, additional demands for oversight and quality in a more complex environment, and additional requests for reporting to various committees and stakeholders. Collaboration is a better way to do things in state government, but it is not easier. In fact, it is more difficult and more staff intensive than doing things in an individualized departmental approach. Many Collaborative functions and all local collaborative support are now being paid for out of a federal transformation grant. Consideration needs to be given to funding with state dollars some of these functions and support. The federal grant will end, leaving the Collaborative and local collaboratives with no infrastructure for the management and oversight of this process unless state general fund support is provided.

Comments specific to the findings and recommendations on the summary page attached to the report are provided below.

SERVICES

Finding 1: We agree generally with this finding, although some of the information in the report are still projections or are miscalculated.

The Collaborative's contract with VONM for FY 2006 has resulted in a projection of just under $300 million spent through this process and served about 70,500 unduplicated individuals served through this process. Not many states are able to provide an unduplicated count of persons served across funding streams, yet most states and advocates desire this type of information. Due to the phased in nature of this process, FY 2006 represents only a portion of the funds and programs that the statewide entity will eventually be responsible for, so the numbers served are less than what will eventually be served through this process. Any comparison to prior years' number of persons served is simply not comparing similar things. The closest thing we have to a comparison is the BH Gap Analysis numbers which indicate that about 51,600 individuals were served in FY 2001 from CYFD, DOH/BHSD & HSD/MAD fund sources. Neither number counts persons served by prevention providers or in-facility state-operated programs.

The report indicates that since the RFP projected 82,000 people might be served in FY04 and approximately 45,000 people were served by VONM in FY06, something must be wrong. Many things occurred that affect this number. First, the 82,000 projection was the first time such a number was projected for the fund source and was an over-estimate. At the time of the RFP, we were using Managed Care Organization (MCO) estimates before we had developed the mixed services protocol that guides which services are to be paid for by the Statewide Entity and which are to be paid by the MCOs. Physical health MCOs continue to provide some behavioral health care by design, especially medication management through primary care physicians. Second, VO saw a significant drop in enrollment generally in Medicaid as a result of HSD cost containment initiatives. Those numbers are beginning to increase in FY07. Third, the intervention of Medicare Part D means that a number of dually eligible individuals who used to receive medications through Medicaid now receive medications through a Medicare plan.

Finding 2: We agree that the Collaborative has made a successful transition, and that there is more to do and more performance information to report.

Beginning the first reporting month (August 2005, with data from July 2005), the Contract Oversight Cross Agency Team (CAT) began receiving all but one of the Critical Indicator reports required of VONM. The Prior Authorization report came the next month. By mid-year, the Oversight Team was receiving the Performance Measure reports, as well. These reports or summaries of this information were provided to the Collaborative in public meetings at least six times during the 15 months from July 2005 through September 2006. The reports and approaches to informing the Collaborative were refined during the year and continue to be refined. The Oversight CAT reported most recently at the September 2006 meeting for the full FY 2006 period, including critical indicators, expenditures, services, client and administrative data. The reports provided then continue to be updated as encounter data are cleaned up and reconciled. It is typical that encounter data will continue to come in, hence data will continue to change for up to two years after the end of a reporting period for at least some fund sources.

The report states that the percentage of clean claims denied increased significantly after the six month "hold-harmless" period and that this "raises questions about the ValueOptions network billing and payment practices". In fact, the early rate of payment was artificially low as ValueOptions ensured that existing providers continued to get paid during the transition. The rate

of roughly 15% denied clean claims seen during the second half of the year is not atypical and is in line with denial rates that we see from the MCOs and the Medicaid FFS fiscal agent, ACS.

Finding 3: We agree that the Collaborative needs to improve its comprehensive plan, but do not agree that the Collaborative planning process is backward or inadequate.

The behavioral health comprehensive plan was finalized and submitted to the federal government, along with an accompanying resource inventory as required by both the federal government and state law, in October 2006. These documents are posted on the Collaborative's website. The planning process was done through extensive interaction with the 15 local collaboratives, all of whom were newly created entities with volunteer labor from around the state, and the statutory Behavioral Health Planning Council (BHPC). While the Collaborative has acknowledged publicly that the plan is preliminary and needs further refinement, still it is in fact a comprehensive plan as required by state law. (It should be noted that the Collaborative's authorizing statute requires a comprehensive plan, not a strategic plan.) The Collaborative took into account the unique needs of rural and frontier areas and of Native Americans through the use of local collaboratives representing all these interests and through the BHPC subcommittees.

The Collaborative also utilized extensive public input to create a concept paper in 2004 that then served as the basis for the Request for Proposals that was released in the fall of 2004. That plan laid out the strategic direction of the phases and what we would try to accomplish during each time period. During the spring of 2006, the Collaborative adopted a strategic work plan called *Taking Stock, Taking Aim*, which did in fact receive public reviews. This document guides the work of the cross agency teams for the 15 months from April 2006 to June 2007. The activities in this document are reflected in the comprehensive plan. Now that the comprehensive plan is completed, staff is working to identify the methods for moving that planning effort into a more strategic focus. We hope to have that completed by June 2007, although the federal government may require additional changes we will have to accommodate. The *Taking Stock, Taking Aim* document does in fact reflect priorities and strategies about what is most important for us to work on at this time – from performance and outcome data to administrative infrastructure to contract oversight to service capacity and workforce development.

We have also completed an extensive legislative budget priorities process that continues to be refined and was most recently presented to the Collaborative and the LHHS interim committee on November 2 and November 1 respectively. This legislative budget priorities list also reflects the priorities and needs identified by local collaboratives, BHPC, Collaborative agencies and other stakeholders. These needs and priorities are also reflected in the larger comprehensive plan.

Recommendation One: We agree with this recommendation and will continue to provide reports and data as required by law.

Currently, no such reporting requirement is in state statute. However, the BHPC does have an obligation to report annually to the Governor and has done so. The Collaborative Co-Chairs have indicated a willingness to report as a Collaborative when such requirements are in fact put into law. We believe that all individual agencies have been providing performance data for FY

2006 and FY 2007 as required by law. If that is not the case or if LFC does not have copies of these reports, we will be happy to follow up with individual agencies and make sure behavioral health performance measures that are currently in law are reported and available to LFC staff.

There is currently no requirement in FY 2006 or FY 2007 House Bill 2 that the Collaborative as an entity provide performance data for these two years. However, as promised and indicated, performance and outcome data are beginning to be available for FY 2006 and have been provided to LFC (attached). We will provide future performance and outcome reports to LFC staff as soon as it is publicly available. We have been providing information each time we testify before a legislative committee about the status of the development of the 21 performance measures and 40+ metrics, including providing extensive information to legislative committees about how the Collaborative cross agency teams were developing the measures and data sources for these measures. We indicated throughout the spring and summer of 2006 that some of this data would begin to be available in the fall of 2006, and in fact, the Collaborative received the latest information on the status of this data at its most recent public meeting on November 2, 2006. We also provided to DFA in the summer of 2006 our recommended measures for the Collaborative as an entity for House Bill 2 for FY 2008. These measures are highlighted on the attached document.

Recommendation Two: We do agree that the comprehensive plan should continue to be refined.

The Collaborative will have another strategic work plan adopted to reflect the realities of FY 2008 budgets and capacities no later than June 2007. However, the planning process will never be finalized or perfect. It will be a continuing refinement as the new behavioral health system emerges and matures. In addition, the Comprehensive Behavioral Health Plan is being used to fulfill the federal requirement for an annual plan to accompany the Mental Health Block Grant. The plan meets those requirements and exceeds any requirements related to the Substance Abuse Prevention and Treatment block grant.

Recommendation Three: We agree that an annual report of the Collaborative should be completed and the Collaborative is in the process of developing this report for the first year (FY 2006).

An annual report is being developed by the newly hired Communications Coordinator for the Collaborative. It will be provided to the legislature and stakeholders when completed. We hope to have an annual report available sooner in upcoming years, however September of each year is not realistic to have expenditures or outcome data for the fiscal year ending June 30. In addition, the Collaborative Co-Chairs have reported to the LFC and to LHHS upon at least three occasions during the 2006 interim period (and other times during the interim of 2005) about the status of the Collaborative and about special issues the Collaborative is working on (e.g., substance abuse, performance indicators, provider issues, comprehensive planning and legislative budget priorities) and will continue to be happy to do so whenever asked.

FINANCE

Finding 1: We disagree that VONM's rates were inappropriately increased.

The Collaborative agreed to have HSD finalize the Medicaid rates for a FY 2006 contract amendment with VONM. These rates were renegotiated in part because the federal government did not allow HSD to fund either VONM or Presbyterian Health Plan (which manages the fee-for-service medical pharmacy benefit for the state) in the manner we originally wanted. As a consequence, HSD had to amend its contract and its payment method with both these companies. This had nothing to do with performance and is allowed by the terms of both contracts (see FY 2006 Contract with VONM, Appendix 3.7). The final amounts VONM received for Medicaid fee-for-service (FFS) and managed care taken together were approximately $50 million less than VONM originally understood it was to receive, based in part on the enrollment changes and based in part on the change in the funding mechanism within the FFS program. The managed care rates paid were based on appropriate costs and actuarially sound rates. It should be noted that staff of other key departments (especially CYFD and DOH, and often NMCD) are invited and encouraged to participate with HSD in discussions with VONM regarding Medicaid rates and requirements.)

In the report, Charts 14 and 15 indicate Medicaid Managed Care rate increases of 15% during FY06 and 25% from FY06 to FY07. We disagree with the way the LFC calculated these rates. HSD uses actuarially sound average weighted rates during contract negotiations and when examining rates during the course of the contract year. Average weighted rates are the most appropriate for use in a managed care program where there is significant variation among several different cohorts. When these average weighted rates are applied, we see an increase of only 5.9% during FY06 (from $58.02 to $61.44) and only 1.15% from FY06 to FY07 ($61.44 to $62.14). Further, the FY07 rate includes an increase for provider fee increases in accordance with an appropriation made to the Department for this year.

It should also be noted that, due to the nature of the populations in managed care versus FFS in New Mexico, per capita FFS rates are expected to be significantly higher. Whereas the majority of Medicaid beneficiaries are in managed care, the FFS population comprises mostly those that are elderly or those with disabilities, as well as the majority of NM Native Americans.

Recommendation 1: We disagree that changes in contracts should always be based on performance.

Not all changes to the VONM contract will have to do with performance. When appropriate, VONM rate changes will be made based on changing federal requirements, changes in costs, actuarial changes, or availability of funds. Where appropriate, increases or decreases to VONM reimbursement amounts or contract changes may be made based on performance. This is consistent with contracts with other vendors and providers doing business with the state.

Finding 2: We disagree that the reimbursement methodology utilized in FY 2007 is contrary to best practice or that it should be changed now.

The practice of pre-paying all or part of a contract is not contrary to state law and is not unusual in state contracts. In fact, the procurement code specifically allows health related contracts to be dealt with differently than other contracts. In addition, this funding mechanism of a $1/12^{th}$ draw

of a set amount or set budget has been used by many state agencies, including CYFD and its predecessor agencies, for years or even decades. It is important to note that contracts using this method of reimbursement have been reviewed by the Department of Finance and, depending on the dollar amount, by the Attorney General's office in the past and have never been cited as an illegal practice. Illegality only occurs when this or any other funding mechanism does not require goods and/or services to be provided for the funds received. A careful examination of the contract with VONM will reveal that services must be provided, and that there is a reconciliation process in place to assure that services are provided or funds are otherwise utilized for services (FY 2007 contract, Article 7.4).

State government is often accused of being bureaucratic and of putting up unnecessary restrictions and requirements that preclude efficiency and make streamlined operations almost impossible. The use of the time-honored $1/12^{th}$ drawdown mechanism, with the appropriate safeguards in place as they are in the VONM contract, is another demonstration of the Collaborative's commitment to efficient and streamlined delivery of services in a highly complex funding environment in which payment of providers is of paramount importance. The Collaborative should be applauded, not chastised, for implementing this mechanism.

Many state contracts provide either regular payments with reconciliation at regular intervals or pre-payment of a portion of the contract amount prior to performance and final payments later in the contract process. In this case, VONM is managing the state's funding for us. VONM must have that funding available to ensure quick payments to providers on the state's behalf, and should not be expected to "float" funds for the state for any length of time. DOH acknowledged this issue for many years and as a consequence provided a $1/12^{th}$ draw to its Regional Care Coordination entities (RCCs), without any reconciliation at the end of the contract period. The VO contract goes beyond prior practices in this regard, requiring a spending plan and potential recovery of funds.

During the first year of the contract with VONM (FY 2006), the reimbursement mechanisms from various funding departments were different. Medicaid managed care paid a monthly capitation up front (recognizing that VONM was responsible for payments to providers and must have the funds to do so up front). Medicaid FFS initially paid a monthly per member amount up front, but later shifted to a monthly amount up front for administration and an amount based on submitted claims, the latter paid within days of claims submission by VONM. These amounts are all reconciled once claims are cleaned and amounts paid reviewed. VONM pays providers *after* receiving funds from HSD. This process can occur because an outside vendor pays Medicaid claims, not the state system. That allows quick turnaround of claims so that VONM is able to pay providers quickly.

During FY 2006, DOH paid VONM a $1/12^{th}$ draw against the total available funds each month and the reconciliation process is continuing. NMCD and CYFD paid VONM only *after* VONM submitted evidence that they had claims in from providers. This created considerable delay as providers were having difficulty transitioning to the new payment/claims system and the state was not able to turn around payments to VONM quickly. This meant that providers were experiencing extreme delays in getting paid. Many times, VONM advanced money to providers to help with their cash flow, pending claims being submitted properly and payments coming

from the state. VONM continues to pay millions of dollars to providers who bill Medicaid Fee-for-Service claims and "floats" those dollars for the state and the system until reimbursed by HSD, therefore benefiting rather than costing the state interest money.

VONM continues to pay some providers (especially those historically funded by DOH) on a $1/12^{th}$ draw against their annual contract amount, as they have been paid for many years. To do otherwise, would cripple some of these providers and put them out of business. For others, they would be able to show significantly more services provided than the funding amount available in their budgets. That would mean the state would find itself without sufficient funds to pay providers for the services rendered or services would have to stop, pending the beginning of the new fiscal year when additional funds are available.

In FY 2007, VONM is receiving Medicaid funding in the same manner as described earlier and DOH, CYFD and NMCD are providing $1/12^{th}$ draws against available funding with a contractual obligation on all parties to reconcile at the end of each quarter. The first quarter reconciliation for FY 2007 (July through September 2006) is in process now. VONM and the state will begin to do projections based on historical expectations and continue reconciling as claims are received against those projections. If VONM is not able to do this projection or not able to show actual expenditures made to providers, there is a process for a planned expenditure in future quarters or the state will do that planning and direct those expenditures.

This reconciliation process, as with other reconciliations done with other fund sources and other contracts, will prevent any inappropriate expenditures or "reallocations" of state funds without legislative authorization. Any unspent funds will be reverted to the general fund as required by law, as part of each agency's annual financial audit process.

Recommendation 2: We do not agree that pre-payment arrangements to VONM should be phased out in FY 2008, although we do agree that these arrangements may begin to transition for some providers in FY 2008.

While the Collaborative has indicated a desire to move toward a "payment for claims submitted" process with providers and VONM, to do so all at once would seriously jeopardize the provider infrastructure, especially for services for uninsured adults with behavioral health and substance abuse needs. The rates paid for these and other services for children and youth are not consistent across the state. The Collaborative has instructed VONM through the FY 2007 contract to begin to equalize rates for similar services and similar provider situations. However, this process must be done slowly, to prevent disruption to providers and services. These rates must be equalized before moving to a payment for claims approach.

The Collaborative and VONM, with input from providers, will continue to move in this direction, beginning in part with pilots or other approaches in FY 2008, but will not complete this process for several years. At the point all providers are on a fee-for-service basis and all state agencies are able to do a quick reimbursement process, the Collaborative will work with VONM or whatever entity is the statewide entity at that point (the next RFP will occur in late 2008 for FY 2010) to assure quick payments to VONM so that quick payments can be made to providers soon after they submit clean claims.

The legislature may then have to work with the Collaborative to provide additional funding for services if providers deliver and bill for services beyond the general fund that has been appropriated in a given year. This will give a better picture of the true need in New Mexico, but will put a strain on state appropriated funding. An alternative to is tell providers they can only bill for a specific number of units of service in any given time period to prevent expenditure of funds meant for a whole year to occur in only a few months.

AUTHORITY AND ADMINISTRATION

Finding 1: We agree. The Collaborative currently has no independent rule-making authority granted by state law.

Recommendation 2: We agree that the Collaborative could be authorized to adopt rules and regulations, with the caveats noted below.

It is true that since the Collaborative does not have rule-making authority on its own, each individual agency retains responsibility for state and federal fund sources appropriated to it. To the extent rule-making occurs, each individual agency does so, but all efforts are made to assure these rules and regulations are done consistently with the Collaborative's direction, as required by state law. Each individual agency receiving federal funds has a "single state agency" designation for those funds as required by federal law. Unless the Governor wants to identify the Collaborative rather than the individual departments as the single state agency for all of these federal fund sources, the Collaborative cannot make rules or policies for those fund sources. The designated single state agency must do so. Since each of these federal fund sources are frequently only partially meant for behavioral health services, it would not be possible to make the Collaborative the designated single state agency for all these fund sources. Therefore, any rule-making authority provided to the Collaborative would have to be implemented carefully to prevent inconsistent state rules and regulations.

The Collaborative can adopt broad rules and regulations regarding access, quality and other activities of the Collaborative or the statewide entity. However, the statewide entity will always need to have its own ability to develop and implement quality and utilization review standards and processes. That expertise is in part what we "buy" when we engage a private entity to manage funds, especially across multiple fund sources.

While the initial contract with VONM in FY 2006 had multiple approaches to quality requirements, that was in part developmental due to the quick process the multiple agencies had to employ to create a single contract for FY 2006. For FY 2007, there is a single contractual approach to quality and utilization review. In most instances the highest requirement is the standard used (often a Medicaid standard). However, in some cases where the fund source or the population requires a different approach, that is identified and required in the FY 2007 contract.

Further refinements of the contract requirements will occur in future years, beginning with the FY 2008 contract amendments, the development of which will begin in December 2006. In the

meantime, VONM has an extensive approach to quality improvement, clinically and programmatically. The VONM Quality Improvement Plan provided to you is an indication of that approach. This plan focuses on clinical and programmatic quality and is in addition to the performance and outcome indicators being tracked by the Collaborative and is in addition to the critical indicator reports received monthly by the Contract Oversight Cross Agency Team.

As the local collaboratives mature and we are able to provide them data by their geographic areas, we expect them as well to play a role in identifying quality issues that need to be addressed.

Finding 2: We disagree that the Collaborative does not have a clear and consistent process to make policy and include and inform the public of its decisions.

The Collaborative does have clear and consistent processes for making policy and informing the public. Public meetings of the Collaborative are held every 4-5 weeks at times and places announced months in advance. Draft agendas are posted on the website. Pursuant to state law, final agendas for these meetings are posted at least 24 hours in advance. General topics for upcoming meetings are provided months in advance as part of the publicly available agenda. Often, the final agenda for a particular meeting is available on the website sooner than 24 hours in advance. A time for public input is provided at every meeting. Minutes of most of these meetings are posted on the website when they are completed, and the Collaborative's new Communication Director is now working to make sure that *all* minutes, as well as handouts and other materials, are posted.

In addition, the Collaborative has been meeting with stakeholders in public meetings that are widely circulated and well attended. Collaborative members have met with local collaborative leadership representatives three times over the past year and another such meeting is scheduled for January 10, 2007. Documents coming out of those meetings have been provided to the Collaborative and in some cases, adopted as policy (e.g., the Community Reinvestment Funds Guidelines, the Membership Guidelines and Definition of Consumer and Family, the Roles Matrix, the Potential Uses of the State Plan, etc.). Several meetings with local collaborative planning committee members occurred over the past year. Public meetings of the Behavioral Health Planning Council also occur monthly with subcommittee meetings including stakeholders held periodically throughout the year.

Collaborative members met with providers on September 8, 2006 and agreed to meet with them as we come out to meet with local collaboratives. Providers and consumers and family members meet once a month with the staff Steering Committee and with VONM as advisors on a regular basis. Collaborative members met with consumers on October 16 in Albuquerque and have a planned meeting with family members on December 7. Collaborative members are conducting a series of meetings with each local collaborative and are meeting with providers as these are planned. LC 1 & LC 8 (northern NM – Region 2) and LC 15 (Native American tribes and pueblos) meetings have already occurred and LC 2 with Bernalillo County Local Collaborative is scheduled for November 28. Meetings with LC 3, LC 5 and LC 9 (southern NM – parts of Regions 4 and 5) are planned for mid-December. A consumer meeting in the southern part of the state is also being planned.

Before this process occurred formally, the Collaborative members held a number of community forums and group meetings in the spring of 2004 to begin the process. Throughout this process, the public has had more opportunities for input than for almost any other process in state government.

In addition to the public meetings and processes, the Collaborative has also produced approximately monthly a written Legislative Briefing called *Transforming Mental Health* which is mailed to all legislators, copies of which are available to the public at Collaborative meetings. A Collaborative Communications Coordinator was recently added using federal grant funding. This individual's job includes keeping up those Legislative Briefings; assuring press and the public have information about the Collaborative's work; developing with consumers and family representatives an approach to address the awareness of mental health and substance abuse issues and needs among the public and combating the stigma that occurs with public discussion of issues such as the mandated community treatment ordinance and legislation; redesigning and keeping up the materials on the Collaborative website; and other public communication activities. We expect this addition to the staff to be critical to producing high quality public information about the Collaborative and about behavioral health for as long as this position is funded.

Finding 3: We disagree that the Collaborative's accountability to the legislature and taxpayers is limited due to outcome measures not being tied to an agency's appropriations.

First, behavioral health outcome measures are currently tied to each individual agency's budget. These outcomes continue to be reported on by each individual agency. We have agreed above that creating Collaborative performance measures in House Bill 2 for the Collaborative itself is appropriate, and we have recommended such measures through the DFA process as required by law and instruction. However, to suggest that this is the only way the Collaborative is accountable to the legislature or taxpayers is simply shortsighted. Information about the Collaborative and its performance has been presented to the legislature and to the public in more forums than any other program. Evaluations from national organizations have occurred and continue. There is extensive planning on how to improve behavioral health services in New Mexico and how to evaluate those efforts over time.

The point of this whole Collaborative process as adopted by the legislature is to have a *cross agency* rather than a single agency approach to the guidance and management of behavioral health system and services delivery. It would be a mistake to attempt to tie the overall Collaborative performance measures to a single state agency's appropriation. The whole point of the Collaborative would have been lost, and the taxpayers would surely be less informed than they are currently or than they will be as this Collaborative process unfolds about how our joint efforts affect people and providers across state agency and fund source boundaries.

Finding 4: We agree that the executive's proposal to transfer some DOH behavioral health functions (a portion of the Behavioral Health Services Division) to HSD is a good idea to streamline behavioral health federal funding and administration, but disagree that it should be the infrastructure for the Collaborative as a whole.

Recommendation 1: We disagree with a recommendation to create a unified behavioral health budget in HSD with Collaborative oversight of BHSD.

BHSD is a critical division managing federal and state funding for behavioral health and substance abuse and providing leadership on evidence-based practices for adults. However, it is *not* the primary place for behavioral health policy and financial management of fund sources and activities for all agencies or populations. Under the executive's proposal, DOH will retain significant responsibility and funding for prevention messaging, licensing and certification of certain behavioral health providers; direction provision of services at state operated facilities (inpatient and outpatient, for both mental health and substance abuse); and direct provision of behavioral health services in public health clinics, including the clinic operated within the Bernalillo County jail.

Significant dollars for behavioral health services are administered by the HSD Medical Assistance Division and will continue to have behavioral health staff and oversight and reporting responsibilities.

CYFD has critical concerns for the oversight of children's behavioral health services, funding by multiple fund sources. It retains responsibility for the delivery of those services within state facilities and for children in state custody or foster care. The additional fund sources and responsibilities that will eventually transfer to the statewide entity are still in development. CYFD is in the unique position of being a major consumer of children's behavioral health services, a provider and a Collaborative member. Part of CYFD's ability to bring that important and unique perspective to the table is the internal focus on children's behavioral health needs. To remove this simply to have all behavioral health service dollars administered out of one state agency would be to weaken the unique and valuable nature of the collaborative process and structure.

NMCD has critical obligations for the delivery of behavioral health services within prisons to the same individuals receiving services once they leave prison from the Collaborative's statewide entity. There is currently no plan to move those in-prison services to the statewide entity, although that possibility could be entertained at a later date.

There is still a significant amount of funding for behavioral health services provided through the Administrative Office of the Courts for individuals served through drug and mental health courts, as well as through local county DWI programs administered through DFA. These funds are not managed by the statewide entity at this time.

Significant dollars are spent by the Public Education Department (PED) on behavioral health services for children, with no easy way to disconnect that funding from PED or from individual school districts.

It is premature to consider a reorganization of these various fund sources. And, it violates the whole point of the legislature's 2004 approach to the creation of a Collaborative. The idea is to have all relevant agencies, whether directly funding behavioral health services or not, working

collaboratively to design and direct a single statewide behavioral health delivery system. Agencies are engaged in this process now because they are responsible for the funding of various parts of this system. We do not want to lose that engagement or investment as we try to bring a coordinated consistent set of directions to the behavioral health system as a whole.

While it may be appropriate to reconsider where the various funding streams are appropriated and through which state agency they are administered at a future time, it is impossible to reorganize our way out of the fact that multiple state agencies are involved in and ought to have a stake in and a responsibility for our state's overall behavioral health delivery system.

We agree that the Collaborative could be considered its own agency since it is a legally created entity of state government, and consider it to be administratively attached to HSD. HSD can then be charged with the responsibility to work with the Collaborative to collect and report whatever financial and performance information is appropriate to the Collaborative as an entity and assure that this reporting is consistent with the individual agency's reports provided to the legislature. However, funding to the Statewide Entity should remain in each agency's appropriation, not moved to HSD or any one agency.

It should be noted however, that in the spirit of the Collaborative approach, multiple agencies share staff working on Collaborative issues. For example, CYFD is the fiscal agent for the federal transformation grant that funds most of the staff working on Collaborative issues and grant deliverables. Some staff are hired by CYFD, DOH, HSD, PED, HED, ALTSD, DDPC, and IAD, but are co-located in a facility paid for by the transformation grant. Other staff members are hired by individual agencies and sit in those agencies but work regularly with Collaborative cross agency teams. This is a different kind of organizational approach to a cross agency effort and has been suggested as an approach the state might want to take on other cross agency efforts (e.g., workforce development).

It should be noted that BHSD is already headed by a Governor's exempt employee and will remain so at HSD. As with other program Division Directors, this individual will report to the Deputy Secretary for programs. The Collaborative Coordinator/BH Manager effectively reports to the Collaborative Co-Chairs and manages the Collaborative Cross Agency Steering Team and coordinates efforts across multiple Departments.

ACCESS TO HIGH QUALITY CARE

Finding 1: We agree that the single entity approach has the potential to improve access to high quality care and that additional information about providers' quality and performance would be helpful for consumers.

The Collaborative will work with VONM to determine appropriate ways to make such information available for consumers. The VONM website might be an appropriate vehicle, although not everyone has access to technology to make use of this information source. There already is some information regarding provider certification and licensure through the CMS website, but that information is only a portion of what constitutes quality.

Finding 2: We disagree that the behavioral health system lacks a comprehensive approach to ensure access to high quality care.

The contract requirements and the VONM quality improvement plan constitute a comprehensive approach to improving the quality of behavioral health care for which the statewide entity is responsible. However, not all services are under VONM's control or management at this point. As additional funding sources are brought into VONM's contract, additional quality management challenges will arise. AOC is currently looking to VONM to help them assess the quality of a provider wishing to be a referral outlet for drug courts. DOH is looking to VONM to assist in improving the quality of care provided by state-operated programs once the management letter regarding these programs is completed and VONM's management of those dollars begin. VONM is identifying quality issues within existing providers that have resulted in some critical changes in provider service delivery and billing practices.

In addition, the Collaborative has a commitment to addressing the workforce issues identified in New Mexico that affect quality and outcomes for clients. The proposal to fund the Consortium for Behavioral Health Training and Research (CBHTR) across multiple academic institutions is a proposal to create an infrastructure to improve behavioral health practitioners' knowledge and use of evidence-based practices. CBHTR's goals also include identification and research of practice-based evidence to support new and emerging practices, especially for Native American and Hispanic populations and consumer and family-operated services. HED is the lead on this initiative with help from DOH and HSD.

The Capacity and Service Development Cross Agency Team is also focused on developing new approaches to services with quality in mind. For example, housing, jail diversion, intensive outpatient services, residential services for children, supported employment, peer specialists, substance abuse services, and a number of other service development initiatives are all focused on what we know about evidence-based practices in these areas.

Table 2 shows all VONM grievances for FY06 by quarter. In the report, these numbers are compared to FY05 baseline. It must be pointed out that our FY05 baseline numbers came from the Medicaid MCOs, while the FY06 VONM data are from all funding sources. It is therefore difficult to say that any increases or decreases can be viewed as significant. Comparing FY06 to FY05 for just Medicaid, there is an increase (although it may not be statistically significant) in consumer grievances and a slight decrease in provider grievances. In some ways, the increase in consumer grievances might be viewed as positive, as more consumers feel that they have a voice that will be heard by VONM and the state.

Quality of care will always need to be improved. Attention to this issue is embedded in the various Collaborative activities.

Recommendation 1: We agree the Collaborative should review the Statewide Entity's clinical treatment guidelines.

Collaborative clinical and program staff do meet regularly with VONM and discuss the use of clinical treatment guidelines, protocols, and processes as part of the ongoing quality of care

improvement process. This review and discussion could be formalized to include formal approval of clinical care guidelines.

Recommendation 2: We would be happy to extend external quality review activities to all fund sources if appropriated the resources to do so.

While the external quality review approach to oversight is a good one, it is wrong to assume that it is the only oversight that could or did occur of VONM's activities, or that it is the most appropriate. The External Quality Review Organization (EQRO) review process is required by federal law of the Medicaid program for managed care organizations. Therefore, only HSD is funded for this activity and only for Medicaid services. No other agency has funding for such an external compliance audit of their fund administrators. However, the EQRO also conducted a provider satisfaction survey that was not limited to providers utilizing Medicaid dollars. While most of the EQRO's efforts were limited to Medicaid services, the Oversight Team always considered findings in a global way, assuming that any issues with one funding stream were pertinent to the others. The EQRO is currently conducting a review of Medicaid encounter data for validation.

All other oversight activities have been performed across agencies and across fund sources by state staff as is typical of all contracts with the state except Medicaid. For example, the Contract Oversight Cross Agency Team conducted a cross-fund source claims audit for the first six months of FY 2006 (July 2005 through December 2005) that will be released soon. This audit resulted in many claims payment improvements that VONM has now implemented.

Cross agency staff also conducted a consumer satisfaction review that included consumers utilizing services funded by VONM from multiple fund sources and agencies. That survey will also be released soon, pending review and input by consumers.

Development of the VONM contract and oversight of VONM has been more extensive and more public than any other major contract in state government. That development and oversight is done by cross agency teams of state staff and by external reviewers and evaluators and is discussed at and reported to the Collaborative in public meetings except where more executive sessions are allowed by law. The Collaborative would be happy to extend the external review part of this oversight to the extent resources are provided to do so. However, the EQRO process will always be only one tool used by state staff to oversee a contract subject to such a review, not as the only or major oversight process conducted.

Recommendation 3: We did consider requiring the statewide entity to obtain NCQA accreditation and decided specifically that the cost would not be worth the result at this time.

NCQA accreditation for behavioral health managed care organizations is relatively new. It does not yet have a wide acceptance nationally and does not review many of the things we care about here in New Mexico. When approached by VONM, NCQA was not eager to jump into accreditation of a unique entity managing multiple fund sources when it is still learning how to conduct such accreditation surveys with Medicaid and commercial managed care organizations. Other accrediting bodies are also looking at and have offered an approach to accreditation of

behavioral health administrative entities. This kind of accreditation is extremely costly for an organization to obtain and hence, that cost is passed along to payers such as the Collaborative. As we developed the RFP for the statewide entity, we considered this requirement and decided instead to ask offerors to meet where possible NCQA or other national standards for certain activities, without actually requiring the entity to go through that national accreditation process with its attendant costs. We are more interested in the statewide entity paying attention to what we require by contract and working with our state's providers to improve the quality of their care than for the statewide entity to worry about its ability to meet national changing standards for administrative management of funds. We may reconsider this recommendation when the Collaborative releases the next RFP in the fall of 2008.

It should be noted that VO nationally is accredited by Utilization Review Accrediting Commission (URAC), another entity that accredits such organizations.

Recommendation 4: While we do not disagree in principle, publishing VONM's quality assessment results compared with evidence-based standards may be difficult to achieve.

To the extent such evidence-based standards exist, the Collaborative will consider how to compare VONM's assessments with those standards. This is an area of discussion in the behavioral health field nationally, with few good examples how to do this benchmarking or comparison. We will continue to participate in those national discussions and determine what if anything makes sense for New Mexico.

In the recently released Compliance Audit Report, completed by the EQRO, access to care was an area in which VONM scored "Fully Compliant". This is an area in which VONM is doing well and is making improvements. Access to care issues existed in this state long before VONM became the Statewide Entity and will continue to be difficult to resolve in our rural/frontier state. The Oversight CAT is working with VONM to develop meaningful and cross-agency geo-access standards. We do currently have standards in the contract and have a way to report Medicaid data in this area. We continue to look for ways to improve upon the way we measure this important area so that we can ultimately improve access to care for consumers.