# REPORT TO THE LEGISLATIVE FINANCE COMMITTEE

***Behavioral Health Collaborative: Follow-Up Review, Report #07-13***
***October 24, 2007***

***Review Team***

- *Manu Patel, Deputy Director for Program Evaluation*
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***Review Objective***

*Assess the implementation status of recommendations from the 2006 LFC report on the Behavioral Health Collaborative.*

**Table 1. Implementation of Recommendations**

| Status | Number |
|---|---|
| Implemented/Partially Implemented | 3 |
| Not Implemented | 10 |
| Not Applicable During Review Period | 1 |
| *Total Recommendations* | *14* |

***Exit Conference***

*Held October 19, 2007 with Pamela Hyde, Behavioral Health Collaborative Co-Chair & Secretary of Human Services Department; Linda Roebuck, Chief Executive Officer, Behavioral Health Collaborative and senior Collaborative staff. Appendix B includes the Collaborative's response to the report.*

***Authority for Review***

*The Legislative Finance Committee has the statutory 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 make recommendations for change to the legislature.*

## EXECUTIVE SUMMARY

The Legislature created the Behavioral Health Collaborative (Collaborative) in 2004 to develop and coordinate a single statewide behavioral health system. In 2006, Legislative Finance Committee (Committee) staff issued a program evaluation report on the Collaborative and progress made to improve behavioral health services to New Mexicans. The Collaborative had generally been successful during its first two years, but additional statutory and management changes were recommended to improve the Collaborative's authority, administration and accountability to the Legislature. The Collaborative also needed to improve financial practices and modify the oversight of its contractor, ValueOptions, to ensure New Mexicans receive sufficient access to high quality services.

This review assessed the status of findings and implementation of recommendations made in the November 16, 2006 report: *Review of the Interagency Behavioral Health Collaborative*. Overall, the Collaborative has implemented few of the report's recommendations shown in Table 1.

The 2006 report recommended changes requiring legislative action, such as a consolidated behavioral health budget. The Legislature adopted the Committee budget recommendation to begin this process by carving out behavioral health services from the larger Medicaid appropriation. The Legislature also passed House Bill 727, which contained many of the report's recommendations and additional legislative provisions. The bill was vetoed and thus not enacted. House Executive Message No. 39 indicated that the bill "violated Article III, Section 1 of the New Mexico Constitution, which prohibits legislative intrusion upon the executive branch of government."

**Key Findings**

- Statutory changes to improve its accountability to the legislature are still needed. Behavioral health appropriations and performance measures remain fragmented despite legislative efforts to streamline programs.
- The Collaborative's payment and business practices continue to cause concerns. Pre-paying ValueOptions for services not yet rendered is still contrary to best practice as specified by the Procurement Code.
- The Collaborative has not fully implemented recommendations to improve oversight of access to care and quality of services.

**Key Recommendations**

- Consider legislation containing staff recommendations from the 2006 report, including continuing to consolidate behavioral health appropriations into a single program.
- Implement recommendations included in Appendix A. Submit an implementation plan no later than December 1, 2007 to the LFC.

## FINDINGS AND RECOMMENDATIONS

*The Collaborative still lacks rulemaking authority.*

**Statutory Changes To Improve Its Accountability To The Legislature Are Still Needed.** The 2006 staff report indicated that improvements were needed to fulfill the promise of New Mexico's behavioral health reform efforts. Specifically the report said "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 Legislature passed House Bill 727, which contained many recommendations from the 2006 staff report. The legislation was vetoed and thus not enacted.*** The report recommended changes, including granting the Collaborative rulemaking authority, requiring a consolidated behavioral health budget, quarterly performance reports and an annual report to the Legislature. All of these recommendations were contained in HB 727. The bill also contained legislative provisions to modify the membership of the Collaborative and authorize the Governor to appoint the Collaborative's chair person. House Executive Message No. 39 indicated that the bill "violated Article III, Section 1 of the New Mexico Constitution, which prohibits legislative intrusion upon the executive branch of government."

*Behavioral health appropriations remain fragmented.*

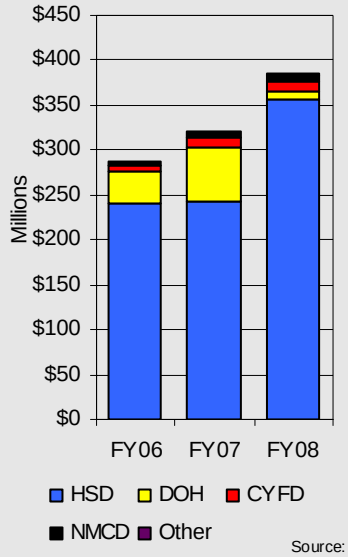
House Bill 371 enacted an executive proposal to transfer the behavioral health services division (BHSD) from the Department of Health to the Human Services Department (HSD). The executive has appointed a single person to coordinate the Collaborative's day to day activities and oversee BHSD as recommended by the 2006 staff report and also contemplated by HB 727.

***No significant changes have occurred that would affect the appropriateness of staff recommendations.*** The Collaborative is statutorily charged with creating a single statewide behavioral health system, which should, therefore, require an alignment of service requirements across multiple agencies and programs. Aligning agency' rules through multiple and separate processes is inefficient, and complicates effective public participation in critical decisions regarding quality of behavioral health services. In addition, using the contract process to make or align policy as is current practice, is not contemplated by state law and puts the public at a disadvantage to effectively participate in the process.

*House Bill 371 transferred BHSD from the Department of Health to HSD.*

***Behavioral health appropriations and performance measures remain fragmented despite legislative efforts to streamline programs.*** The Legislature adopted the FY08 LFC budget recommendation to create a new program in HSD's budget pattern called Medicaid behavioral health program in anticipation of also consolidating BHSD funding into

**Collaborative-ValueOptions Contract Amounts FY06-FY08**




Source: Collaborative

**Behavioral Health Managed Care - Avg. PMPM**

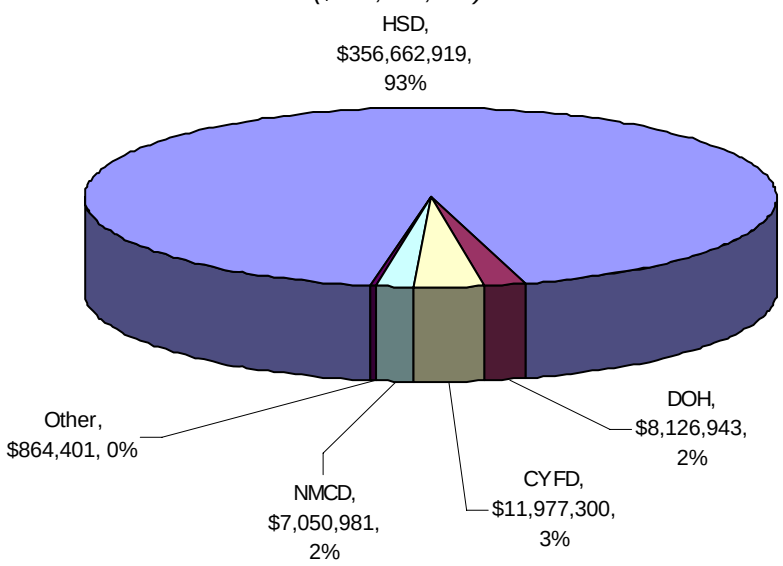

Source: HSD
*Projected

HSD. Consolidating these appropriations would aide in streamlining the budget request process for 93 percent of Collaborative contracted behavioral health services. However, HSD instead created yet another separate program for BHSD resulting in two budget programs for behavioral health services at the agency. HSD has submitted an FY09 budget request that merges Medicaid behavioral health appropriations back into the larger Medicaid appropriation.

HSD appropriations now account for about 93 percent of contract funding, as shown in the chart below. Total contract amounts have increased since FY06 by almost $100 million. Much of the increase can be attributed to the addition of other funding sources and increases in Medicaid behavioral health spending. For example, the average per member per month rate (PMPM) paid to ValueOptions for Medicaid managed care has increased nearly 25 percent since the beginning of the contract.

**Collaborative - ValueOptions FY08 Contract Amount**

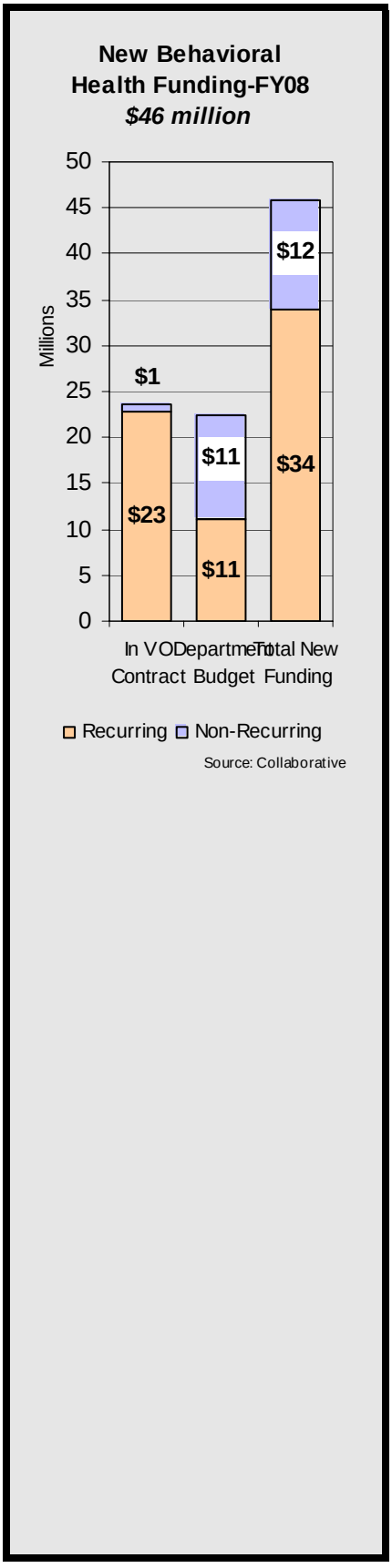
*($384,682,544)*




Source: FY08 Contract - Attachment D; HSD total includes Aug. projections for Medicaid of $356 million; DOH figures do not include $42 million estimated for state operated facilities.

The Collaborative has made efforts to submit a consolidated budget request. The Collaborative's efforts to identify each member agency's appropriations request fell short as many agencies requests were not reflected on the document, such as CYFD.

Separate appropriations requests for one contract (ValueOptions) through separate budget processes is cumbersome and may hamper effective budget and performance discussions between the executive and legislative branches for behavioral health services. For example, the Collaborative intends to equalize provider rates across funding streams. The Legislature will have to approve expansion requests for HSD-BHSD, CYFD, NMCD and DOH for the Collaborative to carry




out this plan. Medicaid has already increased rates during FY07, though not all the increase was part of a clear budget request to do so.

For FY08, about $46 million in new funding (both state and federal) was appropriated for behavioral health and related services. Much of the new funding, about $17.2 million, is attributed to increases in Medicaid and expansion of total community substance abuse services. About 26 percent of the new funding is from one-time sources and includes appropriations for items such as capital projects at state owned facilities.

**Recommendations.** The following recommendations require legislative approval.

Consider legislation containing staff recommendations from the 2006 report on the Collaborative, including requiring a consolidated budget request and granting rulemaking authority to the Collaborative.

Consider continuing to consolidate behavioral health appropriations into a single program by combining BHSD, Medicaid behavioral health and children's behavioral health appropriations (from CYFD) into a single budget program in the General Appropriations Act (GAA). Add appropriate performance measures that include, at a minimum number of people served and measures showing improved consumer functioning as a result of services received. Consider language in the GAA specifying amounts to be used for special categories of non-Medicaid behavioral health services at HSD, NMCD and DOH. This would continue the practice of making funding available for services and populations outside the Medicaid program through the appropriations process.

**The Collaborative's Payment And Business Practices Continue To Cause Concerns.** The Collaborative has not implemented LFC staff recommendations to improve its payment practices to ValueOptions that are necessary to better protect taxpayer expenditures. The 2006 report identified problems with the Collabrative's financial oversight responsibilities, including the following.

- 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. Approval process for contract amendments did not include a clear delineation between what areas staff was authorized to negotiate and that funding agencies and co-chairs could approve amendments without approval from the full Collaborative, particularly for those involving rate increases.

- In FY07, the Collaborative approved an arrangement to pre-pay ValueOptions for services not yet rendered, which appears contrary to best practice.

- The Collaborative lacked efficiency measures to regularly assess the cost-effectiveness of services and administration.

***The Collaborative has not implemented three out of four recommendations from the 2006 report, as shown in Appendix A.*** One recommendation was not applicable because the Collaborative had not executed any contract amendments during the follow-up review period (FY07 – Q1FY08).

***The FY08 contract requires ValueOptions to revert unexpended funds to the state for both FY07 and FY08.***

***While the FY08 contract provides better safeguards, pre-paying ValueOptions for services not yet rendered is still contrary to best practice as specified by the Procurement Code.*** The FY08 contract includes additional provisions to help ensure pre-paid funds are only spent on services delivered within the appropriation period and a process to recover unspent funds timely. Specifically the contract requires providers to submit claims for non-Medicaid services no later than 30 days from the end of the contract year; requires ValueOptions to have paid for contract year services no later than 90 days from the end of the contract; and to revert unexpended funds to the state for both FY07 and FY08.

***The Collaborative may need to recover an estimated $1.7 million in FY07overpayments for non-Medicaid services as a result of pre-payment arrangements in the ValueOptions contract.*** Table 1 provides a breakdown of unexpended funds by agency and purpose.

**Table 1. Estimated Non-Medicaid FY07 Contract Recovery Amounts**

| | CYFD | NMCD | |
|---|---|---|---|
| | Home Visiting | | Total |
| Amount Paid to VONM | $960,572 | $7,179,013 | $8,139,585 |
| Claims paid (As of Sept. 2007) | $556,588 | $5,725,666 | $6,282,254 |
| IBNR | $0 | $ 165,108 | $165,108 |
| Projected Total | $556,588 | $5,890,774 | $6,447,362 |
| Balance - Est. recovery amount | $403,983 | $1,288,238 | $1,692,221 |

Source: Collaborative & ValueOptions

***Home Visiting funding was not completely expended due to slow start-up of the program.***

About 40 percent of legislative appropriations for Home Visiting programs, nearly $400 thousand, went unspent during FY07. According to ValueOptions, the funds were not completely expended due to contracts not being established until November 2006 and slow start-up at the provider level. CYFD indicates that it will recover and revert the unexpended funding.

***Collaborative agencies did not reconcile pre-payments monthly.*** Nor did agencies conduct reconciliation on a regular quarterly basis through FY07. The Collaborative, since it still pre-pays for services, did not establish a standard billing process to ensure timely payment of ValueOptions *after* the company pays for services.

***HSD recovered about $514 thousand in unspent FY06 TANF funding, but not until June 2007.***

***The Collaborative paid out the unspent balance on FY06 funding for CYFD services to ValueOptions.*** This action represented a change in payment methods at the very end of a contract year and may have violated the contract terms. During FY06, CYFD reimbursed ValueOptions after services were delivered. ValueOptions submitted an invoice for $2.4 million in unspent funding to CYFD. The agency had evidence of approximately $1.9 million in provider billings but paid the entire remaining balance on the contract even though ValueOptions did not show it provided that amount in services.

The final payments to providers were not made until May of 2007 through a reallocation process of about $319 thousand. Collaborative agencies reallocate unspent contract funding through ValueOptions among providers after the end of the fiscal year. Provider contracts include a cap on the total amount a provider may bill for services. Overall, the system of providers for CYFD and NMCD generally bill for less than their contracted amounts. However, some providers submit claims far above their contracted amounts. Historically, the practice of reallocating funding among providers occurred during the fiscal year, however this practice now extends almost two quarters into the following fiscal year.

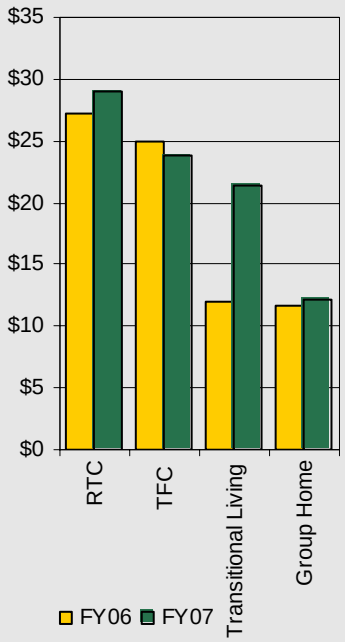
***The Collaborative had about $850 thousand in unspent NMCD funds from FY06.*** About $322 thousand of the unspent funds will be reverted to the general fund by the end of November 2007. The remaining $528 will be retained in the community corrections fund as cash balance.

***TANF has significant unspent funds for substance abuse services for both FY06 and FY07.*** HSD recovered about $514 thousand in unspent FY06 TANF funding, but not until June 2007. About $243 thousand out of $800 thousand was spent on direct services. The Collaborative may need to recoup unspent funds for FY07 as ValueOptions has reported spending only $90 thousand through July 2007. The number of people served for each fiscal year differs between reports submitted by ValueOptions to the Collaborative and TANF program.

***The reconciliation of Medicaid fee for service payments from FY06 appears complete.*** 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 our last report HSD was in the process of recouping the overpayments. HSD had created an "at-risk" payment structure to ValueOptions for FY06, but believed that the federal Center for Medicare and Medicaid Services (CMS) would disallow the payment structure and began a process to reconcile payments made against billed service and administrative charges. During FY07, the Collaborative reimbursed ValueOptions for the Medicaid FFS program.

***Pre-payment arrangements reduce a purchaser's leverage to require the contractor to perform adequately.***

**Avg. Cost Per Person Out of Home Services FY06-FY07**
(In thousands)



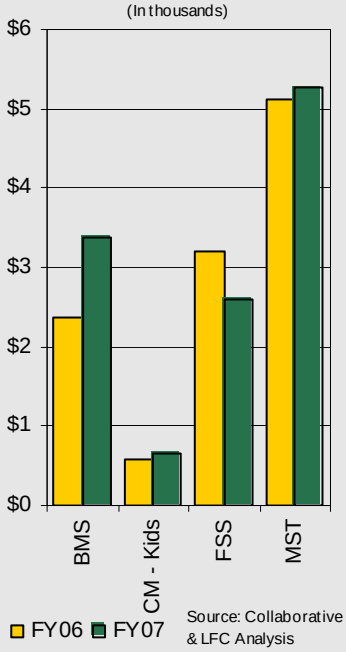

Source: Collaborative & LFC Analysis

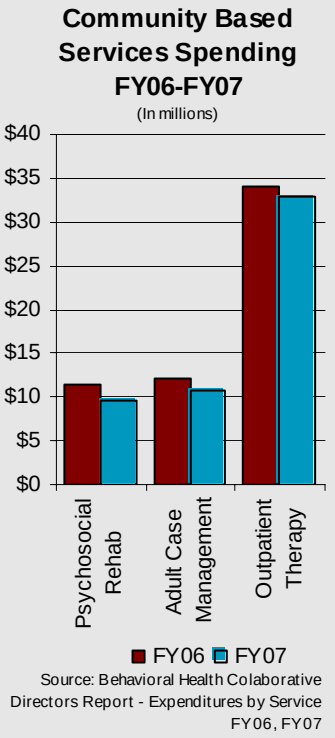
***The Collaborative has expanded the poor practice of pre-paying ValueOptions for services not yet rendered by advancing about $6 million from the general fund for the Medicaid fee-for-service program.*** The FY08 contract attempts to create a reserve pool for ValueOptions to pay providers for the Medicaid-FFS program. Since the federal government only reimburses states for Medicaid expenses the Collaborative could only advance appropriations from the general fund. The Collaborative will have to reconcile payments made by ValueOptions to providers and then draw down federal fund reimbursements.

***The Collaborative's contract with ValueOptions is not exempt from Procurement Code provisions requiring state agencies to certify services were delivered before reimbursing contractors (Section 13-1-158 NMSA 1978).*** Pre-payment arrangements for DOH, HSD, CYFD and Corrections continue to appear contrary to the Procurement Code standard. According to the General Services Department, the Collaborative's contract with ValueOptions has not been certified as exempt from the Procurement Code. Section 13-1-98.1 (b) NMSA 1978 exempts state agencies from provisions of the Procurement Code for specific services, including agreements to create a network of health care providers upon certification by the state purchasing agent. Pre-payment arrangements reduce a purchaser's leverage to require the contractor to perform adequately and demonstrate that it actually incurred costs and provided services needing reimbursement.

***The FY08 contract makes an appropriation without Legislative authority.*** Specifically, for non-Medicaid services, the Collaborative has required ValueOptions to hold pre-payments in a separate account and authorizes the company to spend any interest accruing to that account on behavioral health services as it determines. The contract does not require this same arrangement for Medicaid, particularly the pre-paid Medicaid FFS appropriations from the general fund. The 2006 staff report indicated that pre-payments to ValueOptions transfers interest income earnings from the State of New Mexico directly to ValueOptions. For FY08, the Collaborative has effectively hired ValueOptions to invest this funding and appropriated proceeds to services.

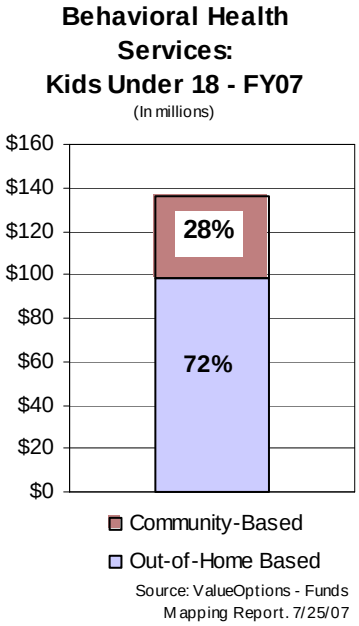
***The Collaborative has partially implemented the recommendation to develop and monitor standard efficiency measures.*** The Collaborative has not developed, nor does it regularly monitor, measures to assess the average cost of services or administration as recommended in 2006. These efficiency measures would be used to monitor the cost-effectiveness of behavioral health services.

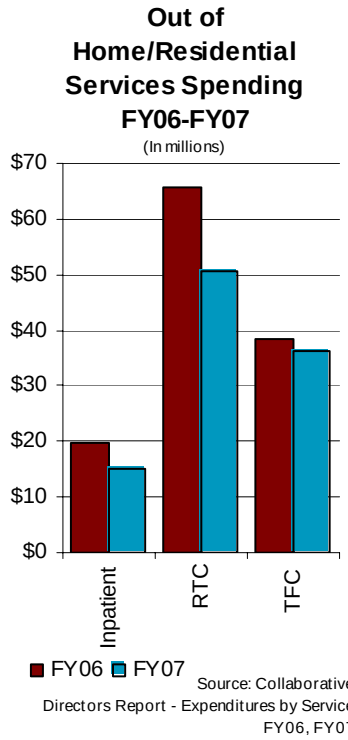


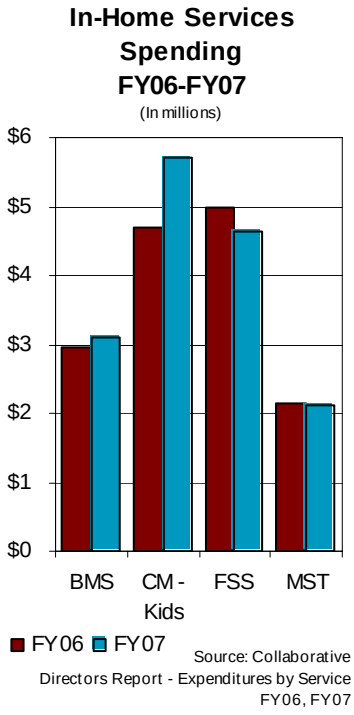




***The Collaborative has developed an initial purchasing plan for children's behavioral health services.*** The plan includes reference to the high average cost per person for residential-based services as compared with community-based services. The Children's plan will help guide the system as it seeks to reduce New Mexico's reliance on expensive out-of-home services for children, according to the Collaborative.

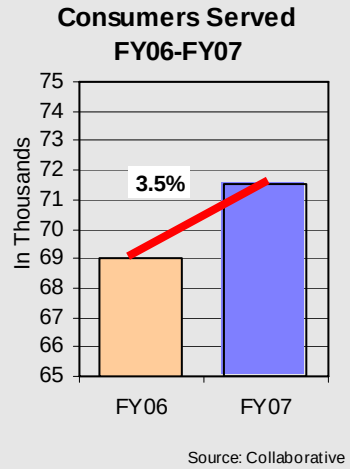
About 72 percent of funding spent on children under 18 goes toward out-of-home care, primarily residential treatment centers (RTCs) and treatment foster care (TFCs). The graphs to the left show the high average cost of selected out-of-home services, with RTCs approaching $30 thousand per child served. Comparatively, the system spending on evidence-based multi-systemic therapy approaches only about $5 thousand per child served.

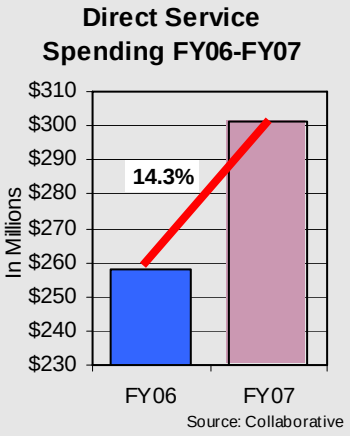



*BMS – Behavior Management Services; CM – Case Management; FSS – Family Stabilization; MST – Multi-systemic Therapy.




***The Collaborative has started a process to define the types of children's services currently provided in each community.***

Aggregate spending on selected out-of-home services decreased between FY06 and FY07, as shown in the graphs above. Most significant is the $15 million dollar decline in RTC spending, though FY07 figures are still not complete due to claims lag. Selected in-home services have not seen a corresponding increase between fiscal years. The Collaborative will want to monitor these figures closely to ensure savings from expensive services are used to expand services the state wants to purchase at increased levels.

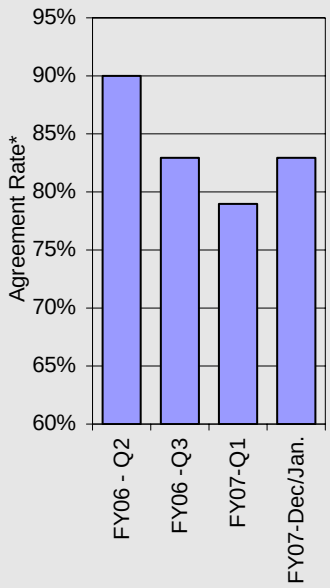
**Recommendations.** The Collaborative should implemented the recommendations included in Appendix A, including phasing out the use of pre-payment arrangements to ValueOptions and appropriating itself investment proceeds. Submit an implementation plan no later than December 1, 2007 to the Committee. Staff does not take a position on payment arrangements between ValueOptions and its providers as long as appropriate service levels justify payments.

Collect FY07 overpayments per the contract and report final reversion amounts to the Committee no later than December 1, 2007.

The Legislature may wish to consider clarifying in statute, as was included in HB727, that the Collaborative's contracts are subject to the Procurement Code.

**The Collaborative Has Not Fully Implemented Recommendations To Improve Oversight Of Access To Care And Quality Of Services.** The 2006 report included six recommendations related to access and quality of care, of which the Collaborative has partially implemented one as shown in Appendix A. Oversight activities previously carried out by the Collaborative have continued, including the use of external quality audits for Medicaid managed care and customer satisfaction surveys. Finding an effective oversight tool for monitoring the adequacy of the provider network continues to be elusive. Though the Collaborative has started a process to define the types of children's services currently provided in each community and where children from the community actually receive services. For example, some communities may end up sending their children to residential services in an urban area because alternatives are not available outside the Rio Grande corridor.

***Direct service spending and the number of people served through ValueOptions' network increased between FY06 and FY07.*** The spending on services increased primarily due to the addition of funding sources new to the FY07 contract. For example, funds from CYFD increased from about $6 million in FY06 to over $11 million in FY07. BHSD added significant new resources to the contract as well. The graphs to the left show that spending increases outpaced increases in the number of people served. FY07 data is based on claims through July 2007 and could increase in the coming quarters.




Source: Focused Clinical Denial Audit, April 2007. NMMRA.
*Agreement Rate - Percent of cases where NMMRA agreed with VONM denial decisions.

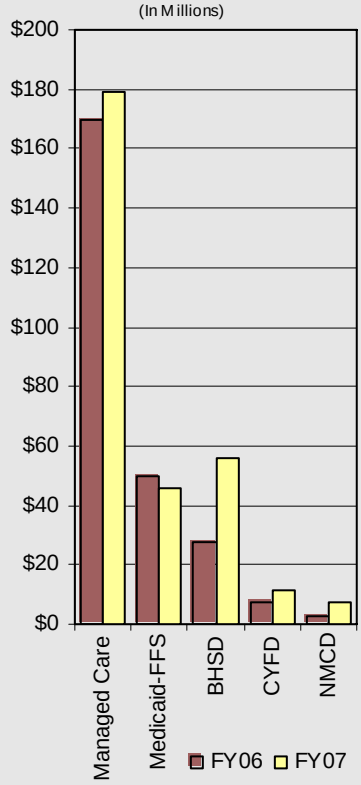
***ValueOptions has shown some improvements through its external Medicaid audit, but some results raise concerns over proper access to services.*** In January 2007, the Collaborative responded to previous reviews and public concerns and initiated a focused external audit of ValueOptions' residential treatment service denials. The Collaborative's external auditor noted despite improvements by ValueOptions it continued "to struggle with timely clinical care decisions, case documentation of denial decision with supporting criteria documentation and documentation of alternative services provided after denied benefits." In addition, the audit raised concerns about the high rate of denials overturned internally through the appeals process and delayed care coordination services. Finally, a significant number of consumers residing in detention, foster care or home settings received no alternative services after receiving denied benefit decisions, according to the report.

The Collaborative required a corrective action plan from ValueOptions and will need to continue monitoring these issues closely as it has publicly supported reductions in the use of out-of-home services.

***The Collaborative's website could be a more powerful tool to provide consumers and families with additional information on the performance of ValueOptions and its provider network.*** No action was taken this past year to publish results of ValueOptions quality assessment of its provider network; information on in-patient and residential providers' utilization rates, length of stay, average cost, and performance outcomes; or regulatory information on certain high risk services such as RTCs. For example, CYFD regulates RTCs and could provide consumers and families with the results, as appropriate, of complaint investigations or regulatory actions taken against non-compliant providers.

The Collaborative could enhance its reporting of information, including posting all compliance and denial audits, on its website. ValueOptions submits a significant amount of reports to the Collaborative quarterly, including performance and other important reports used for oversight, such as denial rates. Most of this information should be compiled, after validation, into the Collaborative's annual report on how well the system is operating.

**Recommendations.** Implement recommendations included in Appendix A. Submit an implementation plan no later than December 1, 2007 to the Committee.



Source: Collaborative. FY07 is estimated. Not all funds may be fully expended.

**The Collaborative Has Taken Steps To Develop An Integrated Strategic And Operational Plan, But Has Not Implemented Other Recommendations To Report Results.** In 2006, LFC staff report found that the Collaborative could still improve on its key statutory duties necessary to ensure a well planned and functioning behavioral health system. Almost two years had 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.

***Collaborative strategic planning has improved.*** During the summer of 2007 the Collaborative has refined a new strategic plan that aligns its staff activities with system goals and objectives. The plan also includes performance measures and speaks to resource needs. However, the plan could include more specific and concrete long-term goals for how the behavioral health system should operate in the future and does not take into account existing resource amounts.

***The Collaborative has not implemented recommendations to report performance information quarterly to LFC or submit an annual report to the Legislature.*** The consolidation of multiple agencies' appropriations and performance measures into a single contract has placed the Collaborative's innovations out of alignment with the Legislature's accountability structure. The Collaborative is not statutorily required to report performance measures under the Accountability in Government Act. The Collaborative has adopted outcome measures that cross agency funding streams, making existing program performance measures obsolete or inappropriate, in some cases. Holding the Collaborative accountable for its own outcome measures is appropriate. However, holding BHSD accountable for those same measures, as is contemplated in FY07 GAA, may not continue to be appropriate.

**Recommendations.** The following recommendations require legislative approval.

Consider legislation to require the Collaborative to report performance information quarterly to the Legislative Finance Committee and submit an annual report to the appropriate interim legislative committees. These staff recommendations were also included in HB 727.

**APPENDIX A**

| *STATUS OF RECOMMENDATIONS* | |
|---|---|
| **The Collaborative's Financial Oversight Of ValueOptions Needs Improvement To Ensure Sound Business Practices.** | |
| **2006 Recommendation** | **Status** |
| 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. | *Not Applicable* – The Collaborative has not adopted any contract amendments during FY07 or FY08 to date. |
| 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. | *Not Implemented* – The Collaborative has not adopted a policy or modified contract language allowing funding agencies and Co-Chairs to approve contract amendments. |
| The Collaborative should phase out the use of pre-payment arrangements to ValueOptions. | *Not Implemented* – The FY08 contract maintains this practice for non-Medicaid services and expands its use to the Medicaid fee-for-service program. |
| 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. | *Partially Implemented* – The Collaborative has reported average cost per person for services in its children's purchasing plan, but has not incorporated efficiency measures for administrative costs or in any ongoing reporting, including an annual report. |
| **The Collaborative Needs A More Comprehensive Approach To Ensure New Mexicans Have Access To High-Quality Behavioral Health Care.** | |
| **2006 Recommendation** | **Status** |
| Amend the ValueOptions contract to require Collaborative approval of the single entities' use of specific clinical treatment guidelines. | *Partial Implementation* – The Collaborative as a policy body has not approved any guidelines. Collaborative staff has approved use of clinical guidelines, but this is not required per the contract. |
| Require external quality audits to include a review of all services funded by the Collaborative, not just Medicaid managed care. | *Not Implemented* – The Collaborative indicates this requires additional funding. |
| Publish results of ValueOptions quality assessment of its provider network. The Collaborative should also publish specific information on in-patient and residential providers' utilization rates, length of stay, average cost, and performance outcomes. At a minimum, system-wide information should be published and compared to evidence-based standards. | *Not Implemented* – ValueOptions collects much of this information, though it is still not reported publicly through the Collaborative. |
| 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. | *Not Implemented* |

| | |
|---|---|
| **Effective Oversight Of Access To Care And Sufficiency Of Valueoptions' Network Of Providers Is Lacking.** | |
| 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. | *Not Implemented* |
| The Collaborative should periodically audit ValueOptions' to ensure the accuracy of provider lists used to assess the sufficiency of the company's network. | *Not Implemented* |
| 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. | *Not Implemented* – The Collaborative indicates this requires additional funding. |
| **The Promise Of Behavioral Health Reforms Are Great, Though The Results Of The Collaborative's First Two Years Are Mixed.** | |
| **2006 Recommendation** | **Status** |
| Report performance measure and other outcome data to the Legislative Finance Committee as a Collaborative. | *Not Implemented* - Consider requiring in statute. |
| 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. | *Implemented* |
| Report annually, no later than September 1, to the Legislature and public on progress made to transform the behavioral health system. | *Not Implemented* - Consider requiring in statute. |

**APPENDIX B**

# 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
Mary Mastrandrea, Acting CEO, ValueOptions New Mexico
Dorian Dodson, Collaborative Co-Chair
Pam S. Hyde, J.D., Collaborative Co-Chair

FROM: Linda Roebuck, Collaborative CEO

RE: Response to the LFC Follow-Up Review of the Behavioral Health Collaborative

DATE: October 22, 2007

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Thank you for the opportunity to comment on the LFC Follow-Up Review of the Behavioral Health Collaborative. 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 and key cross agency team staff leads regarding the findings and recommendations found in the draft report.

## GENERAL COMMENTS

Many of the specific comments that follow are the same or similar to those expressed in our response to last year's review. We continue to agree with the LFC on some areas and to disagree on others. We remain concerned that there may be continued unrealistic expectations for what is a long-term transformation process - a process that is still in its early stages. There are some activities or data that would not have been expected at this point in the ten-year evolution of this process. The original review began toward the end of the first full year of the contract with ValueOptions. We believe that we were able to provide more and better information during this follow-up than we were able to last year. However, some key milestones still lie ahead.

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 original 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.

Other comments from last year's response are also still true today. VONM has been tasked with handling and untangling programs and funding from multiple departments. While VONM, working with Collaborative agency staff, has made great headway with such things as provider contracts, inconsistent billing practices, provider training, billing rules, and multiple rates, there is much more work to be done in each of these areas. Additionally, as we noted before, 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. As we have said many times, Collaboration is a better way to do things in state government, but it is not easier.

Finally, as a general comment, the dialogue throughout this review process was constructive and informative in identifying areas of improvement and areas needing continued improvement. The report recommends that the Collaborative implement all of the recommendations from last year's report but that alone does not reflect the quality of the process of the review and the fact that the process is an interactive one that recognizes the long-term nature of this transformation. Reviews such as this afford the Collaborative and the LFC opportunities to challenge, learn and develop innovative solutions to support the development of the Collaborative. We acknowledge that we have responded numerous times as to why some of these recommendations are good ones that can be implemented, some recommendations are good ones but cannot be implemented at this time for sound reasons, and some of the recommendations are not valid and we do not plan to implement them. We are therefore repeating ourselves below as we respond to many of the same recommendations to which we have already responded and for which our position has not changed.

**Statutory Changes**

The Collaborative members and staff look forward to working with the Legislature in the upcoming session on potential legislation related to the Collaborative. We maintain our position, however, that some of the recommendations from last year's LFC report and some of the key components of House Bill 727 would neither be necessary nor beneficial.

We might agree that it would be helpful to clarify Collaborative authority. However, any rule-making authority provided to the Collaborative would have to be implemented carefully to prevent inconsistent state rules and regulations. We might also agree that we could work with the LFC better as we present budgets and performance measures as they

pertain to behavioral health. But we continue to disagree with a recommendation to create a unified behavioral health budget and believe that funding to the Statewide Entity should remain in each agency's appropriation, not moved to HSD or any one agency.

Currently, each Collaborative Agency is invested in improving behavioral health outcomes for New Mexico. Removing the funds from these Agencies potentially removes incentives to remain invested and the ability to direct decisions about how the funds are to be spent. Behavioral health outcomes may well become the concern of that single agency that receives all of the funds and collaboration may diminish. Additionally, while the single agency receiving all the funds may be focused on behavioral health goals, it may not do so within the context of the Department needing services for its consumers. For example, CYFD can not separate its protective role from that of assuring appropriate behavioral health services are provided to children and youth in the protective services and juvenile justice systems; the two roles go hand in hand. The report says that consolidation of appropriations "would aide in streamlining the budget process". We contend that streamlining the budget process may be a worthy goal, but may be at odds with many other goals of equal or greater worth.

We also disagree with comments that the current structure "complicates effective public participation". The Collaborative does have clear and consistent processes for making policy and informing the public. Public meetings of the Collaborative are held every month 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 handouts and other materials are also posted. The contract with VONM is posted on the website in draft form to allow for public comment and is then posted in final form. In light of this, we're not clear on the LFC comments that "using the contract process to make or align policy…puts the public at a disadvantage to effective participate in the process."

**Payment and Business Practices**

The comments, findings, and recommendations outlined in this section of the LFC report were also contained in the original 2006 review. Of course the Collaborative will recover from VONM any overpayments, as appropriate, but we have made clear that we disagree with most of these findings and recommendations.

During the start up period, quarterly reconciliation and reallocation did not occur as planned but the difficulties are being addressed and we will be moving to quarterly reviews and decisions about allocations to more effectively manage the funds during the appropriate fiscal year.

Regarding the $15 million reduction in RTC service expenditures mentioned in the report, the Collaborative conducted focused audits of RTC denials to determine whether the denials were appropriate and that children denied that level of care get into appropriate community-based services. We currently have VONM under a Directed Corrective Action Plan regarding these very issues and meet regularly with VONM staff to ensure appropriate and timely implementation of all action items. We will also be tracking distribution of funding through the Children's Purchasing Plan process; identifying where community-based services have not been developed; looking to assure that services are developed and that the previous RTC dollars are shifted to cover the community-based services. The Clinical Home pilot has been helpful in identifying what are needed services; what works, especially from the families and youths' perspective; and what providers need in order to retool to develop alternatives. This is a process still underway. We are continuing to meet with families, providers and VONM staff to identify how to make a community-based system work for everyone.

We disagree that the reimbursement methodology utilized in the VONM contract 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 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.

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.

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.

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, despite a good start last year with VONM's Rate Equalization Plan, are not consistent across the state. 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. This process will not be complete 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 the Statewide Entity to assure quick payments so that quick payments can be made to providers soon after they submit clean claims.

Regarding the TANF program, expenditures were low during the first two years of the VONM contract largely due to a limited scope of offered services. Late in FY07, the scope of services offered through TANF funding was broadened and we are confident that this will lead to greater numbers served and increased spending. Reconciliation will take place shortly after the end of each contract year and HSD will recoup any unspent TANF funds.

**Oversight of Access to Care and Quality of Services**

Earlier this year, we received the "LFC Follow-Up Matrix" outlining all of the recommendations from the 2006 report. In our completion of that Matrix, we made clear how we were, or were not, implementing those recommendations. Below are all of the recommendations included in the Appendix A of the current report and our responses.

*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 has a process for approving contract amendments that includes a final vote by the Collaborative. This process was followed for FY06, the FY06 amendment, the FY07 contract and the FY08 contract. The Collaborative does delegate contract negotiations, including rates, to a team consisting of staff from Collaborative Agencies. Some contract changes or explanations of programs are done through management letters and through addendums that can be signed off by the Co-Chairs and by the impacted department. The meeting minutes have been tightened up over this past year so that decisions made at Collaborative meetings will consistently be reflected in the minutes.

*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 has agreed to publish an annual report and that report will include results of performance, as appropriate and as available. We are certainly interested in efficiency and cost-effectiveness. We believe that some of measures that we have in place

are measures of efficiency and cost-effectiveness. Examples are: admissions at equal or higher level of care; and shifting toward less-costly community-based care through the Children's Plan.

*Amend the VONM contract to require Collaborative approval of the single entities' use of specific clinical treatment guidelines.*

VONM follows APA guidelines in establishing their clinical guidelines. These are national guidelines and sustainable (i.e., could readily be implemented by any future vendor). The clinical guidelines are reported in the Utilization Management Program Description (attached). The UM Program Description is updated annually. It is reviewed and approved by the Oversight Cross Agency Team. The FY07 Plan was approved on 5/1/07.

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

HSD's External Quality Review Organization (EQRO) completes a variety of federally-mandated reviews each year that are focused on Medicaid managed care. However, the contract is written broadly enough such that non-Medicaid areas can be included. Funding is not currently available to implement this. HSD is requesting funding for FY09 for BHSD funding sources so that the EQRO activities can include these non-Medicaid areas. Sources of other compliance reviews are being discussed among Collaborative departments.

*Publish results of VONM's 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.*

While we do not disagree in principle with this recommendation, it may be difficult to achieve at this point. We caution against the use of this kind of tool at this early stage of the system change process.

*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.*

Similar to our response above, we do not disagree with this recommendation conceptually, but feel this should come later in the transformational process. Resources and timing are crucial. This will require significant time and effort by VONM and providers, which are better directed to moving to different types of services and to a fee-for-service funding approach at this time.

*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 VONM's 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 Oversight Cross Agency Team does receive regular reports on the VO provider network, but a true Geo-Access report has proven difficult to implement. We now have a prototype for such a report and are working with VONM to get this report into production. There are, however, other ways that we measure access. There is a performance measure related to the distances that individuals need to travel for services. There are also access related questions on the Mental Health Statistical Improvement Project (MHSIP) consumer satisfaction survey that measure the consumers' perspective on the length of time from request of services to receiving services and the convenience of the location. The 2007 results ranged from 87% to 93% positive on these survey items. A recently implemented VO provider survey also addressed access issues. The Collaborative is in the process of developing a Children's Purchasing Plan that will provide guidance regarding the nature and quantities of BH services to be purchased by the state. This is a preliminary step to being able to specify the geographic distribution of those services.

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

Cross-agency staff regularly review all VONM performance areas. The Oversight Team does regularly review the provider network. In addition, Provider Networks and Standards for Access are items in the annual Compliance Audit that is completed by the HSD contracted External Quality Review Organization. VO scored "Full Compliance" on both of these items for 2007.

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

Reduction of VONM administrative fees to fund this type of external audit would be inappropriate. Other MCOs and other contractors are not asked to contribute to such reviews. VONM's administrative rate for Medicaid managed care is already lower than for other Medicaid managed care contractors, and VONM is already obligated to contribute to evaluation efforts and annually to provider capacity efforts over and above what other contractors are required to do. Compliance auditing is a state oversight obligation. HSD is appropriated funds to do this type of auditing for Medicaid because it is a requirement of the fund source. Neither HSD nor any other department is funded for this type of externally contracted compliance auditing beyond staff to do oversight. HSD is requesting funding to do additional compliance auditing for the FY09 budget process.

In the meantime, the Collaborative includes as much external compliance auditing as it can with limited staff and EQRO contract resources available.

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

The Collaborative reports to the LFC as requested. In a September 2006 presentation, a great amount of information was reported to the Committee, including the Directors' Reports. Performance outcomes on 21 measures are reported quarterly to the Collaborative (most recently on 8-23-07), and provided to LFC whenever BH is the topic of a hearing. Performance outcomes from April 2007 were provided to LHHS on July 19, 2007. We plan on providing information, as appropriate, to the LFC on October 24, 2007. If the LFC has a preference for reporting formats or timelines, we will accommodate to the best of our ability.

*Report annually, no later than September 1, to the Legislature and public on progress made to transform the behavioral health system.*

An annual report covering the first two years of the Collaborative's existence is in process. An annual report for each year thereafter will be developed by the beginning of each Calendar Year for the prior fiscal year, consistent with the annual reports for state departments. Data for prior year quarters are provided to the Collaborative quarterly and are available publicly.