



Presentation to Behavioral Health Services Subcommittee
Linda Homer, CEO, NM Behavioral Health Collaborative
December 2, 2011

Collaborative Overview

New Mexico Behavioral Health Purchasing Collaborative

- ◆ Co-Chairs:
 - Sidonie Squier, Secretary, Human Services Dept.
 - Yolanda Deines, Secretary, Children, Youth & Families Dept.
 - Dr. Catherine Torres, Secretary, Dept. of Health
- ◆ Meetings are held quarterly in Santa Fe and by video conference. Next meeting is on January 12, 2012



Total NM Behavioral Budget FY12/13

(State facilities, Statewide Entity and Other Funds)

- ◆ FY 2012 Operating Budget for Behavioral Health activities is \$425,056.8 of which \$174,125.7 is supported by the general fund.
- ◆ FY 2013 Base Appropriation Request is \$421,799.0 of which \$173,144.2 is from the general fund.
- ◆ This represents a decrease in the FY 2013 Base Appropriation Request:
 - \$981.5 decrease in General Fund request from FY 2012
 - \$3,257.8 decrease in overall request from FY 2012

AGENCY	FLAT	DECREASE	INCREASE
HSD		\$1,650.8	
CYFD		\$2,134.5	
ALTSD	Flat		
DOT		\$514.0	
DDPC			\$402.2
AOC			\$23.2
NMCD		\$2.1	
DFA			\$618.2
DOH	Flat		



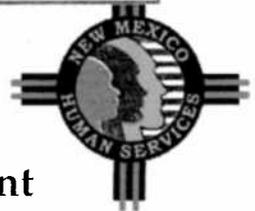
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Budget FY12/FY13

Collaborative Combined Agency Budget for Behavioral Health FY12

AGENCY	GF	OSF	FF	TOTAL
AOC	5,628.4	1,004.4	1,194.7	\$ 7,827.5
DFA		9,381.8		\$ 9,381.8
ALTS	57.5			\$ 57.5
HSD	123,799.5	87.3	213,786.8	\$ 337,673.6
DOH	21,858.5	18,096.8		\$ 39,955.3
CYFD	13,976.0	476.3	2000.0	\$ 16,452.3
Corrections	5,439.9	189		\$ 5,628.0
DOT			4,314.0	\$ 4,314.0
PED				
DDPC	3,365.9	400.0		\$ 3,765.9
GRAND TOTAL				\$ 425,056.8

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Budget FY12/FY13

Collaborative Combined Agency Base Budget Request for Behavioral Health FY13

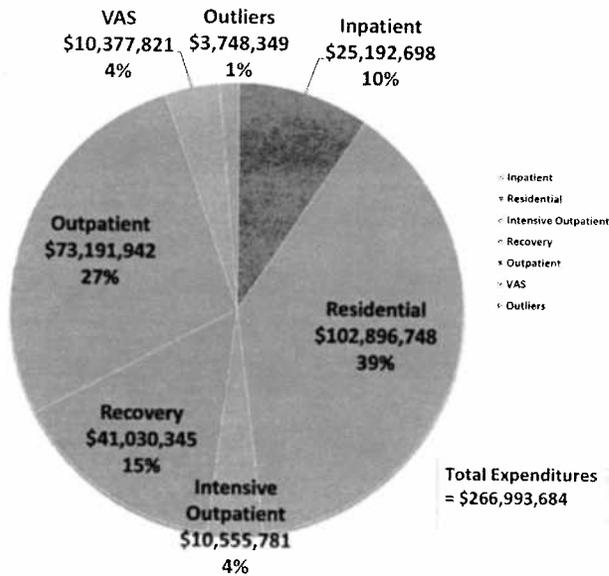
AGENCY	GF	OSF	FF	TOTAL
AOC	5,755.7	995.0	1,100.0	\$ 7,850.5
DFA		10,000.0		\$ 10,000.0
ALTS	57.5			\$ 57.5
HSD	122,425.1	21.0	213,576.7	\$ 336,022.8
DOH	21,858.5	18,096.8		\$ 39,955.3
CYFD	13,841.5	476.3		\$ 14,317.8
Corrections	5,437.8	189.0		\$ 5,626.8
DOT			3,800.0	\$ 3,800.0
PED				
DDPC	3,768.1	400.0		\$ 4,168.1
GRAND TOTAL				\$ 421,799.0

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Statewide Entity Director's Reports – Claims Based Expenditures

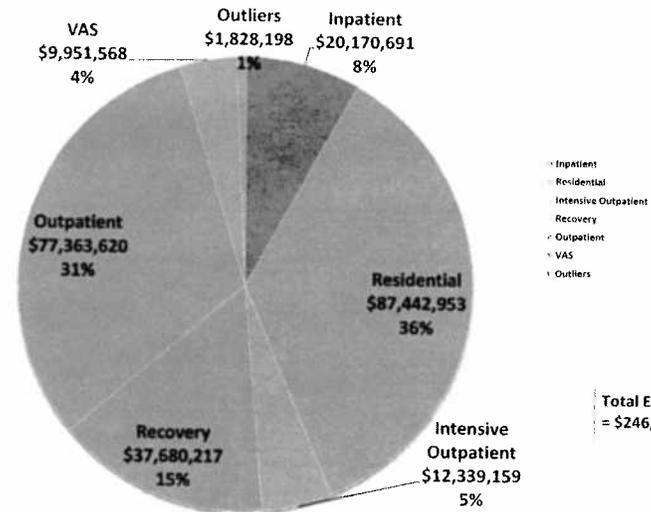
Collaborative Funding FY10
Based on Claims Paid thru 6/26/11



FY10 CI-09 Data as of 6/26/11

Service	Dollar Amount	Percentage
Inpatient	\$25,192,698	9.44%
Residential	\$102,896,748	38.54%
Intensive Outpatient	\$10,555,781	3.95%
Recovery	\$41,030,345	15.37%
Outpatient	\$73,191,942	27.41%
VAS	\$10,377,821	3.89%
Outliers	\$3,748,349	1.40%
Total	\$266,993,684	100.00%

Collaborative Funding FY11
Based on Claims Paid thru 7/16/11



FY11 CI-09 Data Paid Thru 7/16/11

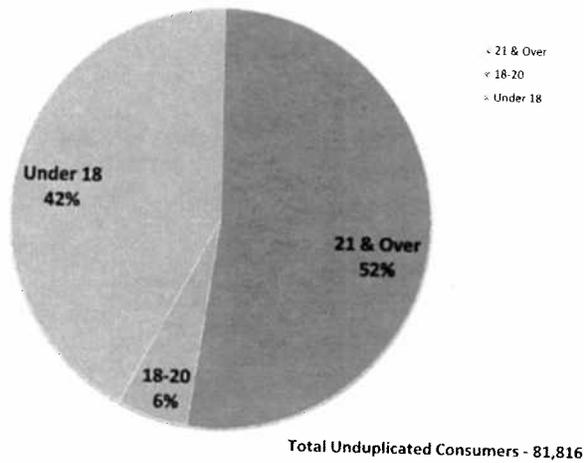
Service	Dollar Amount	Percentage	Difference from FY10
Inpatient	\$20,170,691	8.17%	-\$5,022,007
Residential	\$87,442,953	35.43%	-\$15,453,795
Intensive Outpatient	\$12,339,159	5.00%	\$1,783,378
Recovery	\$37,680,217	15.27%	-\$3,350,128
Outpatient	\$77,363,620	31.35%	\$4,171,678
VAS	\$9,951,568	4.03%	-\$426,253
Outliers	\$1,828,198	0.74%	-\$1,920,151
Total	\$246,776,406	100.00%	-\$20,217,278



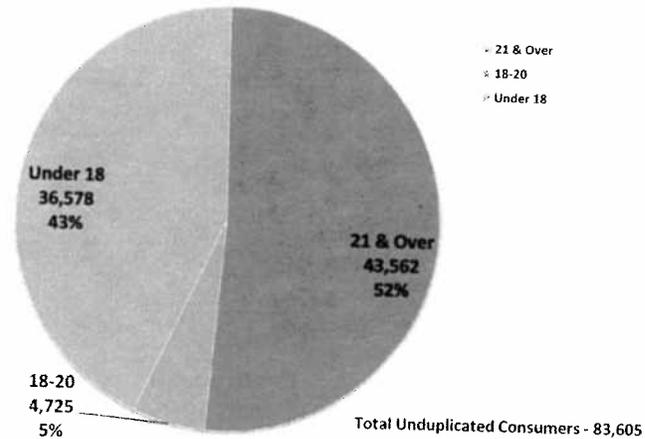
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Statewide Entity Director's Reports – Claims Based Expenditures

Collaborative Funding FY10
Total Unduplicated Consumers by Age Group
Based on Claims Paid as of 6/26/11



Collaborative Funding FY11
Total Unduplicated Consumers by Age Group
Based on Claims Paid through 7/16/11



FY10 Total Unduplicated Consumers Served By Age Group

Age Group	Total Unduplicated Consumers by Age Group	% of Total Unduplicated Consumers
21 & Over	43,346	52.98%
18-20	4,547	5.56%
Under 18	35,104	42.91%
Total*	81,816	100%

*Total represents distinct consumers and may not equal the sum of the column.

FY11 Total Unduplicated Consumers Served by Age Group

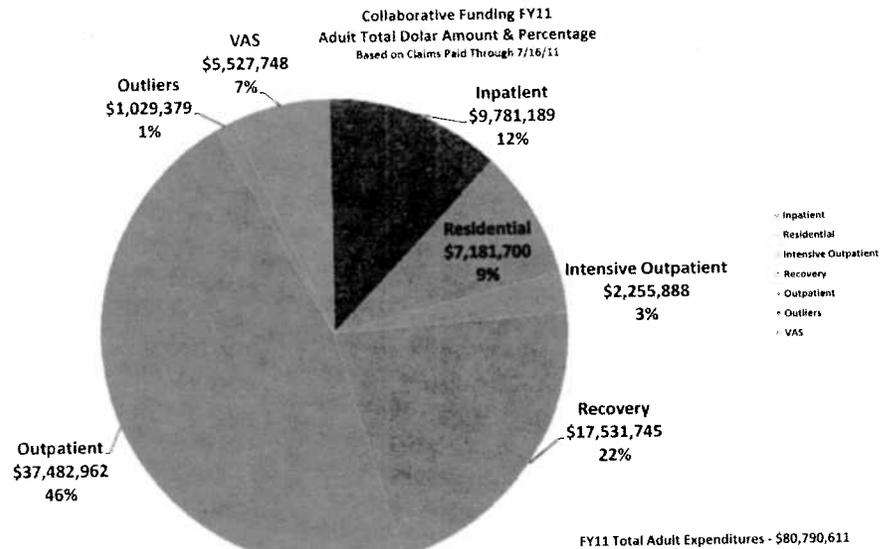
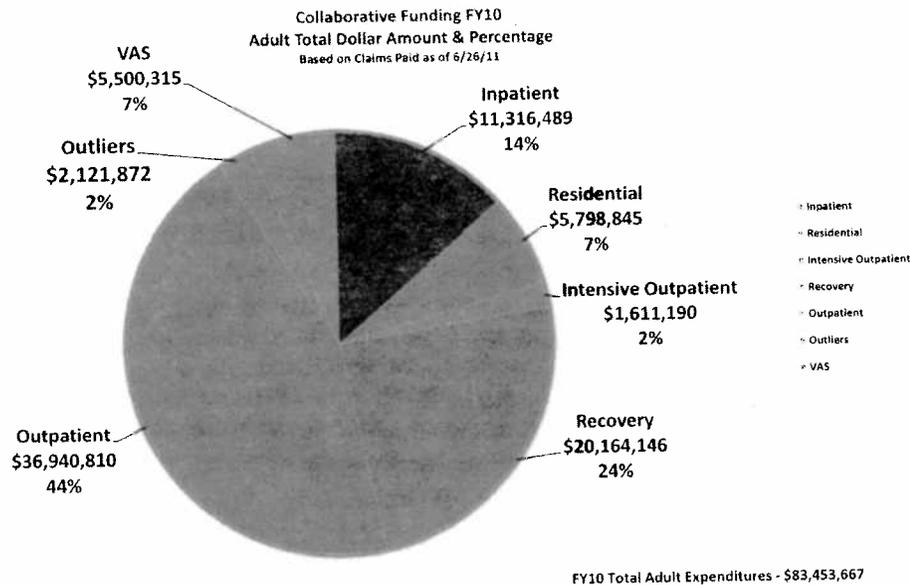
Age Group	Total Unduplicated Consumers by Age Group	% of Total Unduplicated Consumers	Difference From FY10
21 & Over	43,562	52.10%	216
18-20	4,725	5.65%	178
Under 18	36,578	43.75%	1,474
Total*	83,605	100%	1,789

*Total represents distinct consumers and may not equal the sum of the column.

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Statewide Entity Director's Reports – Claims Based Services Adult Services



FY10 Adult Total Dollar Amount & Percentage

Service	Dollar Amount	Percentage
Inpatient	\$11,316,489	13.56%
Residential	\$5,798,845	6.95%
Intensive Outpatient	\$1,611,190	1.93%
Recovery	\$20,164,146	24.16%
Outpatient	\$36,940,810	44.27%
Outliers	\$2,121,872	2.54%
VAS	\$5,500,315	6.59%
Total	\$83,453,667	100.00%

FY11 Adult Total Dollar Amount & Percentage

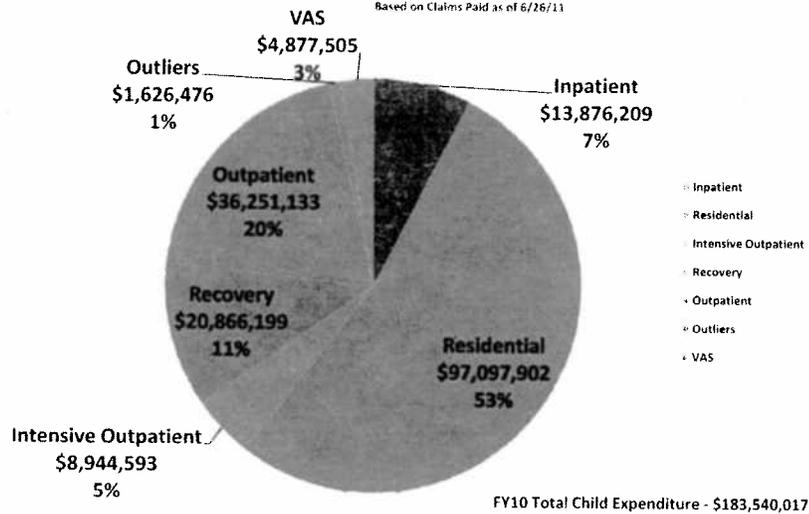
Service	Dollar Amount	Percentage	Difference From FY10
Inpatient	\$9,781,189	12.11%	-\$1,535,300
Residential	\$7,181,700	8.89%	-\$1,382,855
Intensive Outpatient	\$2,255,888	2.79%	\$644,698
Recovery	\$17,531,745	21.70%	-\$2,632,401
Outpatient	\$37,482,962	46.40%	\$542,152
Outliers	\$1,029,379	1.27%	-\$1,092,493
VAS	\$5,527,748	6.84%	\$27,433
Total	\$80,790,611	100.00%	-\$2,663,056

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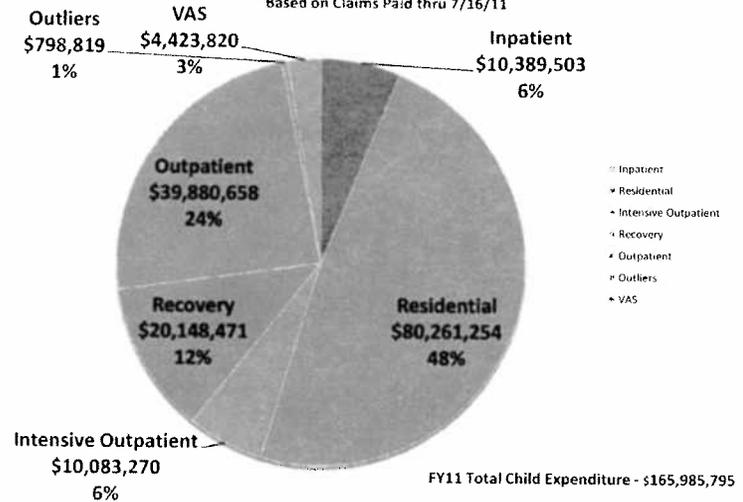


Statewide Entity Director's Reports - Claims Based Expenditures, Child Services

Collaborative Funding FY10
Child Total Dollar Amount & Percentage
Based on Claims Paid as of 6/26/11



Collaborative Funding FY11
Child Total dollar Amount & Percentage
Based on Claims Paid thru 7/16/11



FY10 Child Total Dollar Amount & Percentage

Service	Dollar Amount	Percentage
Inpatient	\$13,876,209	7.56%
Residential	\$97,097,902	52.90%
Intensive Outpatient	\$8,944,593	4.87%
Recovery	\$20,866,199	11.37%
Outpatient	\$36,251,133	19.75%
Outliers	\$1,626,476	0.89%
VAS	\$4,877,505	2.66%
Total	\$183,540,017	100.00%

FY11 Child Total Dollar Amount & Percentage

Service	Dollar Amount	Percentage	Difference for FY10
Inpatient	\$10,389,503	6.26%	-\$3,486,706
Residential	\$80,261,254	48.35%	-\$16,836,648
Intensive Outpatient	\$10,083,270	6.07%	\$1,138,677
Recovery	\$20,148,471	12.14%	-\$717,728
Outpatient	\$39,880,658	24.03%	\$3,629,525
Outliers	\$798,819	0.48%	-\$827,657
VAS	\$4,423,820	2.67%	-\$453,685
Total	\$165,985,795	100.00%	-\$17,554,222

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Status of Collaborative Contract Actions

Status of Directed Corrective Action Plan (DCAP) of Statewide Entity

- ◆ Ongoing monitoring of OHNM by the Collaborative
- ◆ Began July 1, 2011 led by Deputy CEO and Oversight Team of the Collaborative
- ◆ Oversight Team with working subcommittee structure assists with monitoring functions
 - Monitoring Quality Issues
 - Monitoring Contract Performance
 - Oversight of all Policy and Procedures
 - Closing out DCAP items

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Status of Collaborative Contract Actions

DCAP ITEMS PENDING CLOSURE:

- ◆ Expedited Payment Reconciliation – Closed pending communication to providers
- ◆ Encounter Data – Closed pending final meeting with Medicaid
- ◆ Fund management and mapping – Closed pending Oversight Team review of new policies and procedures for fund management
- ◆ Call Center and Complaint Monitoring – OHNM regional offices have been restructured, item closed pending implementation of restructuring plan
- ◆ Oversight continues to monitor steady state for 6 months



Status of Collaborative Contract Actions

Clinical Triggers

◆ History

- OptumHealth New Mexico was sanctioned on February 16, 2011 for not adopting guidelines for clinical triggers for claims submitted for Behavioral Management Skills (BMS) and Psychosocial Rehabilitation (PSR) services in consultation with contracting health care professionals, network providers or the Collaborative.

◆ Remediation

- OHNM implemented newly established guidelines for BMS & PSR of 350 units per month, instead of 4 units per day in April 2011.
- OHNM began the reconsideration process of BMS & PSR claims from January – March 2011 on 4/7/11.
- OHNM agreed to pay providers that resubmitted claims from January – March, 2011, based on the newly established guidelines, including paying interest from when claims were first submitted in the January – March timeframe.



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Status of Collaborative Contract Actions

Remediation (cont.)

- ◆ January 1 – March 31, 2011 OHNM received invoices in the adjusted amount of \$2.9M
 - Out of those invoices, OHNM initially paid \$1.7M
 - OHNM denied \$1.2M in the amount of adjusted claims because of clinical triggers
- ◆ Since April, 2011:
 - OHNM has paid \$626,503.85 from reconsideration requests
 - Final Total Amount of Claims Paid: \$2.3 M out of \$2.9 M in claims (79%)
 - Final Total Interest Paid: \$55,676.32
 - \$335,309.63 was billed by 17 providers and submitted for reconsideration and denied. The review of these records is being conducted internal to HSD to finalize completion of the sanction.
 - The remaining amount was not resubmitted to OptumHealth for reconsideration.



Performance and Quality Measures

◆ Quality Services Review

- Systematic approach to clinical practice improvement among the core services agencies
- 173 staff in 23 core services agencies trained

◆ Telehealth Services

- Provided to over 1,100 consumers, 59% of whom resided in rural counties and another 25% lived in rural counties
- Primary services were pharmacologic management and diagnostics services
- Eighty one (81%) of the services were to children under 18 years of age.
- Over 85% were very positive with their telemedicine service experience.

◆ Monitoring appropriate psychotropic prescribing practices for children throughout the state

- Criteria have been developed to identify “outlier prescribing practices.”

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Grants of the Collaborative

- ◆ **Mental Health and Substance Abuse Prevention**
 - **State Prevention Framework State Prevention Enhancement Award:** Amount: \$600,000.
 - **State Epidemiological Outcomes Workgroup:**
Amount: \$150,000
- ◆ **Enforcement**
 - *Sales of tobacco Products to Underage Youth:*
Amount: \$684,720.00 Year One Base Amount, \$657,922.14 Option Period 1, and \$655,452.16 Option Period 2.



Priorities of the Collaborative

◆ Research

- *Implementing Best Practices:* Amount: Year One-\$187,624; Year 2-\$178,222 and Year 3-\$174,587.

◆ Treatment

- *Residential Substance Abuse Treatment for Pregnant and Post Partum Women and their Children:* Amount: \$524,000 per year.
- *Veteran Services:* Jail Diversion Veterans First grant: Amount: \$393,711 per year for five total of \$1,968,555.
- **Substance Abuse Services:** Access to Recovery grant: Amount: \$3,303,775 per year for five total of \$13,215,000



Priorities of the Collaborative

- ◆ Integration of Behavioral and Physical Health Practice
 - Health Homes Initiative
- ◆ 10 x 10 Campaign
 - Behavioral Health Planning Council
- ◆ Suicide Prevention
 - Native American focus
- ◆ Substance Abuse Treatment System
 - Critical need for adolescent programs
- ◆ Opioid Memorial
- ◆ Crisis Memorial
- ◆ Medicaid Modernization/Rebid of Behavioral Health



Expert Panel

TABLE 1: FOUR QUADRANTS OF CLINICAL INTEGRATION BASED ON PATIENT NEEDS

HIGH → BEHAVIORAL HEALTH RISK/COMPLEXITY ← BEHAVIORAL HEALTH RISK/COMPLEXITY → LOW	QUADRANT II	QUADRANT IV
	Patients with high behavioral health and low physical health needs Served in primary care and specialty mental health settings (Example: patients with bipolar disorder and chronic pain) Note: when mental health needs are stable, often mental health care can be transitioned back to primary care.	Patients with high behavioral health and high physical health needs Served in primary care and specialty mental health settings (Example: patients with schizophrenia and metabolic syndrome or hepatitis C)
	QUADRANT I	QUADRANT III
	Patients with low behavioral health and low physical health needs Served in primary care setting (Example: patients with moderate alcohol abuse and fibromyalgia)	Patients with low behavioral health and high physical health needs Served in primary care setting (Example: patients with moderate depression and uncontrolled diabetes)
	LOW ← PHYSICAL HEALTH RISK/COMPLEXITY → HIGH	
	Source: Adapted from Mauer 2006.	

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Quadrant I
BH ↓ PH ↓

- PCP (with standard screening tools and BH practice guidelines)
- PCP-based BH*

- ◆ Screening and early detection, early intervention as priority
- ◆ Potential SBIRT site
- ◆ Wellness and education support
- ◆ Cost- Savings from early detection, early treatment, prevention of movement to high end behavioral health/ medical conditions



Expert Panel

Quadrant III
BH ↓ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- Care/Disease Manager
- Specialty medical/surgical
- PCP-based BH (or in specific specialties)*
- ER
- Medical/surgical IP
- SNF/home based care
- Other community supports

- ◆ Primary health site with strong behavioral health consultation
- ◆ Early screening of people with medical conditions for behavioral health problems
- ◆ Savings come when people with chronic illness get depression treatment, leading to better self-care, less time in ER, hospital, and with less BH treatment needs.
- ◆ Cost savings mostly seen on medical side



Expert Panel

Quadrant II
BH ↑ PH ↓

- BH Case Manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and BH practice guidelines)
- Specialty BH
- Residential BH
- Crisis/ER
- Behavioral Health IP
- Other community supports

- ◆ BH side of system, with community based & Core Service Agency (CSA) services for people with SED and SMI
- ◆ Physical health is done as a potential consult or with warm handoff to primary care
- ◆ Cost-savings come from effective early intervention and treatment for BH, leading to decreased inpatient and RTC services
- ◆ Later cost savings after several years with successful community care

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Expert Panel

Quadrant IV
BH ↑ PH ↑

- PCP (with standard screening tools and BH practice guidelines)
- BH Case Manager w/ responsibility for coordination w/ PCP and Disease Mgr
- Care/Disease Manager
- Specialty medical/surgical
- Specialty BH
- Residential BH
- Crisis/ ER
- BH and medical/surgical IP
- Other community supports

- ◆ Strongest Integration quadrant for people with chronic or severe behavioral health and medical conditions
- ◆ BH medical home in CSAs
- ◆ Easy access to both BH and PC services, working side-by-side to ensure quality care
- ◆ Cost savings come from both effective community-based BH care, minimizing IP and RTC, and effective medical care, minimizing ER and medical IP visits.



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Expert Panel

◆ Overarching Conclusions- Structure

- Consensus that improvement in specific behavioral health outcomes for consumers and families is more critical than the specific model selected (carve in, carve out, or a hybrid model)
- Critical need to increase integration of behavioral health with primary care
- Interest in local/regional governance and administrative structures within any new model
- Some strong voices that the next entity/entities that manage the behavioral health system should be a non-profit(s) and possibly a New Mexico agency(ies)



Expert Panel

- ◆ Overarching Conclusions-Funding
 - The need to protect behavioral health funding
 - Funding for behavioral health services should be tracked and administered separately
 - A greater percent of behavioral health dollars should be spent on services and a smaller percent on administration



Expert Panel

◆ Collaborative Action

- October 2011 Collaborative voted to proceed with carve-in with physical health with protections for behavioral health
- Examples of Protection for Carve-In
 - Examples of Protections for Hybrid Model
 - Separate per member per month rate for behavioral health
 - Requirement that MCO(s) contract directly with New Mexico providers/provider networks
 - Requirement that behavioral health savings be tracked and reinvested into BH system



Next Steps and Timeline

- ◆ Next Collaborative Meeting: January 12, 2012
- ◆ RFP/Development: January-March
- ◆ Rebid of Behavioral Health Contract – TBD
- ◆ Health Home Phase In – Spring 2012
- ◆ Crisis Services – FY13

