Report
to
The LEGISLATIVE FINANCE COMMITTEE

Human Services Department
Cost and Outcomes of Selected Behavioral Health Grants and Spending
May 16, 2013

Report #13-04

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David Abbey
Director

May 16, 2013

Ms. Sidonie Squier, Secretary
Human Services Department
2009 S. Pacheco St. – Pollon Plaza
Santa Fe, New Mexico 87505

Dear Secretary Squier:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the *Evaluation of the Cost and Outcomes of Selected Behavioral Health Grants and Spending* for the Human Services Department. The evaluation team examined the state and federally funded adult behavioral health services under the purview of the Behavioral Health Services Division and the current health and the consumer outcomes being achieved through the behavioral health system.

The report will be presented to the Committee on May 16, 2013. An exit conference was conducted with the Human Services Department to discuss the contents on May 10, 2013. The Committee would like a plan to address the recommendations in this report within 30 days from the date of the hearing.

I believe this report addresses issues the Committee asked us to review. We appreciate the cooperation and assistance from the agency's staff and OptumHealth New Mexico.

Sincerely,

David Abbey, Director

Cc: Representative Luciano "Lucky" Varela, Chairman, Legislative Finance Committee
Senator John Arthur Smith, Vice-Chairman, Legislative Finance Committee
Representative Henry "Kiki" Saavedra, Legislative Finance Committee

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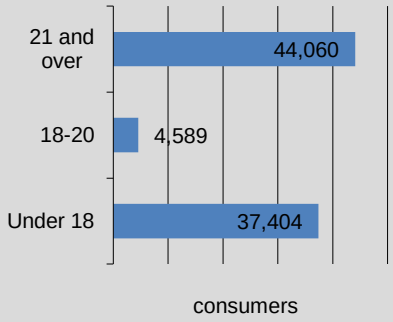
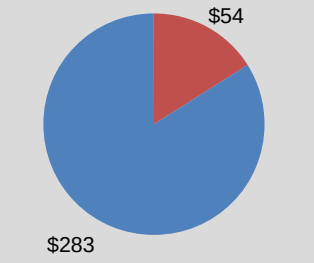
Collaborative Funding: Total Unduplicated Consumers by Age Group, FY12



Source: OptumHealth Service Utilization Report, FY12

Eight of the 10 leading causes of death in New Mexico are at least partially the result of the abuse of alcohol, tobacco, or other drugs.

HSD Behavioral Health Spending, FY12
(in millions)



Source: BHC FY14 Master Compilation

New Mexicans face serious substance abuse and mental health issues affecting personal health and families, and impacting societal issues including unemployment, crime, poverty and homelessness. Over the past 30 years, New Mexico has consistently had among the highest alcohol-related death rates in the United States and the highest drug-induced death rate in the nation. Suicide is also a serious and persistent public health problem in the state and is the second leading cause of death among New Mexico youth of high school age. A 2002 behavioral health needs assessment estimated 165 thousand New Mexicans' conditions likely required services through publicly funded programs.

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 and assess ongoing needs and gaps in services. In FY12, agencies spent $424 million for services to 85 thousand consumers of behavioral health services though a single statewide managed care organization, OptumHealth. Most of this spending, $337 million, is by the Human Services Department (HSD), and includes $283 million from Medicaid and $54 million for non-Medicaid services.

The Legislative Finance Committee (LFC) has conducted a number of evaluations on behavioral health over the past decade, including examining the Collaborative. This evaluation focused on the cost and outcomes of non-Medicaid behavioral health programs funded through the Behavioral Health Services Division (BHSD). This funding serves as the safety net for those individuals not eligible for Medicaid, such as childless adults, or to pay for services not covered under Medicaid. The importance of these services is highlighted by federal changes to health insurance under the Affordable Care Act and the expansion of the state's Medicaid program. Many New Mexicans will now receive behavioral health services through Medicaid rather than BHSD non-Medicaid funding. As a result, the level and purpose of state funding for these services requires a re-examination.

The BHSD needs to provide better oversight and monitoring of service delivery and program integrity for these critical access services, particularly as the state transitions into a more complicated administrative arrangement. Under the Medicaid Centennial Care program, the HSD will contract with four managed care organizations (MCO) to provide physical and behavioral health services to Medicaid enrollees, while OptumHealth will continue to manage the non-Medicaid funds. Reporting over the network availability of providers and the use and outcomes of these services currently needs improvement. The state has mixed results in using BHSD funds to develop new and innovative evidence-based behavioral health services. For example, one service found highly effective was discontinued because a federal grant ended, and the service was not integrated into the regular continuum of Medicaid and non-Medicaid services. In other cases, evidence-based services, such as intensive outpatient therapy, are not available in high need areas like Albuquerque.

New Mexico leads the United States in deaths from drug overdoses, now exceeding deaths from motor vehicle crashes. The Department of Health estimates as many as 200 thousand abusers of illicit or prescription drugs, with at least 25 thousand of those being injection drug users.

New Mexico Behavioral Health Collaborative Regions

Region 1	Northwestern NM
Region 2	Northeastern NM
Region 3	Bernalillo County
Region 4	Southeastern NM
Region 5	Southwestern New NM
Region 6	Native Americans

Source: NM Behavioral Health Collaborative Regional Map

KEY FINDINGS

Despite increased funding, since FY10, fewer people have received services through BHSD funding sources, and outcomes still fall short of performance targets. In FY12, the BHSD non-Medicaid spending served 24 thousand New Mexicans not eligible for Medicaid at a cost of $54 million, or 16 percent of the total $337 of the HSD's total behavioral health spending. Since FY11, the BHSD non-Medicaid state and federal appropriations increased from $54 to $59 million. The number of consumers served in FY12 decreased 10 percent from FY11 despite an increase in state expenditures and a demonstrated need for services.

The BHSD non-Medicaid state appropriations for contractual services for provider reimbursement have declined. From FY10 to FY13, the general fund portion of contractual services appropriations decreased by $2 million, offset by an increase in $4 million from other sources. As a result, the system has replaced flexible funding (state) with more targeted grant funding from the federal government. In FY12, OptumHealth reports show that $33.4 million services funded patient services. In FY12, OptumHealth was paid more than $4 million in the BHSD state general appropriations for administrative fees.

Statewide expenditures have increased, but significant variations exist across the state. The differences in consumers served by region are significant. The number of consumers served per 1,000 population ranges from eight in Region to 32 in Region 4. The FY12 increase in expenditures is primarily driven by Region 4 expenditures. Region 4 (southeast) continues to provide more consumers with more services than other regions, even though it has the lowest population of all the regions.

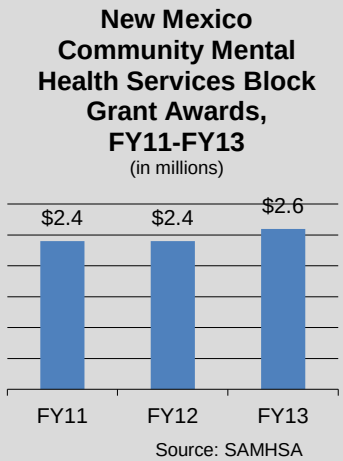
Units of service are driving the expenditure increase from FY11 to FY12. OptumHealth reports a $1.5 million increase in provider reimbursement from FY11 to FY12 despite a decrease in number of consumers served. The increase is driven by increased utilization of services. OptumHealth is not at risk for expenditures and providers are reimbursed through a fee-for-service method, minimizing the need to monitor utilization as it relates to quality or cost. Although non-Medicaid funding is limited, attention to cost-efficiency and value-based purchasing is necessary to ensure state funds are appropriately used to improve the health status of consumers.

More than $1 million in FY12 expenditures were labeled as "uncategorized" in OptumHealth reports. When a provider does not assign a diagnostic category to a consumer the claims is identified as uncategorized. Without knowing diagnostic categories, such as seriously mentally ill or co-occurring disorders, the BHSD is handicapped in evaluating incidence of disease and need for services, important in resource allocation.

Consumer outcome results have been inconsistent for past three years. Based on quarterly reporting, consumers with alcohol dependency ranked their progress higher than those with drug dependency and exceeded the target. However, based on these measures, consumers do not appear to have adequate access to follow up care within 30 days of inpatient discharge.

Source: BHSD 06 Reports

The Community Mental Health Services Block Grant is the principal federal discretionary program supporting community-based mental health services for adults with serious mental illnesses and child with serious emotional disturbances.



Source: SAMHSA

Consumer outcomes may be negatively impacted when the state fails to react to available data. While the creation of programs to decrease hospitalizations and improve system efficiency expanded available services to consumers, they have not positively impacted high intensity, high cost service utilization. Regional choice of services may not be tied to consumer need. Regions 1 and 2 rely heavily on residential support services to treat substance abuse problems. The average length of stay for two of the residential facilities is 24 days, while the third has an average length of stay of 54 days.

With the expansion of New Mexico's Medicaid program, the need for state-funded behavioral health services may decrease. Given previous assessments of service needs and gaps, many more New Mexicans who currently do not access the system or receive some services through BHSD non-Medicaid, will likely access behavioral health services through Medicaid. Currently, a source of payment acts as a major impediment to thousands of individuals, primarily childless adults, eligible BHSD through non-Medicaid funding. More information on projected newly eligible Medicaid behavioral health consumers and a current service gaps analysis is needed to assess future funding needs for the BHSD in light of potential decreased need. For example, the state should explore repurposing some of the appropriations from the general fund from the BHSD to Medicaid.

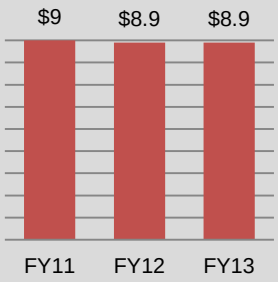
The two longest-standing block grants, the Community Mental Health Services Block Grant and the Substance Abuse and Prevention Block Grant, average $11.5 million per year for BHSD funding. The Substance Abuse and Mental Health Services Administration (SAMHSA) allows latitude in use of the two block grants, which affords the state the opportunity to address state-specific issues. Block grants are only available to state mental health and substance abuse authorities. The BHSD, through the statewide entity, contracts with eligible providers to provide services funded from federal grants. These grants can and have been used to implement new and innovative evidence-based services that could eventually be included in the full Medicaid benefit package.

The maintenance of effort (MOE) requirement for future block grant funding may provide reason for the state to evaluate the value of block grant funding with regard to Medicaid expansion. A major provision of the block grant awards requires states to maintain expenditures for authorized activities at a level no less than the two-year average of expenditures preceding the year in which the state is applying for the grant. With more consumers becoming eligible for Medicaid behavioral health services under program expansion, the existing level of state funding used to meet MOE requirements for the block grants could be repurposed to support the growth in the Medicaid behavioral health population.

Other federal grant funding can be used as seed money to initiate new programs targeting special needs and gaps and to support existing programs. Grant funding supplements the state's ability to provide services to consumers. Two types of funding, formula block and discretionary grants are awarded through SAMHSA. Discretionary grants are open to the state, local governments, and service providers. From FY10 to FY12, state departments received $26 million in discretionary grants.

The Substance Abuse Prevention and Treatment Block Grant supports substance abuse programs. The grant funds are dedicated to treatment and prevention services for substance abuse and are more prescriptive in use of funds than the Community Mental Health Services Block Grant.

New Mexico Substance Abuse Prevention and Treatment Block Grant Awards, FY11-FY13
(in millions)



Source: SAMHSA

The New Mexico Drug Policy Task Force found the Collaborative partially addresses the multi-departmental fragmentation of behavioral health services, but with its focus primarily on the financing of patient services, leaves many programs separated and scattered working with various degrees of independence.

Recent events like the investigation of potential Medicaid fraud at a provider facility demonstrate the need for a stronger, better coordinated system to monitor program integrity of non-Medicaid BHSD funds as well. Gaps in the existing system are highlighted by this occurrence. Provider agency personnel reported potential fraud. OptumHealth reports identify the provider as high- cost, high-volume with a significant number of claims centered on a single service. These factors should have placed the provider on high surveillance as an at-risk agency. Several other OptumHealth contracted providers match this profile. Ensuring the integrity of financial practices and delivering services which have proven effective are fundamental components of a health system. Four MCOs and one statewide entity will increase the need for the BHSD to more closely the monitor system for program integrity to prevent misuse of public funds.

The HSD has contracted for $3 million with an outside vendor to audit the billing practices and quality of care of many providers across the state. The contract is to prepare audit teams, establish standards for financial and IT/policy audit, lead audit teams, coordinate audits with MCOs and state staff, lead interviews of provider staff and others as appropriate, and prepare a final audit report. The BHSD anticipates a late May 2013 report from the auditing firm.

As the statewide entity, OptumHealth and the HSD Inspector General are responsible for reviewing program integrity for the BHSD. The contract between the BHSD and OptumHealth specifies key program integrity components, but the contract lacks direction to OptumHealth, minimizing the BHSD's knowledge of program effectiveness. The contract does not specify any performance measures which would enable the division to assess program effectiveness nor does it provide for incentives or disincentives for operation of an effective program. The HSD's Inspector General is responsible for prevention, detection, and investigation of fraud, waste, and abuse in the public assistance programs administered by the HSD but has not conducted audits of the programs.

Diligence in monitoring provider activities for program integrity is weak for BHSD funding. While the contract does not preclude monitoring of state general fund use, prevention and detection efforts have been directed only to Medicaid funds. With New Mexico's limited ability to expand state funding, it is important the dollars are protected for their intended use.

The HSD denied access to records for LFC staff that was necessary to assure clients were actually receiving high quality care and ensure the appropriate use of public funds. Requests were made to the BHSD to allow evaluation staff to conduct a review of claims and then validate receipt of service and quality of service through on-site reviews of consumer records. The reviews would have allowed analyses of billing processes and clinical care delivery. The HSD denied the request for access citing federal privacy laws. However, other legislative offices similar to LFC have conducted the same type of file review, including Arizona and Utah. Federal health and behavioral health privacy laws specifically allow for this type of review.

Letter of Direction #163: Directs OptumHealth to identify and fund a qualified consultant to fulfill the duties of the federally-mandated substance abuse treatment authority until the BHSD employed a person for the vacant position. The consultant was to be paid $55 per hour, not to exceed $24,750.

Centennial Care requires individuals with behavioral health expertise be members of each MCO's leadership structure.

NM Behavioral Health Providers Licensed in 2013

Credential	Number
Licensed Alcohol and Drug Abuse Counselors	650
Licensed Professional Clinical Counselors	1875
Licensed Mental Health Counselors	832
Licensed Marriage and Family Therapists	314
Licensed Professional Counselors	357
Licensed Substance Abuse Associate	326
Psychologists	705
Prescribing Psychologists	39
Licensed Bachelor's Social Workers	650
Licensed Master's Social Workers	1,296
Licensed Independent Social Workers	1,668

Source: NM Regulation and Licensing Department

The Collaborative's Letters of Direction impede transparency on the use of public funds. From 2009 to 2012, the Collaborative issued over 170 letters to the statewide entity. Most of the letters issued relate to changes in funding, services, or programs. Dispersing funds through multiple letters and funding sources does not give a true accounting of all reimbursements received by a provider.

The BHSD must ensure letters maintain the intent of funding, are not primarily a mechanism to expend unallocated money, and do not violate statute or regulation. End-of-year letters do not appear to allow time for completion of directions. Also, letters may excuse a provider's inability to submit accurate or timely claims, deliver services for which accounting is difficult, or lack of capacity to meet workload expectations. Letters are issued relieving providers of using claim submission for reimbursement purposes. Transferring funds to a private entity, OptumHealth, allows state purchases which otherwise would require requests for proposals in the state system.

The Collaborative has not maintained an ongoing assessment of system capacity to prepare for major changes in behavioral health delivery. However, the BHSD has implemented programs and services to enhance New Mexico's behavioral health system. System enhancements include the establishment of core service agencies modeled after the medical home concept, New Mexico's first crisis and access line staffed by mental health professionals, mental health first aid training to inform the public how to interact with at-risk behavioral health consumers, and free services to veterans until their federal benefits are approved.

Significant healthcare reform under the federal Affordable Care Act and state Medicaid expansion will change the delivery of both Medicaid and non-Medicaid behavioral health services. Beginning in January 2014, four MCOs will have contracts with the HSD to implement Centennial Care integrating behavioral health into Medicaid physical health for clients within the MCOs, while OptumHealth will continue as the statewide entity for federal and state general funding. Centennial Care will expand services for Medicaid behavioral health consumers through health homes. A health home mimics the medical home model with responsibilities to provide comprehensive care management. The plan over the next four years is to provide incentives to MCOs to proliferate health homes.

Stronger control of the behavioral health system could occur with improvements in authority and administration. With multiple changes occurring simultaneously in the behavioral health system, active participation of all Collaborative members is needed. The HSD has not articulated how the statewide entity for non-Medicaid behavioral health funding would interact with MCOs and providers to ensure the coordination of care between the BHSD and Medicaid services.

The BHSD does not regularly inventory behavioral health needs statewide and the OptumHealth reporting of differences in provider access is inadequately presented to the BHSD. A thorough analysis of the gap between the need for and provision of behavioral health services has not been performed since 2002 to inform New Mexico's major behavioral health

Evidence-based practices are the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.

BHSD Administered Federal Behavioral Health Grants and Contracts, FY12

Federal Funds	Amount
Access to Recovery III	$2.9 million
Jail Diversion Veterans First	$394 thousand
Data Infrastructure Grant	$13 thousand
Drug and Alcohol Information Services	$21 thousand
National Institute on Drug Abuse	$144 thousand
Strategic Prevention Framework State Prevention Enhancement Grant	$600 thousand
Mental Health Transformation Grant: Healthy Homes	$670 thousand
Federal Drug and Administration (FDA) Tobacco Inspection Contract	Reimbursement
Pregnant and Postpartum Women-Crossroads Supporting Families	$392 thousand
Projects for Assistance in Transition from Homeless	$295 thousand

Source: HSD

system transformations, in spite of statutory requirements. The Collaborative is directed to identify behavioral health needs statewide, with an emphasis on that hiatus between needs and services set forth in the Department of Health's (DOH) gap analysis and in ongoing needs assessments, and develop a master plan for statewide delivery of services.

Evidenced-based practices provide a high-probability that outcomes for consumers will improve and the use of public monies will be more efficient. In recognition of the value of evidenced-based practices, the SAMHSA provides grant funding targeting the implementation of evidenced-based practices for mental illness and substance abuse. New Mexico has funded evidenced-based practices through federal grants and state general funds, but implementation is minimal.

Policymakers are becoming more aware of the benefits of evidenced-based practices and have taken actions to ensure public funding is directed to health interventions which have monetary and health benefits. From 2009 to 2011, the Oregon legislature directed state agencies to spend increasing shares of public dollars on evidenced-based practices, culminating in 75 percent by the end of the budget period. In the mid-1990's, the Washington state legislature directed the Washington State Institute on Public Policy to research interventions that have been shown to improve particular outcomes. With this information, policymakers can budget for better outcomes for service recipients and a more efficient use of taxpayer dollars.

Screening Brief Intervention and Referral to Treatment (SBIRT) and drug courts are examples of evidence-based programs with demonstrated success in New Mexico. An independent evaluation of the New Mexico SBIRT program found participants decreased the number of days of alcohol use, the days of illegal drug use, and the rate of substance abuse caused by stress. Data on drug courts both locally and nationally shows them to be effective at reducing the substance abuse and recidivism of drug-dependent offenders at a relatively low cost.

KEY RECOMMENDATIONS

The Legislature should:

The Legislature should require the HSD to complete a Medicaid eligibility projection and a behavioral health needs and gaps analysis to justify the BHSD funding at existing levels. Consider repurposing at least 50 percent of current state funding levels for the BHSD non-Medicaid services to Medicaid by FY16, or based on results of the HSD needs and gaps study.

The BHSD should:

Report the results of the behavioral health provider audits to the LFC.

Require a sustainability plan be developed prior to the submission of grant applications;

Clarify the role of the HSD Inspector General in the auditing process;

Strengthen oversight of the statewide entity's monitoring of program integrity;

Direct the process by which information will be exchanged between the statewide entity and the MCOs to ensure the BHSD has consistent data by which to administer the system and to ensure consumer services are efficient and timely;

Require the statewide entity and Centennial Care MCOs to provide more detailed analyses of financial, service utilization, and provider access information for monitoring of the behavioral health system performance and to target resources appropriately;

Establish performance measures in MCO contracts which would aid in monitoring the level of provider oversight for program integrity by MCOs;

Develop a minimum provider outcome data set to present to the Legislature, to display on public websites or to provide to the public on request; and

Prioritize service funding to evidence-based practices.

Over the past 30 years, New Mexico consistently has among the highest alcohol-related death rates in the United States and the highest drug-induced death rate in the nation. Prescription opioid sales are now greater than in the rest of the United States and prescription drug overdose deaths are now more common than illicit drug overdose deaths. Suicide is also a serious and persistent public health problem in the state and is the second leading cause of death among New Mexico youth of high school age. Thirty percent of adults served through the state's mental health agency have a co-occurring mental health and substance abuse disorder while the United States average is 21 percent.

New Mexicans face serious substance abuse and mental health issues affecting their personal health and families and impact other societal issues including unemployment, crime, poverty and homelessness. Over 500 thousand people in the state have substance abuse/dependence or mental health disorders and about a third of this population needs services from the publicly funded behavioral health system, based on estimates from the 2002 New Mexico behavioral health needs assessment and gap analysis project. Eight of the 10 leading causes of death in New Mexico are at least partially the result of the abuse of alcohol, tobacco, or other drugs. According to the New Mexico Department of Health (DOH), the economic cost of alcohol abuse alone in New Mexico was more than $2.5 billion in 2006, or $1,250 per person.

New Mexico's residents not only display concerning behaviors of illicit and prescription drug abuse, but those needing treatment for substance abuse lack access to services in comparison to national estimates of substance use among persons aged 18 or older.

Table 1. State and National Estimates of Substance Use-Percentage of Persons Aged 18 or Older, 2007-2008

	United States	New Mexico
Illicit Drug Use in Past Month	7.9	8.4
Nonmedical Use or Pain Relievers in Past Year	4.7	5.1
Alcohol Dependence of Abuse in Past Year	7.7	8.1
Illicit Drug Dependence or Abuse in Past Year	2.6	3.1
Needing But Not Receiving Treatment for Illicit Drug Use in Past Year	2.3	3.1
Needing But Not Receiving Treatment for Alcohol Use in Past Year	7.3	7.9

Source: National Surveys on Drug Use and Health, SAMHSA

In New Mexico, Rio Arriba County had the highest drug-induced death rate, 51 deaths per 100 thousand, and unintentional drug overdose death rate among all New Mexico counties from 2005 to 2009. Rio Arriba County had the third highest unintentional/undetermined drug overdose rate in the nation from 2003 to 2007. From 2005 to 2009, the highest number of unintentional drug overdose deaths, 781, occurred in New Mexico's most populous county, Bernalillo, which ranks second behind Rio Arriba County in the rate of unintentional drug overdose death rates.

Individuals encounter mental health issues ranging from everyday challenges with stress and anxiety to serious life-threatening situations such as suicidal ideation and suicide attempts. People in good health with higher incomes and more education are significantly less likely than the general population to report frequent mental distress, a measure used by the Centers for Disease Control and Prevention to help evaluate a person's mental health status. Conversely, people with less education, with chronic health conditions such as obesity, diabetes, or asthma, or with lower income, were significantly more likely to report frequent mental distress.

The statewide estimate of people over the age of 18 years who reported frequent mental distress in the past 30 days was 11 percent in 2009, the same as the national rate. However, people in 18 counties across the state reported higher rates of frequent mental distress than the state or national rate, with Grant County having the greatest percentage of people reporting frequent mental distress at 21 percent, followed by Eddy County at 18 percent and Torrance County at 16 percent.

Depression is one of the most prevalent and treatable mental disorders. In New Mexico, depression is highest among young adults, ages 18 years to 24 years and higher among Hispanic and American Indian adults than white adults. Depression is associated with higher rates of unhealthy behavioral including physical inactivity, smoking, binge drinking, and drinking and driving. The Centers for Disease Control and Prevention estimates one in two Americans have a diagnosable mental disorder each year that can be as disabling as cancer or heart disease in terms of premature death and lost productivity. Of those individuals with a diagnosable mental disorder, fewer than half of adults and only one-third of children get help.

System Transformation. In response to the alarming behavioral health trends of New Mexicans, the state has responded with a number of system transformations spanning over a decade to promote the recovery and resiliency of behavioral health consumers. The most significant action was the 2004 legislation establishing the Interagency Behavioral Health Purchasing Collaborative (Collaborative) to administer, develop, and coordinate a single statewide behavioral health care system.

HISTORY OF MAJOR EVENTS IN NEW MEXICO'S BEHAVIORAL HEALTH 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	The New Mexico Behavioral Health Needs Assessment and Gap Analysis Project commissioned by the Legislature completed.
2003	Governor 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 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 Collaborative and Behavioral Health Planning Council.
2005	The Collaborative selects ValueOptions New Mexico, Inc. as the single statewide entity to manage mental health and substance abuse programs and funding from six separate state agencies.
2008	The Collaborative selects OptumHealth New Mexico to replace ValueOptions as the single statewide entity.
2009	After the go-live of the OptumHealth New Mexico system, significant issues arose. A Directed Corrective Action Plan imposed with consultant, Alicia Smith and Associates to monitor.
2011	OptumHealth New Mexico was sanctioned for issues relating to Behavioral Management Skills and Psychosocial Rehabilitation services.
2012	The HSD submits a 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services. The New Mexico plan is called Centennial Care. The plan is still awaiting approval by the federal government.
2013	Governor Martinez announces New Mexico will expand access to Medicaid for up to 170 thousand eligible New Mexicans under the Patient Protection and Affordable Care Act.
	The HSD selects the four new MCOs that will be charged with providing care to the some 700 thousand New Mexicans who receive services through the Medicaid program. Medicaid behavioral health services will no longer be "carved-out" from physical health services, while OptumHealth will remain the statewide entity for non-Medicaid behavioral health funding.

Source: LFC Files

By creating the Collaborative, the state sought to ameliorate issues identified in the Behavioral Health Needs and Gap Analysis conducted in 2002, such as the insufficient access to evidence-based care, the confusing array of uncoordinated public and private agencies and providers, and the redirection of support for consumers to adapt and lead productive lives rather than managing their problems. While the promise of behavioral health reforms was

great, the results of the Collaborative's execution as the state's behavioral health authority and manager of the contract with the statewide entity have been mixed. Previous Legislative Finance Committee (LFC) reports have found the Collaborative's financial management of the statewide entity needs improvement to better monitor utilization and cost of provider services, the effective oversight of access to care and sufficiency of the statewide entity's network of providers is lacking, and the impact of publicly funded treatment efforts in New Mexico is virtually unnoticeable with the continuous trend of substance abuse by the population and the lack of sufficient data to determine treatment outcomes.

LFC Program Evaluations of Behavioral Health. In 2005, the LFC staff reviewed the DOH's substance abuse program and found that illicit drug overdoses were the predominant manner of drug-caused deaths in New Mexico and Rio Arriba County's drug-caused death rate far exceeded all other counties in the state. Substance abuse treatment outcomes could not be adequately measured without post-treatment follow ups and sufficient outcome data. The methods used for measuring and monitoring utilization and cost of provider services were inefficient, ineffective, and an open invitation for abuse and possibly fraud. The Collaborative's request for proposals and resulting contract were not specific with regard to performance outcomes, utilization rates, contract oversight, data ownership, and incentives and sanctions for providers and the statewide entity.

In 2006, the LFC staff reviewed the Collaborative and observed it still needed to improve on its key statutory duties necessary to ensure a well planned and functioning behavioral health system. The Collaborative's financial oversight of ValueOptions required improvement to ensure sound business practices and the agency lacked rulemaking authority needed to streamline regulations common to all behavioral health programs and improve access to quality services. The Collaborative did not have a clear and consistent process to make policy and include and inform the public of its decisions. New Mexico still lacked a unified behavioral health budget and behavioral health outcome measures could not be tied to individual agency's appropriations, limiting the Collaborative's accountability to the Legislature and New Mexico's taxpayers. Consumers and families lacked access to information on the quality and performance of ValueOptions and its network providers.

In 2007, the LFC staff conducted a follow-up review of the Collaborative. The program evaluation found statutory changes to improve accountability to the Legislature were still needed and behavioral health appropriations and performance measures remained fragmented despite legislative efforts to streamline programs. The Collaborative's payment and business practices continued to cause concerns. Pre-paying the statewide entity for services not yet rendered was contrary to best practice as specified by the Procurement Code. The Collaborative had not fully implemented recommendations from previous LFC program evaluations to improve oversight of access to care and quality of services.

Behavioral Health Collaborative. The Collaborative, established in 2004, is a cabinet-level group representing 15 state agencies involved in the direct or indirect delivery of behavioral health services, advocacy, health policy and research. 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 the DOH rotating annually as the other co-chair. The acting chief executive officer of the Collaborative is currently serving as the acting director for the Behavioral Health Services Division (BHSD) of the HSD.

The Collaborative's main responsibilities include:

- Oversight of the contract with OptumHealth New Mexico (OptumHealth), the statewide entity responsible for braiding multiple funding streams across the Collaborative state agencies and managing a single statewide provider network;
- Submission of a consolidated behavioral health budget that inventories all expenditures for mental health and substance abuse services through the Collaborative state agencies;
- Monitoring the behavioral health system service capacity and consumer utilization to measure performance and outcomes;
- Making decisions regarding Medicaid, state funds, and federal funding to sustain the policy priorities and resource needs of multiple departments and programs;
- Coordinating stakeholders and developing plans to meet state and federal requirements;

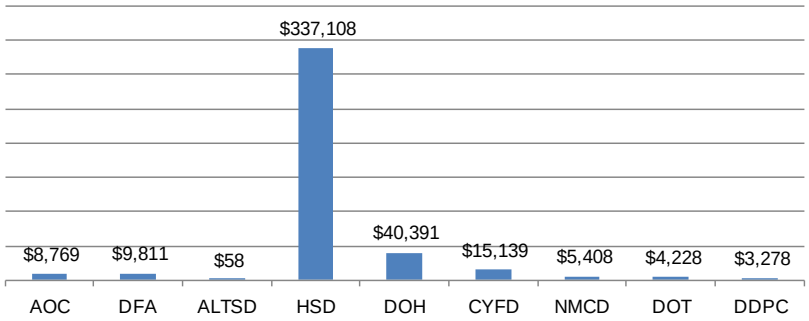
- Directing systems of care, data management, rate setting, service definitions, training, performance, and outcome indicators; and
- Oversight for fraud and abuse and licensing and certification of behavioral health providers and agencies.

The work of the Collaborative is informed by the Behavioral Health Planning Council (BHPC), an advisory body consisting of 79 governor-appointed members representing consumers, family members, providers, and state staff. The Collaborative and BHPC work together to fulfill a range of statutory duties, including reporting to the governor and the Legislature on the adequacy and allocation of mental health services throughout the state, encouraging and supporting the development of a comprehensive, integrated, community-based behavioral health system of care, advising state agencies responsible for behavioral health services for children and adults, and making recommendations on various plans and applications for the comprehensive mental health state block grant and the substance abuse block grant application, the state plan for Medicaid services, and any other plan or application for federal or foundation funding for behavioral health services. There are five statutory subcommittees: the adult subcommittee, children's subcommittee, Medicaid subcommittee, Native American subcommittee, and the substance abuse subcommittee.

The Collaborative also provides for the organization of 18 local collaboratives (LCs) throughout the state. The LCs' representation corresponds geographically to New Mexico's 13 judicial districts as well as five LCs to represent Native American communities. The LCs were intended to provide structure and local ownership of health and human services issues and to provide input and make recommendations to the Collaborative about state-sponsored funding, service development, and program oversight activities at the local level. The LC structure was not created in law and a 2012 transition document issued by the Collaborative recommending a little to no-cost opportunity for LCs to continue the work they have begun and to be connected to the initiatives of the Collaborative and the BHPC indicates the LCs will no longer be financially supported by the OptumHealth after the contract expires in December 2013. No evidence suggests local service delivery, planning, or coordination efforts by a similar structure to the LCs will be funded by the managed care organizations (MCO) under Centennial Care.

Human Services Department (HSD). The HSD spends the most on behavioral health services of all Collaborative agencies, with $337 million of the total expenditure amount of $424 million. The HSD provides funding through two primary sources: $283 million in Medicaid through the Medical Assistance Division and $54 million administered through the BHSD to OptumHealth to serve consumers through direct and indirect spending of state and federal funding for non-Medicaid behavioral health services and programs.

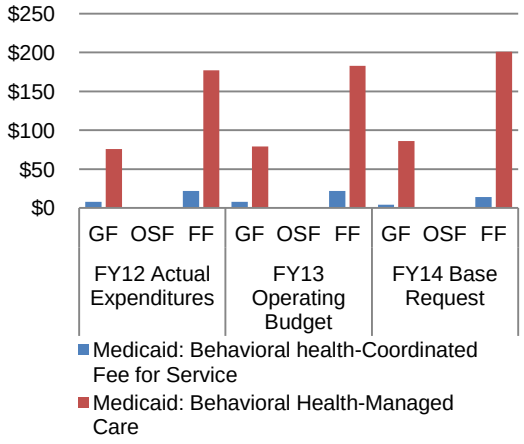
Graph 1. State Agency Behavioral Health Actual Expenditures, FY12
(in thousands)



Source: BHC Budget Compilation, FY14

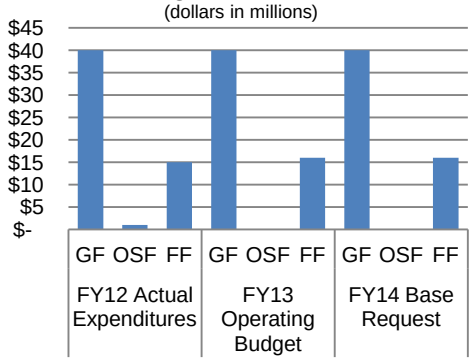
Behavioral Health Services Division (BHSD). The BHSD's primary role is to serve as the adult mental health and substance abuse state authority and thus plays a major role in behavioral health policy and oversight. According to the Collaborative Director's Report, in FY12, approximately 26 thousand adult consumers, ages 18 years and older, received Medicaid behavioral health services and nearly 24 thousand adult consumers received non-Medicaid services. State and federal funding for non-Medicaid behavioral health was16 percent of the total behavioral health budget in FY12.

Graph 2. HSD Behavioral Health Medicaid Expenditures and Operating Budget, FY12-FY14
(dollars in millions)



Source: BHC FY14 Master Compilation

Graph 3. HSD Behavioral Health Non-Medicaid Expenditures and Operating Budget, FY12-FY14
(dollars in millions)



Source: BHC FY14 Master Compilation

The BHSD, under the direction of the Collaborative, ensures the continuation and growth of behavioral health programs and services statewide and manages community-based treatment services for persons over 18 years old with substance use disorders, mental health diagnoses, and co-occurring disorders. In addition to standard treatment services, the BHSD service array includes services not covered by other funding streams managed by the Collaborative. Almost 40 percent of the funding pays for a collection of integrated services and activities for special populations, such as jail diversion for veterans, substance abuse treatment for pregnant women, and supported housing, that are not part of the purchasing plan (**See Appendix C**). The BHSD contracts with OptumHealth which is responsible for contracting with providers for these programs and once the funds are expended for the year, no more claims can be paid from that funding source. The BHSD funding is also used administratively by the division to issue contracts for evaluation of the grants and other indirect services allowable by the terms of the funding source.

Table 2. HSD Behavioral Health Benefit Summary, FY13

Adult Behavioral Health Services (HSD/BHSD)	HSD/Medical Assistance Division (Medicaid)
Assessment and Evaluation	Psychiatric Inpatient Hospital Services in a Psychiatric Unit of a General Hospital
Forensic Evaluations	Inpatient Professional Services by Behavioral Health Professional
Outpatient Therapies, Screening and Testing (Mental Health and Substance Abuse)	Partial Hospitalization Services
Medication Management	Hospital Outpatient Services in a General Hospital
Substance Abuse Intensive Outpatient Treatment	Outpatient Behavioral Health Professional Services (including evaluation, testing, assessment, medication management, and therapy
Opioid Replacement Treatment	Lab Services (when provided by a Behavioral Health Provider)
Sexual Assault Services	Comprehensive Community Support Services
Supported Employment	Telehealth Services
Supportive Housing	Pharmacy Services (when prescribed by a Behavioral Health Provider)
Specialized Veteran and Family Services	Intensive Outpatient Services for Substance Abuse Smoking Cessation
Jail Diversion	Smoking Cessation
Native American Traditional Services	Transportation (provided through the Physical Health MCOs)
Patient Education	Medication Assisted Treatment (Methadone)
Comprehensive Community Support Services	
Psychosocial Rehabilitation Services group	
Residential Substance Abuse Treatment	
Social Detox	
Transitional Living Services	
Inpatient Services *not available statewide	
Substance Abuse Prevention Services	

Source: Behavioral Health Collaborative

The BHSD has four sub-divisions: finance and contracting, clinical and quality, policy and planning, and program delivery. The 2012 organizational chart identifies 35 permanent employees and two consultants. Eleven employees have the title of manager. The powers and duties of the BHSD, as directed by statute and subject to appropriations include:

- Contract for behavioral health treatment and support services, including mental health, alcoholism, and other substance abuse services;
- Establish standards for the delivery of behavioral health services, including quality management and improvement, performance measures, accessibility and availability of services, utilization management, credentialing and re-credentialing, rights and responsibilities of providers, preventive behavioral health services, clinical treatment and evaluation, and the documentation and confidentiality of client records;
- Ensure all behavioral health services, including mental health and substance abuse services, that are provided, contracted for, or approved comply with the requirements of state statute;
- Assume responsibility for and implement adult mental health and substance abuse services in the state in coordination with the CYFD;
- Establish criteria for determining individual eligibility for behavioral health services; and
- Maintain a management information system in accordance with standards for reporting clinical and fiscal information.

In FY11, the BHSD began to administer the Office of Substance Abuse Prevention and the Pre-Admission Screening and Resident Review, transferred over from the DOH. In 2011, the Office of Substance Abuse Prevention lost 61 percent of its funding because of the expiration of federal grants and a reduction in state funding.

New Mexico was the recipient of nearly $30 million in formula and discretionary funding in FY12 from the federal Substance Abuse and Mental Health Services Administration (SAMHSA), with some of the funding used to support state agencies that are part of the Collaborative and some funding going directly to other applicants. The largest sources of federal formula funding are the Substance Abuse, Prevention, and Treatment Block Grant and the Community Mental Health Services Block Grant. States have greater authority to design programs and services to target specific populations with non-Medicaid funding and to pay for mental health services Medicaid does not cover.

The block grant funds are directed toward four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low income individuals and that demonstrate success in improving outcomes and supporting recovery;
- Fund primary prevention-universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and plan the implementation of new services on a nationwide basis.

In most states, including New Mexico, the block grant dollars are blended with other federal and state funding or are allocated to community-based providers where they are combined with other resources. As a result, it is not always possible to attribute specific outcomes to block grant funding. According to the BHSD, the SAMHSA strongly emphasizes the use of evidence based practices and tracking outcome data to demonstrate effectiveness. In past years, states provided summaries of what was accomplished. In the future, states will need to demonstrate the number of persons served, the number of units provided, and the effectiveness of funding particular programs, agencies, and services.

DESPITE INCREASED FUNDING, SINCE FY11, FEWER PEOPLE HAVE RECEIVED SERVICES THROUGH BHSD FUNDING SOURCES, AND OUTCOMES STILL FALL SHORT OF TARGETS

In FY12, the Behavioral Health Services Division (BHSD) non-Medicaid funding served 24 thousand New Mexicans not eligible for Medicaid at a cost of $54 million. The HSD non-Medicaid behavioral health state and federal funding serves as the safety net for those individuals not eligible for Medicaid or to pay for important services, like substance abuse prevention, not covered by Medicaid. Use of state and federal funds is less restrictive than Medicaid, giving the BHSD more authority to design programs and services for specific populations. The importance of non-Medicaid behavioral health services is highlighted by the potential federal changes to health insurance and the expansion of the Medicaid program. With these changes, currently uninsured or underinsured individuals receiving behavioral health services through non-Medicaid funds could have coverage for basic treatment services, but New Mexico's Medicaid program may not cover other services important for individuals with substance abuse and mental health issues. Currently, both state and federal funding is available to Medicaid enrollees, creating a richer benefit package for those individuals.

Table 3. State and Federal Fund Appropriations to HSD for Behavioral Health Services, FY12
(in thousands)

	General Fund	Other State Funds	Federal Funds	Total
Personal services and employee benefits	$1,897		$282	$2,179
Contractual services	$39,073		$12,788	$51,861
Other	$417	$21	$54	$492
Other financing uses	$279		$1,073	$1,352

Source: GAA FY12

The BHSD administers many clinical and financial functions of the state's behavioral health system. Medicaid, state funds, and federal dollars support the system. The state contracts with OptumHealth of New Mexico (OptumHealth) to manage services and funding. OptumHealth's organizational structure includes five offices in regions identified by the state **(See Appendix D).**

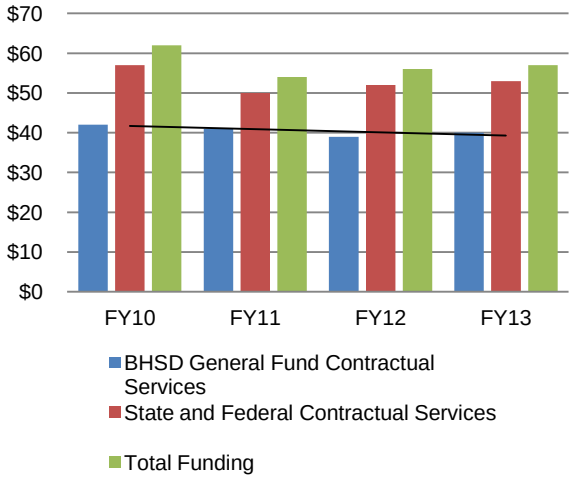
Table 4. New Mexico Behavioral Health Collaborative Regions

Region 1	Northwestern New Mexico
Region 2	Northeastern New Mexico
Region 3	Bernalillo County/Central New Mexico
Region 4	Southeastern New Mexico
Region 5	Southwestern New Mexico
Region 6	Native Americans

Source: NM Behavioral Health Collaborative Regional Map

Most of the BHSD non-Medicaid appropriations pay for contractual services for provider reimbursement. Contractual services are the category of state general funds which include reimbursement to providers for patient services and administrative fees to OptumHealth. In FY12, $39 million of the $56 million total appropriation was directed to contractual services, of which $33 million funded patient services.

Graph 4. Appropriations to the Behavioral Health Services Division, FY10-FY13
(in millions)

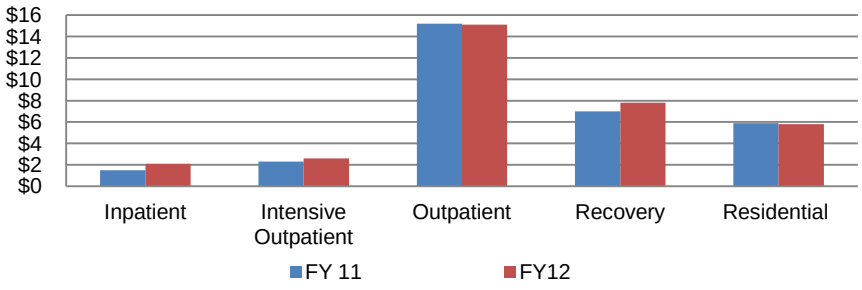


Source: GAA FY10-FY13

In the same year, more than $4 million in the BHSD state appropriations funded OptumHealth administrative fees to manage the non-Medicaid state general fund appropriations. The allowable percentages range from 8 percent to 11.8 percent, depending on the funding category. Specifics are not provided on how the remainder is spent but include payments to providers for other than claims reimbursement and other consulting services purchased by the BHSD. Federal grants seldom allow administrative fees to subcontractors.

The majority of expenditures are for services delivered in the community or home. The service categories purchased are inpatient, intensive outpatient, outpatient, recovery, and residential.

Graph 5. Expenditures by Major Service Category, FY11-FY12
(in millions)



Source: BHSD 06 Reports, FY12

Each of the major service categories includes specific services. Recovery support services are wide-ranging and should be provided based on the needs of individuals and their families. The interventions are non-clinical services that assist individuals and families working toward recovery from substance use conditions. They include social supports and services such as child care, employment services, housing, peer coaching, and drug-free social activities.

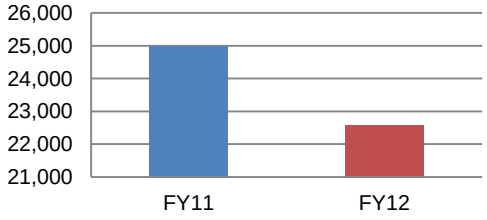
Table 5. Major Category of Service Descriptions

Inpatient	Inpatient hospitalization, psychiatric emergency room
Intensive Outpatient	Multi-faceted, structured outpatient program for treatment of substance abuse, delivered over a period of 3 to 6 months.
Outpatient	Individual, group, and family therapy, drug testing, treatment plan updates, forensic evaluations, diagnostic interviews, medication and pharmacological management, patient education, psychological testing, traditional healers
Recovery	Comprehensive community support services, employment services, psychosocial rehabilitation
Residential	In facility detoxification, in facility substance abuse treatment

Source: OH CI09 FY11-FY12 Reports

Although state expenditures increased, the number of consumers served declined and significant variations exist across the state. The number of consumers served in FY12, 24 thousand, decreased by 10 percent from FY11. Examples of the need for services are repeated each year in the DOH epidemiological reports: the percentage of adults with depression is higher than the national average, New Mexico's drug overdose rate has been the highest in the nation for the last two decades, and drug overdose deaths in the state were 26 per 100 thousand, compared with the national rate of 12 per 100 thousand.

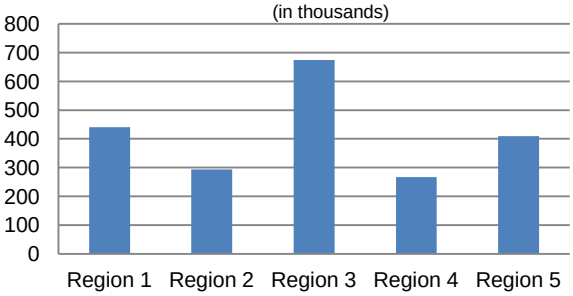
Graph 6. Unduplicated Counts Of Consumers Served, FY11-FY12



Source: BHSD-02 FY12

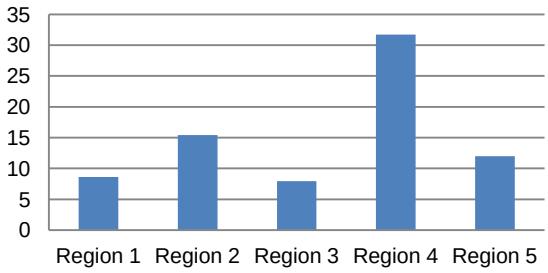
Greater attention is needed to monitor regional variations in number of consumers served, service utilization, and expenditures. The differences in consumers served by region are significant. The number of consumers served per 1,000 population ranges from 8 in Region 3 to 32 in Region 4.

Graph 7. Total Population by Region, 2012
(in thousands)



Source: 2012 US Census

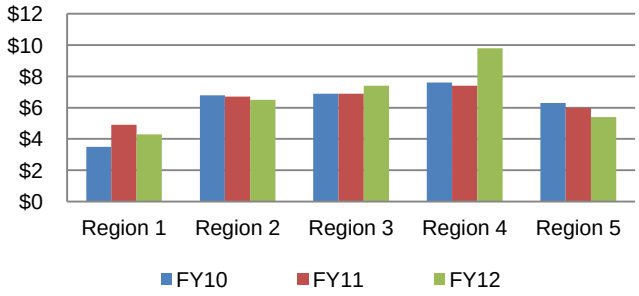
Graph 8. Population Served by Region, FY12
(per one thousand population)



Source: BHSD 06 Reports

The FY12 increase in expenditures is primarily driven by Region 4 expenditures. Region 4 (southeast) continues to provide more consumers with more services than other regions, even though it has the lowest population of all the regions. The overall increase in expenditures for FY12 was $1.5 million. In the same year Region 4 expenditures increased by $2.4 million.

Graph 9. Total Non-Medicaid Expenditures by Region, FY10-FY12
(in milllions)

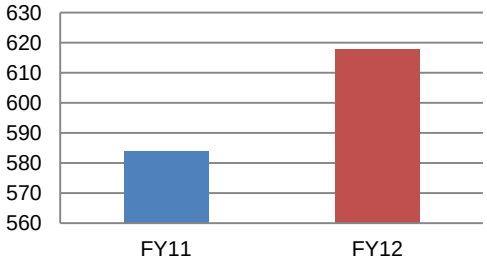


Source: OH Report 6a FY10-FY12

Both Region 2 and 5 decreased health care expenditures each year over the three-year period. However, expenditures for FY11 may not accurately reflect reimbursements for services. On July 8, 2010, OptumHealth issued a provider alert recommending that providers re-register clients served in the previous year for which the provider did not receive reimbursement. The alert states funds were exhausted and registration dates should change to the new year. This would suggest that FY11 funds were used to fund FY10 services.

Units of service are driving the expenditure increase from FY11 to FY12. Units of service are the measure of the number of times an intervention occurs. Although the number of consumers deceased between FY11 and FY12, the total number of units of service increased while rates remained relatively stable.

Graph 10. Comparison of FY11 and FY12 Units of Service
(in thousands)



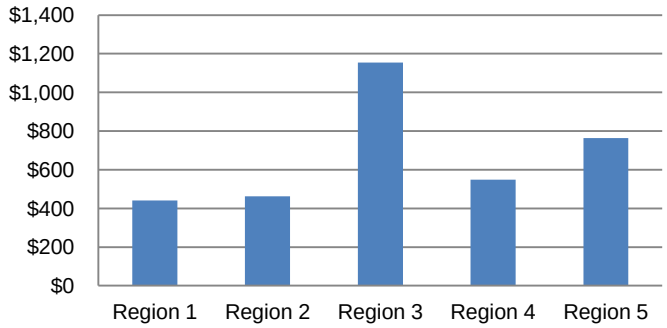
Source: BHSD 06 FY11, FY12 Reports

OptumHealth is not at risk for expenditures and providers are reimbursed through a fee-for-service method. Although non-Medicaid funding is limited, attention to cost-efficiency and value-based purchasing is necessary to ensure state funds are appropriately used to improve the health status of consumers. OptumHealth analyses of utilization do not identify reasons for change between years and reporting does not target specific services for utilization review to identify the impact on health status, appropriateness of service utilization, or staff availability. Contractually, OptumHealth is responsible for this oversight.

Comparison of comprehensive community support services average cost-per-consumer and units of service provided demonstrates another example of practice differences. Community support services consist of a variety of interventions, primarily face to face and in community locations that address barriers that impede the development of skills necessary for independent functioning in the community, specifically independent living, learning, working, socializing, and recreation. It serves to facilitate a consumer's access to services, to better prepare the

consumer to navigate the system, and to be more involved in their own treatment planning. OptumHealth service utilization analyses do not tie utilization to outcomes to see if that is occurring. Assessing the cause of the increased average units of service per client in Regions 3 and 5 is not possible. Differences could be the effect of severity of illness, willingness of consumers to participate in therapy, poor billing practices, or under-utilization or over-utilization. Region 3 delivered an average of 17.1 units of service per consumer, while Region 1 delivered an average of 7.2 units. The variances across regions lack the scrutiny needed to justify needs and costs.

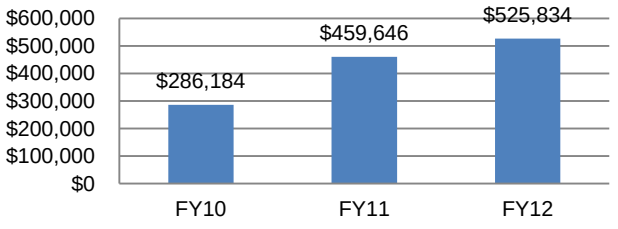
Graph 11. Comparison of Average CCSS Cost per Consumer, FY12



Source: BHSD 06a FY12 Report

More than $1 million from FY10 through FY12 expenditures were labeled as "uncategorized" in OptumHealth reports. When a provider does not assign a diagnostic category to a consumer, the claims is identified as uncategorized. Without knowing diagnostic categories, such as seriously mentally ill or co-occurring disorders, the BHSD is handicapped in evaluating incidence of disease and need for services, important in resource allocation. Uncategorized claims increased from FY10 through FY12, with Region 4 accounting for nearly $600 thousand dollars in unidentified diagnostic categories. Provider reimbursement is based on claims submission, but certain providers are still allowed non-encountered reimbursement. Providers are allowed to submit invoices rather than submitting claims through OptumHealth's claims system. This reimbursement system lacks accountability and prevents accurate reporting of fund use. Without relating expenses to specific clients for specific services the state lacks accurate information by which to make decisions and eliminates the ability to tie services to clinical outcomes. Managing non-encountered data in a claims system creates a second industry for the contractor and produces an easy path for errors in utilization data.

Graph 12. Uncategorized Expenditures FY10-FY12



Source: BHSD 06c Reports FY10-FY12

Not accounting for services for which payment is not made also impacts monitoring of service utilization. At the beginning of each fiscal year, the BHSD allocates a specific amount of state general fund and federal funds available to individual providers. Expenditures are monitored and redistributions are made between providers who have exceeded anticipated workload from those who have not. Some providers, by the fiscal year end, have

provided non-obligated services for which no funding is available. The BHSD does not require providers to submit "no pay" claims when this occurs. OptumHealth claimed systems are not capable of accounting for a "no pay" transaction and the BHSD has no leverage to direct these submissions. This practice inhibits the state's ability to accurately identify utilization and funding and service needs. Other health plans' claims systems allow accounting for claims and contracts with providers could require submission, placing contracts at risk in failing to do so.

The BHSD does not require OptumHealth to report incurred, but not yet paid expenses in state general fund use reporting. OptumHealth does project Medicaid claim expenditures. Projecting fund use is important because the state general fund is a defined amount of funding. Maintaining real-time accounting may prevent the end of year directives to OptumHealth to exchange funding streams, allow more timely service access to consumers, and more current information by which OptumHealth can monitor utilization.

Outcome results have been inconsistent over past three years. Performance reporting for behavioral health services includes both Medicaid and non-Medicaid consumers, preventing identifying which funding streams and services impact outcomes. Based on quarterly reporting, consumers with alcohol dependency ranked their progress higher than those with drug dependency and exceeded the target. However, based on these measures, consumers do not appear to have adequate access to follow up care within 30 days of inpatient discharge.

Table 6. Behavioral Health Performance Measures and Outcomes

	Target	FY10	Target	FY11	Target	FY12
Percent of people receiving substance abuse treatment who demonstrate improvement in the drug domain of the Addiction Severity Index	80%	55%	75%	70%	75%	71%
Percent of people receiving substance abuse treatment who demonstrate improvement in the alcohol domain of the Addiction Severity Index	80%	73%	80%	92%	80%	87%
Percent of individuals discharged from inpatient facilities who receive follow up services in 7 days.	37%	30%	37%	34%	37%	34%
Percent of individuals discharged from inpatient facilities who receive follow up services in 30 days.	59%	44%	59%	51%	56%	49%

Source: Agency Quarterly Performance Report Cards

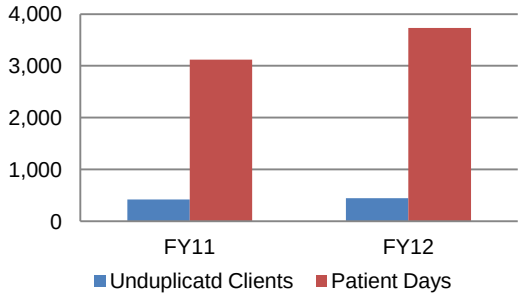
In 2011, LFC staff suggested the HSD include more meaningful outcomes measures which could be benchmarked with other states, action plans for improvement, and explanations for changes, with which the department has partially complied.

Consumer outcomes may be negatively impacted when the state fails to react to available data. While the creation of programs to decrease hospitalizations and improve system efficiency expanded services to consumers, they have not positively impacted high intensity, high cost service utilization. The establishment of core service agencies, and the implementation of services designed to prevent crisis situations, such as comprehensive community support services and intensive outpatient therapy, have not decreased inpatient utilization or emergency room visits. Core service agencies are multi-service agencies designated by the Collaborative to coordinate care and provide psychiatric services, medication management, everyday crisis services, comprehensive community support services, and other clinical services to eligible children, youth and adults who have a serious mental illness, severe emotional disturbance, or dependence on alcohol or drugs.

Inpatient admissions and lengths of stay both increased from FY11 to FY12. The OptumHealth analysis of inpatient services for FY11 cites a 14 percent decrease in inpatient utilization from FY10 to FY11. Although patient days in

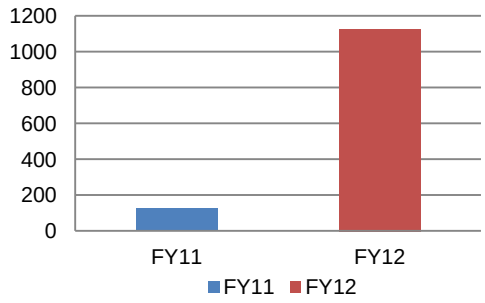
facilities decreased, the number of consumers admitted increased, data which is not shared in the analysis. In spite of the implementation of core service agencies, the 37 percent increase of inpatient admissions and the increase in length of stay from an average of 7.42 days to 8.33 days in FY12 raise concerns about the ability the core service agencies to improve patient outcomes or decrease costs. The total annual cost of inpatient services increased by $300 thousand between FY11 and FY12. Also, crisis services appear inadequate given the increase in inpatient and emergency room utilization.

Graph 13. Comparison of Inpatient Admissions, FY11-FY12



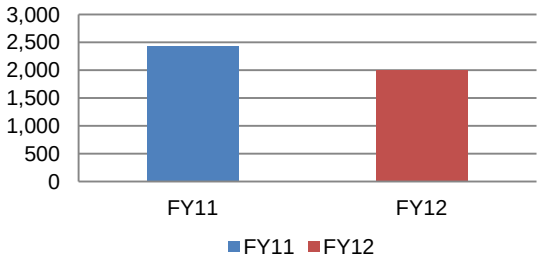
Source: OH CI09 FY11, FY12 Reports

Graph 14. Psychiatric Emergency Room Visits, FY11-FY12



Source: OH CI09 FY11, FY12 Reports

Graph 15. Clients Served Through Crisis Intervention, FY11-FY12



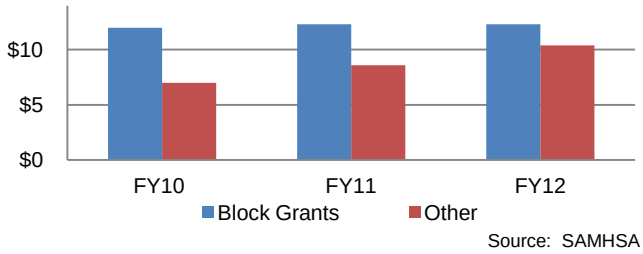
Source: OH CI09 FY11, FY12 Reports

Region 3 (Bernalillo County), the most populated region does not serve the greatest number of consumers and utilization is lower than other regions for most services. The review of FY11 and FY12 OptumHealth expenditures for Region 3 indicates no intensive outpatient programs, an evidenced-based practice requiring credentialed and licensed personnel. Geo Access data shows this region is the area most likely to have capacity to perform the service. The FY12 OptumHealth report, All Services by Service Category or Service Code, cites an overall increase in intensive outpatient program services, but states no intensive outpatient program services were utilized in Region 3. More explanation about the absence of intensive outpatient programs in Region 3 was not in the analysis. The disparities in services across regions should be explained to ensure their use is directed to individual needs and not as provider preference for other reasons.

The Substance Abuse and Mental Health Services Administration (SAMHSA) offers opportunities for states to apply for grant funding to be used as seed money to initiate new programs targeting special needs and gaps and to support existing programs. Grant funding supplements the state's ability to provide services to consumers. New Mexico has a long history of successful federal grant applications to expand and enhance behavioral health services. Two types of funding, formula block and discretionary grants are awarded through the SAMHSA. Block

grants are only available to state mental health and substance abuse authorities. The other discretionary grants are open to the state, local governments, and service providers. Federal funding for discretionary grants are determined based upon the SAMHSA's surveillance of population needs and service capacity and often directs services and programs to be implemented using evidenced-based and promising practices. From FY10 through FY12, state departments, local governments, and provider agencies in New Mexico received over $49 million in block and other discretionary federal grant funding, of which $26 million was awarded to state agencies. The "other" category in **Graph 16** represents all grants awarded from FY10 to FY12 to entities in the state, not only those directed to state agencies. Specific use of federal grant dollars could not be assessed. Detailed reporting by OptumHealth did not begin until FY13.

Graph 16. New Mexico SAMHSA Grant Funding, FY10-FY12
(in millions)



Source: SAMHSA

Provider applicants for other discretionary grant funding are not obligated to report their application or award for other discretionary grants. The BHSD indicated applicants would be unwilling to share this information because it is a competitive process. However, from FY10 to FY12, non-state entities received $23.6 million in other discretionary grant funding. Failure to disclose this information to the state presents the possibility of uncoordinated services and duplication of state funding to the same provider for the same purposes (**See Appendix E**).

The two longest standing block grants, the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant average $11.5 million per year for the BHSD funding. The SAMHSA allows latitude in use of the two block grants, which affords the state the opportunity to address state-specific issues. With successful application, the block grants can continue for years. The BHSD, through the statewide entity, contracts with eligible providers to provide services funded from federal grants.

The SAMHSA awards approximately $2 million per year in Community Mental Health Services Block Grant funding to New Mexico in support of community-based mental health services for adults with serious mental illness and children with severe emotional disturbance. The funding can be used to support new services and programs, enhance existing programs, expand access, and leverage additional state and community funding. Up to 5 percent of the grant funds can be used for administration. Funding cannot be used for the following purposes as a condition of the receipt of federal funds:

- Providing inpatient services;
- Making cash payments to intended recipients of health services;
- Purchasing or improving land;
- Purchasing, constructing, or permanently improving any building or facility;
- Purchasing major medical equipment; or
- Providing financial assistance to any entity other than a public or non-profit private entity.

The Substance Abuse Prevention and Treatment Block Grant supports New Mexico's substance abuse programs with over $8 million each year. The grant funds are dedicated to treatment and prevention services for substance abuse and are more prescriptive in use of funds than the Community Mental Health Services Block Grant. The Substance Abuse Prevention and Treatment Block Grant funding must:

- Establish a base of expenditures for special treatment services for pregnant women and women with dependent children;

- Establish a capacity management system requiring programs providing treatment of intravenous drug abuse to report to the state when the provider has reached ninety percent capacity, report excess capacity to the state, and maintain a waiting list from which arrangements for enrollment for services are completed as quickly as possible, to include available interim services;
- Conduct outreach activities to encourage persons in need to seek services;
- Dedicate at least 20 percent of the fund for primary prevention purposes;
- Have an independent peer review system that assesses the quality, appropriateness, and efficacy of Substance Abuse Prevention and Treatment Block Grant-funded treatment services; and
- Provide screening and treatment referral for individuals suspected of or diagnosed with tuberculosis.

The funding restrictions for the Substance Abuse Prevention and Treatment Block Grant are the same as the Community Mental Health Services Block Grant with the addition of restrictions on providing individuals with hypodermic needles or syringes and expending more than the block grant expended in federal FY1991 for services provided in penal institutions.

Sustainability of funding is not considered when federal grant applications are submitted. The expiration or decrease in federal grant funding does create gaps in the system, even when programs have proven beneficial for recipients. The state's grant applications do not specifically require how services, if proven valuable to the behavioral health system, will be sustained once the grant funding expires. If accommodation is not made to fund through other funding sources, services are discontinued. This concern is evidenced in the Independent Peer Review which the Substance Abuse Prevention and Treatment Block Grant requires to occur every year. Reviewers for the 2012 cycle cited statements from site visit agencies:

- "Treatment partners report that funding continues to be an issue. Some services are funded and then shortly thereafter are not funded, for example comprehensive community support services."
- "When a grant is obtained there is no funding to sustain it once the grant is over."

Recommendations

The BHSD should

- Require a sustainability plan be developed prior to the submission of grant applications;
- Require providers contracted by the state through the statewide entity inform the state of all grants awards made specifically to the provider;
- Require OptumHealth to detail analyses of differences, changes in service utilization and costs and take appropriate action; and
- Require providers to submit "no pay" claims to ensure utilization data is accurate.

WITH THE EXPANSION OF NEW MEXICO'S MEDICAID PROGRAM, THE NEED FOR STATE-FUNDED BEHAVIORAL HEALTH SERVICES MAY DECREASE

Given previous assessments of service needs and gaps, many more New Mexicans who currently do not access the system or receive some services through BHSD non-Medicaid, will likely access behavioral health services through Medicaid expansion. Currently, a source of payment acts as a major impediment to thousands of individuals, primarily childless adults, eligible through non-Medicaid BHSD funding. More information on projected newly eligible Medicaid behavioral health consumers and current service gaps analysis is needed to assess future funding needs for the BHSD in light of potential decreased need since many consumers will access services through Medicaid instead. For example, the state should explore repurposing some of the appropriations from the general fund BHSD non-Medicaid services to Medicaid.

However, the BHSD has not formally projected the number of behavioral health consumers presently receiving state-funded services who would be eligible for Medicaid. Separately, the HSD projects an increase of 98 thousand new enrollees with Medicaid expansion. If that projection holds, an estimated 17 thousand additional individuals may access Medicaid-funded behavioral health services based on current rates of usage. Again, it is unclear at this time how many consumers using BHSD non-Medicaid funding will begin to access services through Medicaid after January 2014. But, it is highly likely that many current consumers of BHSD funded behavioral health will become newly eligible for Medicaid. The state then could reallocate funding to the BHSD to the state-funded portion of Medicaid or to programs which better promote the health of consumers unless there is a current behavioral health needs and gaps analysis to justify funding for non-Medicaid services at current levels.

The maintenance of effort (MOE) requirement for future block grant funding may provide reason for the state to evaluate the value of block grant funding with regard to Medicaid expansion. A major provision of block grant awards includes a MOE requiring states to maintain expenditures for authorized activities at a level no less than the average level in expenditures maintained by the state for the two-year period preceding the year in which the state is applying for the grant. This obligation is the federal government's attempt to preserve state funding for behavioral health programs. If consumers become eligible for Medicaid services with program expansion, the existing level of state funding may not be necessary. If that occurs and the MOE requirement is unchanged, the state must evaluate the value of block grant funding.

Recommendation

The Legislature should require the HSD to complete a Medicaid eligibility projection and a behavioral health needs and gaps analysis to justify BHSD funding at existing levels. Consider repurposing at least 50 percent of current state funding levels for BHSD non-Medicaid services to Medicaid by FY16, unless, based on results of needs and gaps study, funding is still needed for BHSD services.

RECENT EVENTS DEMONSTRATE THE NEED FOR A STRONGER, BETTER COORDINATED SYSTEM TO MONITOR PROGRAM INTEGRITY

The HSD has contracted for $3 million with an outside vendor to audit the billing practices and quality of care of many providers across the state. The contract is to prepare audit teams, establish standards for financial and IT/policy audit, lead audit teams, coordinate audits with MCOs and state staff, lead interviews of provider staff and others as appropriate, and prepare a final audit report. The BHSD anticipates a late May 2013 report from the auditing firm.

As the statewide entity, OptumHealth and HSD Inspector General are responsible for reviewing program integrity for the BHSD. The HSD submitted an 1115 Medicaid waiver application to the Centers for Medicare and Medicaid Services to implement Centennial Care, the state's revision of the Medicaid program. Centennial Care proposes to create a comprehensive managed care delivery system in New Mexico under which contracted health plans will offer the full array of current Medicaid services, including behavioral health. The HSD awarded four MCOs with contracts to provide both Medicaid physical and behavioral health to consumers, while OptumHealth will continue as the statewide entity for federal and state behavioral health funding. The BHSD will need to be diligent about monitoring the system for program integrity to prevent misuse of public funds with the increased number of MCOs and one statewide entity receiving behavioral health funding. A well-developed, standardized monitoring program will ensure public resources are used as intended by the funder and in compliance with all laws and regulations regarding the funding. The program should be guided by processes for detecting, investigating, and reporting potential violations.

The key program integrity components in the contract between the BHSD and OptumHealth are:

- Have a comprehensive program to address prevention, detection, preliminary investigation, and reporting;
- Have and implement policies and procedures to support the program;
- Designate a compliance officer;
- Have specific controls of prevention and detection, such as claim edits, post-processing review of claims, provider profiling and credentialing, prior authorizations, utilization management and quality improvement actions, and relevant provisions in the OptumHealth contract with providers; and,
- Cooperate with the member agency's investigation unit, the Medicaid Fraud Control Unit, the Drug Enforcement Administration, the Federal Bureau of Investigation, and other investigatory agencies.

The contract lacks direction to OptumHealth, which minimizes the BHSD knowledge of program effectiveness. The contract does not specify any performance measures which would enable the division to assess program effectiveness nor does it provide for incentives or disincentives for operation of an effective program. OptumHealth is not required to report the value of recovered overpayments creating utilization errors in reporting and resulting in wasteful spending.

Competition has prevented increasing safeguards in the system. Although ensuring a fraud and abuse-free system should take priority, MCOs are not required to share information regarding fraud, waste, and abuse violations with each other. This issue will be exacerbated by Centennial Care when four MCOs and one statewide entity contract with providers.

Diligence in monitoring provider activities for program integrity is weak. The contract does not preclude monitoring of state general fund use, but it does not specifically enumerate that non-Medicaid funds are included. The program integrity section of the OptumHealth contract focuses on Medicaid, while oversight expectations of state and federal funding are vague. Prevention and detection efforts have not been directed to state general funds. Although the dollars pale in comparison with Medicaid funding, state general funds serve as the safety net for needy individuals not eligible for Medicaid-sponsored services. With the state's limited ability to expand state funding, it is important the dollars are protected for their intended use.

Findings in the 2011 LFC program evaluation: *Medicaid Fraud, Waste, and Abuse Controls* are also relevant to state and other federal funds. The same findings and recommendations can be applied to the BHSD-funded provider network:

- Structural, functional, and oversight issues need to be addressed to ensure the effective use of state and federal resources;
- All providers are not consistently and thoroughly vetted at the state agency level; and
- Meaningful performance measures are lacking for the statewide entity and the BHSD-funded providers.

The HSD's Inspector General is responsible for prevention, detection, and investigation of fraud, waste, and abuse in the public assistance programs administered by the HSD. The HSD description of duties includes conducting investigations, auditing, performing special reviews, and financial recovery operations, the Inspector General has not been involved in any monitoring activities.

A recent investigation of potential Medicaid fraud resulted in the closure of a provider facility. Gaps in the existing system are highlighted by this occurrence. Although OptumHealth may have had concerns with the provider, the informants were provider agency personnel who identified the problems as long standing.

OptumHealth routine reports identify the provider as a high cost, high volume provider with a significant number of claims centered on a single service. All of these factors should have placed the provider on high surveillance as an at-risk agency. Several other OptumHealth contracted providers match this profile.

More active monitoring of service utilization could reduce waste in the system. Similarities exist among high volume providers in each region. For example, Regions 1 and 2 rely heavily on residential support services to treat substance abuse problems. The average length of stay for two of the residential facilities is 24 days, while the third has an average length of stay of 54 days. Outcome data was not received from OptumHealth so it is not possible to determine if the length of stay in the outlier agency has proven effective in reducing recidivism or increased days of alcohol or drug-free days upon discharge.

Psychosocial rehabilitation is a high volume service in three of the regions. The BHSD service definition for psychosocial rehabilitation is an array of services designed to help an individual to capitalize on personal strengths, to develop coping strategies and skills to deal with deficits, and to develop a supportive environment in which to function as independently as possible. Psychosocial rehabilitation services are provided in a variety of settings. Psychosocial rehabilitation intervention is intended to be a transitional level of care based on the individual's recovery and resiliency goals.

Comprehensive community support services are identified by the BHSD as a key component in the service delivery array for core service agencies. In spite of five high volume providers in Region 4 being core service agencies, comprehensive community support services is not a high-cost, high-volume service for any one of them. Psychosocial rehabilitation is the high volume service for three of the provider agencies. Comprehensive community support services support activities addressing goals specifically for independent living, learning, working, socializing, and recreation. The service consists of a variety of interventions, primarily face-to face and in community locations, which address barriers impeding the development of skills necessary to independent functioning. There may be overlap in interventions provided in the two services. There is no evidence in the OptumHealth analyses which addresses the appropriate use of the two costly services for individual consumers.

Within the same region, pharmacological management is the second most expensive service for two agencies. This service does not appear in any other region as a high cost/high volume service. In Region 5, mental health assessment is the highest cost service for two provider agencies. The same is not true in any other region.

The HSD denied access to information, limiting policymakers' ability to ensure the appropriate use of public funds. Requests were made to the BHSD to allow LFC evaluation staff to conduct on-site reviews of consumer records. The reviews would have allowed analyses of billing processes and clinical care delivery. The evaluation

proposed to compare medical record documentation with claim submissions, validate appropriate personnel were delivering services, evaluate adherence to fidelity of evidenced-based practices, and gauge the progress of a patient through the treatment regime.

The request for access was denied despite assurances that consumer identifying information would not be collected or removed from the provider site. The LFC staff willingness to enter into a confidentiality agreement was not accepted. While the HSD legal counsel validates that the Health Insurance and Portability and Accountability Act (HIPAA) exempts "health oversight agencies," it determined the LFC "is not a health oversight agency, and is therefore not authorized to obtain confidential health information." In addition to HIPAA legislation, federal law 42 CFR governs confidentiality in the substance abuse field. According to Dr. Wesley Clark, Director of the Center for Substance Abuse Treatment of SAMHSA, the term "health oversight agency" is not a term defined in or used in the federal 42 CFR Part 2§2.53 Audit and Evaluation Activities.

In other states, legislative staff are allowed access to client records and claims data. As a basis for access, Utah cites HIPAA section 1178 (B) (b), "Nothing in this part shall limit the ability of a state to require a health plan to report, or to provide access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure certification."

Over the past three years, Utah's state government interest in Medicaid operations resulted in several legislative audits. The projected cost savings to Utah of $30 million to $45 million result from state agency implementation of legislative staff recommendations.

Similarly, in 2009, Arizona legislative staff evaluated the substance abuse system by accessing client records and claims data and interviewing providers and clients. Recommendations included:

- Fund evidenced-based practices proven to improve treatment results;
- Increase the use of information about treatment outcomes, particularly regarding differences across regions and providers; and
- Expand utilization reviews of service costs, consumer assessments, and case management. Auditors' review of division data from fiscal years 2006 to 2008, for example, brought 14 substance abuse consumers with service costs over $100 thousand to the division's attention.

LFC staff were not afforded the same access to information which is available to the public. Other information requested had not been provided at the conclusion of this report. Initial requests for BHSD information began in October 2012 and the OptumHealth data request was made in February 2013. The requests were for information, which for the most part, should be routine reports generated by OptumHealth. If this request had been made through New Mexico's Inspection of Public Record Act, there would be penalties for non-response.

The Collaborative's Letters of Direction impede transparency on the use of public funds. The BHSD Letters of Direction (letters), issued on behalf of the Collaborative, provide instructions to OptumHealth on substantive contract changes or funding transfers between providers and sources, but impede transparency on the use of public funds. Many of these transactions occur throughout the year. From 2009 through 2012, over 170 letters were issued to the OptumHealth. The evaluation team was not provided documentation of deliverables directed through letters. It is also unclear if the BHSD or OptumHealth monitors the value of letter directives. Many of the letters issued relate to multiple changes in funding, services, or programs as shown in **Table 7**. Letter #150 is being used as an example to demonstrate how difficult it would be for funders to track use. Language in the letter is verbatim from the original document. Most of the actions in this letter refer to Partners in Wellness, a behavioral health provider in Valencia County.

Table 7. Letter of Direction #150: Allocation of Core Service Agency Funds

General Direction: This letter of direction provides guidance to OptumHealth New Mexico as the statewide entity on the use of CSA unallocated funded in the amount of $260,000.
OHNM shall increase PIW's allocation by $60,000 to serve as the fiscal agent for CSA training activities as follows: $10,000 shall be allocated for the organization of two core panels for the training; $10,000 shall be allocated for videotaping the trainings and for the distribution of written material; $10,000 shall be allocated for operational costs associated with the organization of training; $20,000 shall be allocated to stipends to CSAs; and $10,000 shall be allocated for a series of three- or four-hour trainings to occur at the monthly Collective Learning meetings. The recommended topics would be: Principles of recovery and shared decision-making/self-directed care. Donald Naranjo-suggested lead organizer), Use of wraparound principles and natural supports in community-based systems of care (Lorraine Freedle), Role of Wellness in primary care and behavioral health (Bill Belzner);Working with transition (Diane Lopes, Kim Cobb; Peer integrations and consumer-run programming (Michael DeBernardi; Best Practices in community-based intervention (Shannon Freedle, Mark Boschelli); Use of IIDT model in treating co-occurring MH/SA disorders (Michael DeBernardi); Trauma-informed care for veterans (PMS VFSS/JDVF staff).
OHNM shall use any fund balance of the training activities listed above to support CSA infrastructure costs.
OHNM shall transfer the remaining balance of $15,537 in the BC90 from Life Link to the CSA unallocated fund for the purpose of executing this contract. The new total in the BC90 fund after transfer of the unused Life Link funds will be $257,171.
OHNM shall transfer $14,669 from Pathway's BC90 to BC90 unallocated. This will increase BC90 unallocated to $271,840.
OHNM Shall amend the subcontracts of the following providers and allocate $100,000 of the unallocated BC90 to PIW, $50,000 to Hogares, and $50,000 to Youth Development Inc for infrastructure costs associated with implementation of new CSAs. Infrastructure may include costs related to staff wages and benefits, temporary contracting and consulting (training) from member CSA agencies, telephone, computer, videoconferencing, and other support technology, travel, and miscellaneous administrative costs associated with implementation of CSAs.
The amount of $11,840 will remain unallocated based upon $260,000 being allocated to providers in this LOD.
The agencies will submit invoices for reimbursement. Invoices shall be approved by OHNM and reviewed by BHSD. All funds must be expended by 6-30-11.

Source: BHSD LOD #150

Dispersing funds through multiple letters and funding sources does not give a true accounting of all reimbursements received by a provider. When viewed in isolation from other letters and appropriation information, policymakers and the public would not be aware that Partners in Wellness, a group of providers housed in a state-owned facility, also receives Medicaid funding for claims reimbursement and other miscellaneous funding through other letters and the GAA. As an example, the FY13 GAA provided $750 thousand for operations of the Partners in Wellness facility with another $750 thousand in the FY14 GAA. In the past, letters were posted on the BHSD website, but are no longer available, denying the public information related to public fund use.

The BHSD must ensure letters maintain the intent of funding, are not primarily a mechanism to expend unallocated money, and do not violate statute or regulation. End-of-year letters do not appear to allow time for completion of directions. For example, a letter issued June 6, 2011, has a mandate that all funds be expended by June 30, 2011. Letters are used to reimburse agencies for work completed in the past year for which money was not available or for future costs from a previous year's funding. Many end-of-year letters direct exchanges of federal fund use for state general funds use. A letter issued at the end of calendar year 2010 directed OptumHealth to reduce funding from two major block grants by a total of $464 thousand and increase state general revenues use in the same amounts. Reasons for the exchange are not cited in the letter but federal grants are allowed to carryover funds to a new fiscal year, while unused state general funds could revert to the state. This transaction also resulted in a $55 thousand increase in OptumHealth's administrative allowance, which would not have been available from a federal grant.

A letter issued in February 2011 provided specific instructions to OptumHealth to amend contracts with Partners in Wellness. The HSD has authorized the facility to be used by the provider group to provide behavioral health services and training. Per the HSD, the facility was intended to be operated by private providers, but with operating funds provided by the state. The facility was built using state capital appropriations, with occupancy occurring in January of 2011. Plans for the complex also include a residential treatment program for women with children. This

project has been delayed, waiting additional funding. The letter identifies mandated expenditures for Partners in Wellness and how they may invoice OptumHealth for reimbursement for a portion of those costs. The letter directs Partners in Wellness to fund liability insurance for staff, pay for maintenance of all provider-owned equipment, and pay all utility, phone and fire alarm and monitoring costs. The letter then allows Partners in Wellness to seek reimbursement up to $30 thousand for those costs.

On May 26, 2011, another letter was issued for an additional $80 thousand to Partners in Wellness's state-funded allocation for a total allocation of $597 thousand, which can be drawn down by invoice. The letter states, "Partners in Wellness is in the development phase of the creation of a comprehensive behavioral health program in Los Lunas and moved into a state-owned facility. These activities precipitated unplanned administrative expenses requiring reimbursement through an invoice system. Partners in Wellness is currently able to draw down $416,978 in claims and $120 thousand by invoice." The letter then allows Partners in Wellness to increase the amounts which can be drawn down by invoice by $80 thousand so that $396,978 can be drawn down by claims. Directed uses of the invoice funds include:

- $30 thousand for utilities, $20 thousand for management personnel and fringe benefits for hours building management, establishment of access cards, security system, etc, as documented on time sheets;
- $10 thousand for supplies and small non-capital equipment for group rooms and children's waiting space;
- $14 thousand for library, therapeutic art, and gardening supplies; and
- $6 thousand for explorations groups provided by Licensed Alcohol and Drug Abuse Counselor staff.

Based upon a 1963-1964 New Mexico Attorney General opinion and Article 9, Section 14 of the New Mexico constitution, it is incumbent upon any public agency or commission to obtain reimbursement for any actual expenses occasioned by reason of permitted private use of public facilities. Users of public facilities must reimburse state for expenses. Allowing state funds to be used to reimburse for private agency staff time, travel expenses, and communication technology, without any further agreement in place, appears to violate the anti-donation clause of the New Mexico constitution. A 2013 Attorney General opinion reiterated interpretation of the statute by informing the city of Las Cruces it was in violation of the statute's intent and must begin to charge fair market rents to non-profit agencies housed in city buildings.

Also, letters may excuse a provider's requirement to submit accurate or timely claims, because accounting is difficult, or providers' lack of capacity to meet workload expectations. The agencies are allowed to do invoice billing which may inhibit the state's ability to capture all data related to service delivery.

- On June 24, 2010, the BHSD directed the statewide entity to change the billing method for Vistas Sin Limites from fee-for-service to invoice billing for FY11. This letter was issued six days prior to the end of FY11.
- On November 10, 2010, a letter was issued directing the statewide entity to allow invoice, rather than fee-for-service billing, for Cornerstone Counseling, with invoice billings acceptable retroactively for services rendered from March 2010 onward.
- On December 14, 2010, a letter directed a change for the billing method for Santa Fe Mountain Center from fee-for-service to invoice billing for activity therapy services. Date of service limitations were not addressed in the letter.
- A letter was issued on July 26, 2011, directing the statewide entity to pay claims to Carlsbad Mental Health, despite the failure of the agency to use modifiers as directed to the specific time period. The letter refers to significant time period, all of FY10 and FY11. Seeing no other letters were issued to other providers for the same issue, this agency is either the only one in the state delivering the services or is the only agency not able to meet billing requirements.

Finally, letters allow the BHSD to avoid requirements of New Mexico's procurement code. Transferring funds to a private entity, OptumHealth, allows state purchases which would require requests for proposals in the state

system. Several letters direct the statewide entity to contract with specific individuals for evaluation or consultation services. As an example, a letter dated September 23, 2010 directs the statewide entity to contract with Coop Consulting, in the amount of $125 thousand, to support strategic directions to re-build and strengthen the Office of Substance Abuse Prevention and Treatment. New Mexico's Procurement Code for small purchases of professional services, Section 13-1-125 NMSA 1978, requires requests for proposals for contracts of $50 thousand or greater.

The second means by which the BHSD transmits direction to OHNM is the Change Request Form. The Change Request Form was introduced to separate documents used for contract and funding changes. The division intends the Change Request Form to be used when moving allocations among providers or between different funding pools. The letters of direction are to be used for substantive contract changes. Examples of Change Request Forms issued in 2012 appear in the table below.

Table 8. Examples of HSD/BHSD 2012 Change Request Forms

Date	Directive	Purpose	Issues
3/2/12	Transfer $72,000 from Los Lunas residential fund to Partners in Wellness	To provide mental health services	HSD/BHSD appears to maintain a fund for program which is not yet in existence. Construction funding has delayed the planned residential program
4/24/12	Transfer $2,706 from De Baca Family Practice to Life Link	To provide: $2,000 for Youth Jam $15,000 for Burbank contract $5,600for NM Hispanic Medical Association contract $2,000 to JB Bryon design $2,460 to Life Link for admin fees	A state agency is funding sponsorship for a non-state entity
5/16/12	Transfer $20,000 to Coop Consulting	To provide up to 16 days of technical assistance between Counseling Associates or Dona Ana BH Services Division. To be reimbursed via invoice.	Funder is not determining where services will be provided leaving the decision to the vendor or OptumHealth. If all consulting fees for this vendor were in a single contract and issued by a state agency, an RFP would be required.
6/8/12	Transfer $109,501 from Otero County Council to Carlsbad Mental Health	To provide regional IOP services	The funds were transferred approximately three months prior to the Attorney General's fraud investigation.
6/30/12	Transfer $50,000 for PMS Veterans PTSD project to Partner in Wellness	Scope of work to be developed by OHNM. Reimbursement by invoice.	Funds are being transferred without a stated purpose from BHSD.
7/23/12	Transfer $30,000 from underutilized Veterans and Family Support services from Judicial 2 District 2 to Partners in Wellness	To provide Construct on Coaching Opportunities to Reach Employment activities at Partners in Wellness	From March through December 2012, Partners in Wellness received $172,000, most of which will not be claim-based reimbursement, but invoice billing.
12/20/12	Transfer $50,000 to Partners in Wellness from the PMS Veterans PTSD fund	No purpose stated. Reimbursement by invoice	

Source: LFC Analysis of BHSD CRF report

Recommendations

The BHSD should

- Report the results of the behavioral health provider audits to the LFC.
- Clarify the role of the HSD Inspector General in the auditing process;
- Require the statewide entity to revise their program integrity monitoring to ensure early detection of failures to comply with state and federal laws to include: specific program integrity monitoring for state general and federal grant funding streams, the BHSD conducted validation reviews of MCO provider audits, and the evaluation and implementation of successful incentive/disincentive practices for the statewide entity to ensure program integrity protects the use of public resources; and
- Establish performance measures in MCO contracts which would aid in monitoring the level of provider oversight for program integrity by MCOs.

THE BHSD HAS NOT MAINTAINED AN ONGOING ASSESSMENT OF SYSTEM CAPACITY TO PREPARE FOR MAJOR CHANGES IN BEHAVIORAL HEALTH DELIVERY

Significant healthcare reform at the federal and state level will change the delivery of both Medicaid and non-Medicaid behavioral health services. With the implementation of the Affordable Care Act, the SAMHSA will be working with states to consider new factors when developing their annual grants plans. The SAMHSA has identified new directions for federal grants:

- Taking a broader approach in reaching beyond the populations they have historically served through block grants;
- Conducting needs assessments and developing a plan that will identify and analyze the strengths, needs, and priorities of the state behavioral health system;
- Designing and developing Collaborative plans for health information systems;
- Forming strategic partnerships to provide individuals better access to good and modern behavioral health services;
- Increasing focus on recovery for person experiencing mental health and/or substance abuse problems;
- Redesigning systems and services to be more accountable for improving the caliber and performance of services funded; and
- Describing tribal consultation activities.

Although many of these issues are not new, states should be aware of the heightened interest by the SAMHSA in promoting these efforts. The following statement from the SAMHSA should alert states to upcoming changes in federal funding, "as other programs are reduced, restructured, or eliminated, it will be necessary to rethink performance targets to reflect realistic expectations and viable management paradigms".

The Centennial Care plan, New Mexico's Medicaid waiver request, marks the third major behavioral health system transformation since the Behavioral Health Purchasing Collaborative was created in 2004. In 2005, consumers and providers adjusted to a "carved out" behavioral health model by which the statewide entity, ValueOptions New Mexico, was contracted to manage Medicaid and non-Medicaid mental health and substance abuse programs and funding from six state agencies. In 2009, the statewide entity contract was awarded to OptumHealth. Beginning in 2014, four MCOs will have contracts with the HSD to implement Centennial Care which integrates or "carves in" behavioral health into Medicaid physical health for clients within the MCOs, while OptumHealth will continue as the statewide entity for federal and state general funding. If New Mexico's Medicaid waiver is approved, additional consumers will be eligible for sponsored services and the behavioral health benefit package will be expanded. The department has not provided an assessment of the number of individuals who could move from state general funded care to Medicaid.

The MCOs that have been selected through a competitive request for proposal (RFP) process are United Healthcare Community Plan of New Mexico, Blue Cross Blue Shield New Mexico, Molina Health Care of New Mexico, Inc. and Presbyterian Health Plan, Inc.

Consumer and advocate concerns that the pooled physical health and behavioral Medicaid funding streams would cause harm to behavioral health funding are alleviated by the HSD's implementation of a per-member-per-month rate for behavioral health services. In addition, each MCO must:

- Employ a full-time senior executive who is a board-certified psychiatrist to oversee and be responsible for behavioral health activities;
- Include behavioral health expertise on the pharmacy and therapeutic committee;
- Require the MCO contract managers develop mutually agreed upon policies and procedures for addressing areas such as information sharing, billing procedures, and MCO's participation in non-Medicaid initiatives;
- Require each MCO to make its best effort to contract with core service agencies;

- Require each MCO to examine a member's behavioral health needs in the health risk assessment and in identifying those in need of care coordination;
- Require each MCOs to cooperate with HSD's initiative to develop health homes; and
- Establish respite and family support as new Medicaid behavioral health services.

Centennial Care will expand services for Medicaid behavioral health consumers through health homes. A health home mimics the medical home model to provide comprehensive care management, care coordination and health promotion, and transitional care from inpatient to other settings, including appropriate follow-up and referral to community and social support services. As stated in the Centennial Care concept paper, the HSD believes up-front investment in health homes and health literacy will improve health outcomes at reduced costs. Other states, such as Iowa, are implementing health homes at a projected savings of $7 million to $15 million over a three-year period.

Non-Medicaid behavioral health consumers with severe mental illness or substance dependency currently access comprehensive care coordination through certified core service agencies (CSAs), a model similar to health homes. Additionally, the HSD plans to designate some CSAs as health homes, although only Medicaid-eligible consumers may participate.

Stronger control of the behavioral health system could occur with improvements in authority and administration. With multiple changes occurring simultaneously in the behavioral health system, active participation of all Collaborative members is needed. Centennial Care, the Affordable Care Act, and the addition of four MCOs plus a statewide entity, bring a multitude of changes impacting the behavioral health system, creating a broader oversight need.

The Collaborative meeting minutes reflect a waning interest in attendance by Collaborative member designees. As the governing authority for the behavioral health system, active involvement of members will be required to ensure a successful transition to a new system. Participating departments have reclaimed responsibilities previously administered by the statewide entity. As an example, the management of forensic evaluations has returned to the CYFD.

Without increased oversight of all the changes, the result may be a more convoluted system for the consumer to navigate. The HSD has not articulated how the statewide entity for non-Medicaid behavioral health funding would interact with MCOs and providers to ensure the coordination of care between the BHSD and Medicaid services. Separation of the funding streams will also complicate reporting of services by provider agency and individual consumers. Without real-time access to consumer information between the MCOs and the statewide entity, care coordination could be compromised. It is unclear what the HSD will require regarding the information exchanges between these entities, although the HSD has indicated the MCOs contract managers will work with the statewide entity to develop policies and procedures for exchange of information. This could result in four distinct systems, making it difficult to integrate data for global reporting and be too onerous for the statewide entity.

The BHSD does not regularly inventory behavioral health needs statewide and the OptumHealth reporting of differences in provider access and service delivery among regions is inadequately presented. A thorough analysis of the gap between the need for and provision of behavioral health services has not been performed since 2002 to inform New Mexico's major behavioral health system transformations, in spite of statutory requirements. Under Section 9-7-6.4 NMSA 1978, the Collaborative is directed to identify behavioral health needs statewide, with an emphasis on that hiatus between needs and services set forth in the DOH's gap analysis and in ongoing needs assessments, and develop a master plan for statewide delivery of services. The 2002 New Mexico Behavioral Health Needs Assessment identified over 500 thousand individuals with substance abuse and dependence or mental health disorders, representing about 22 percent of the state's total population. According to a Con Alma Health Foundation report on health disparities in New Mexico, of these individuals, approximately 25 percent to 35 percent need behavioral health services from the publicly funded system of care.

Employing psychiatrists, advanced practice nurses, and medication prescribers is important to assuring appropriate services for behavioral health consumers. New Mexico's licensed behavioral health workforce is mainly composed of psychologists, psychiatrists, social workers, marriage and family therapists, and psychiatric nurses. According to the New Mexico Regulation and Licensing Department (RLD), there are only 922 psychiatrists and psychologists and 1,875 total Licensed Professional Clinical Mental Health Counselors licensed to practice in New Mexico. These professionals hold a master's degree in counseling or a counseling related field from an accredited institution and have successfully completed the National Counseling exam and the National Counseling Mental Health Clinical Exam. There are 1,668 Licensed Independent Social Workers (LISW) in New Mexico; these professionals hold a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education and have successfully completed the Association of Social Work Board Clinical Exam.

An insufficient number of licensed behavioral health providers serve consumers with behavioral health needs and current monitoring of contracted providers and agencies is too broad to target improvement. New Mexico faces challenges in recruiting and training behavioral health professionals outside of Bernalillo County and many rural and frontier areas have provider shortages. The OptumHealth Geographic Distribution of Behavioral Health Providers, or Geo Access Report, allows Medicaid managed care and OptumHealth to monitor consumers' access to identified behavioral health services to determine whether or not access requirements are being met. However, the geographic information contained in the Geo Access Report is limited to the performance of providers within urban, rural, and frontier areas and does not analyze specific localities to be targeted for improvement.

Geo Access Reports for FY11 and FY12 show OptumHealth is meeting the overall compliance for the geographic distribution of independently contracted behavioral health providers, but exceptions persist. Psychiatrists, psychologists, and certified nurses with prescriptive authority are below the 90 percent standard in rural and frontier areas. The Geo Access Report notes when all prescribers from all areas are combined, the 90 percent standard is exceeded. A comparison of fourth quarter reports demonstrate that between FY11 and FY12, shortages of independently contracted providers in rural and frontier areas remained despite efforts to improve access for consumers in these locations.

Table 9. OptumHealth Performance by Provider Type, Quarter 4: FY11 and FY12

Clinician Type	Standard	FY11	FY12	Performance Goal
Psychiatrist	Urban: estimated 30 miles	99%	99%	90%
	Rural: estimated 60 miles	73%	78%	90%
	Frontier: estimated 90 miles	66%	66%	90%
Psychiatrist	Urban: estimated 30 miles	94%	94%	90%
	Rural: estimated 60 miles	81%	81%	90%
	Frontier: estimated 90 miles	60%	61%	90%
Certified Nurse with Prescriptive Authority	Urban: estimated 30 miles	93%	93%	90%
	Rural: estimated 60 miles	43%	43%	90%
	Frontier: estimated 90 miles	40%	49%	90%
All Other Licensed Providers	Urban: estimated 30 miles	99%	99%	90%
	Rural: estimated 60 miles	100%	98%	90%
	Frontier: estimated 90 miles	97%	97%	90%

Source: OptumHealth Geo Access Reports, FY11 and FY12

The licensure data maintained by RLD may over-represent the number of behavioral health professionals practicing in the state, because not all licensed providers are active in New Mexico. New Mexico law requires that the DOH create and maintain the health care workforce database. The law directs what information will be required of new licensee and renewal applicants. Collection of this information by licensing boards will provide a more accurate picture of the workforce needs. At this time, only psychiatrists and nurses provide the required information. Other licensing boards have not developed a survey collecting information specific to practice status which would identify those individuals actually practicing in New Mexico.

The 2012 OptumHealth Behavioral Health Provider Directory illustrates a lack of providers and agencies that receive the BHSD funding for services to consumers that do not meet Medicaid qualifications. About 34 percent, or 173, of all agencies contracted with OptumHealth serve consumers that receive services funded by the BHSD, other than Medicaid. Because Medicaid does not have a defined funding limit and the federal and state general funding sources are the payor of last resort, providers may be more inclined to only serve Medicaid consumers and fill in gaps with the BHSD funded services when Medicaid will not reimburse for a service. Therefore, Medicaid clients have a broader array of behavioral health options and non-Medicaid eligible consumers have more limited provider options.

The OptumHealth network is inconsistent in meeting targets for behavioral health facilities and agencies across all locations. Targets are being met with community mental health centers in urban, rural, and frontier areas, but no other type of facility and agency is available in all locations across the state.

Table 10. OptumHealth Performance by Facility/Agency, Quarter 4 of FY12

Facility/Agency Type	Standard	Performance Goal	OHNM's Results
Inpatient Hospital Facilities	Urban: estimated 30 miles	90%	99%
	Rural: estimated 60 miles	90%	53%
	Frontier: estimated 90 miles	90%	58%
Partial Hospitalization Facilities	Urban: estimated 30 miles	90%	71%
	Rural: estimated 60 miles	90%	0%
	Frontier: estimated 90 miles	90%	0%
Indian Health Services and Tribal 638	Urban: estimated 30 miles	90%	72%
	Rural: estimated 60 miles	90%	61%
	Frontier: estimated 90 miles	90%	47%
Outpatient Therapy	Urban: estimated 30 miles	90%	93%
	Rural: estimated 60 miles	90%	73%
	Frontier: estimated 90 miles	90%	40%
Community Mental Health Centers (CMHCs)	Urban: estimated 30 miles	90%	99%
	Rural: estimated 60 miles	90%	98%
	Frontier: estimated 90 miles	90%	100%
Rural and Federally Qualified Health Centers (RFQHCs)	Urban: estimated 30 miles	90%	100%
	Rural: estimated 60 miles	90%	87%
	Frontier: estimated 90 miles	90%	80%

Source: OptumHealth NM Geographic Distribution of Behavioral Health Providers by Provider Type

The BHSD has implemented programs and services to enhance New Mexico's behavioral health system. Over the past three years, the BHSD has implemented programs and services to enhance New Mexico's behavioral health system. Most of the new programs and services are recognized as promising practices.

Care coordination is a cornerstone in providing high quality care. Core service agencies (CSA) , modeled after the medical home concept, provide care coordination by engaging consumers, coordinating comprehensive assessments that involve the consumer, family and other key supports, creating consumer-driven service plans and providing a range of prevention, early intervention, treatment, and recovery services. These agencies serve as the clinical home for consumers with chronic and complex disorders. This includes adults:

- Who are a significant current danger to self or others or present active symptoms of a serious mental illness;
- Who have three or more emergency room visits or psychiatric hospitalizations within the last year;
- Who experience trauma symptoms related to sexual assault, domestic violence, or other traumatic event;
- Who have a severe impairment in at least one Axis IV functional domain or moderate functional impairment in multiple domains; or
- Who have serious mental illness and potentially life-threatening medical condition (e.g. diabetes, HIV/AIDS).

There are 36 CSAs designated in the state for adults and children. The CSAs' primary responsibility is care coordination, but based upon the availability of other qualified providers in an area, CSAs may also provide clinical services. CSAs received enhanced reimbursement for initial assessments and certain CSA were provided with start-up funding. Service providers who have been designated are assigned specific geographic areas and may be the designee for several counties (**See Appendix F**).

Comprehensive community support services are based on the principles of recovery and resiliency. Providers form relationships with consumers to assist them in reaching their individual goals and to help them live a more independent life. The service is not time-limited. Core to the team members are certified peer specialists, individuals who have first-hand knowledge of living with mental illness or substance abuse. Duties which may be assumed by the peer specialists include aiding the client in: applying for Social Security and Social Security Disability, state general assistance, food stamps, and supported or independent housing and navigating the health care system. The intent of the service is to provide the consumer with a better life through improved health and to decrease the need for intense services.

In February 2013, the New Mexico Crisis and Access Line went live. The line provides access to local help and resources for individuals experiencing a mental health crisis. Unlike the statewide Nurse Advice Line, this resource is staffed by mental health professionals. Once a person is stabilized over the phone, the mental health specialist will refer the person to local resources. This is an added resource to the CSAs 24-hour hotline. In the first full month of operations, the center fielded 115 calls, 49 percent of callers with suicidal thoughts and 40 percent with concerns about alcohol or substance abuse.

Mental health first aid training is expanding in New Mexico. OptumHealth and other mental health organizations are providing training throughout the state. According to the mental health first aid website, the program helps the public identify, understand, and respond to signs of mental illnesses and substance abuse disorders. The OptumHealth website explains that as with any first aid class, action plans are in place to help someone in crisis. Trainees learn how to assess the person for risk of harm or suicide, listen non-judgmentally, give reassurance, and encourage the person to seek professional help.

New Mexico Department of Veterans Services (DVS) and behavioral health providers are collaborating to offer free services to veterans who have served in Iraq and Afghanistan. The United States Department of Veterans' Affairs (VA) eligibility process is onerous, leaving veterans without services until approval is granted. A team of licensed practitioners from every county in the state provides free services to veterans until their benefit applications are processed.

Recommendations

The BHSD should

- Direct the process by which information will be exchanged between the statewide entity and the MCOs to ensure the BHSD has consistent data by which to administer the system and consumer services are efficient and timely;
- Closely monitor the referral activity of CSAs to protect the survival of qualified non-CSA providers;
- Review the legislation governing the Collaborative to ensure the intent is being met and if opportunities exist to strengthen oversight of the system;
- Require the statewide entity and Centennial Care MCOs to provide more detailed analyses of the financial, service utilization, and Geo Access reports for monitoring of New Mexico's behavioral health system performance and to target resources appropriately; and
- Work with the DOH to enforce the legislatively required workforce data collection by appropriate licensing boards from all independently licensed behavioral health providers.

EVIDENCED-BASED PRACTICES PROVIDE A HIGH PROBABILITY THAT OUTCOMES FOR CONSUMERS WILL IMPROVE AND USE OF PUBLIC MONIES WILL BE MORE EFFICIENT

Implementing programs with demonstrated effectiveness should be the top priority for the BHSD. Dr. Davis Sackett, a pioneer in evidenced-based practices, defines the practices as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients." The goal of an evidenced-based practice is to integrate clinical expertise and opinion, external scientific evidence, and patient perspectives and address the community's risk and contributing factors.

In recognition of the value of evidenced-based practices, the SAMHSA provides grant funding targeting the implementation of evidenced-based practices for mental illness and substance abuse. New Mexico has also funded evidenced-based practices through federal grants and state general funds.

The BHSD needs a stronger focus on increasing the use of evidenced-based practices in the treatment of mental illness and substance abuse. The New Mexico federal grant application for FY13 informs SAMHSA that New Mexico, through the Collaborative, funds approximately $340 million for behavioral health services in the state with approximately 15 percent specifically linked to evidenced-based practices. New Mexico's evidenced-based initiatives are shown in **Table 11**. Reviews of capacity shows the practices are not available to many consumers.

Table 11. Evidence-Based Initiatives in New Mexico

Initiative	Purpose
Milwaukee Wraparound	An approach used the standard for emotionally disturbed or at risk children focusing on care coordination and family advocacy.
Multisystemic Therapy	Services provided to adolescents to address criminal offending, out of home placement, behavioral health problems, school achievement, and family functioning.
Matrix Model for Intensive Outpatient Programs	Package of therapeutic strategies (cognitive behavioral therapy, relapse prevention, motivational interviewing) for treatment for addictions.
Assertive Community Treatment (ACT)	Team treatment approach to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness
Trauma-informed Care	A broad range of services for people with a history of trauma, including mental health, substance abuse, housing, vocational or employment support, domestic violence and victim assistance, and peer support.
Substance Abuse Treatment Model for Pregnant Women	Residential and outpatient treatment for pregnant women and their children
Supportive Housing	Move-in assistance

Source: 2012 NM Block Grant Application

Several of the evidenced-based practices are a combination of services and are not identifiable in OptumHealth utilization reporting. However, intensive outpatient programs have increased in use in Regions 1, 2, and 4, decreased in Region 5, and are not available in Region 3. As a package of services, all of which are claimed separately, it is not possible to assess utilization of trauma-informed services. The concept is newer than others and it appears the state is strongly invested in educating providers to be aware of the issues relating to trauma victims.

Promising practices are those that are judged to be clinically sound, designed to meet priorities of health resource consumers, and are associated with positive outcomes. The practices lack the sufficient, scientific-based evidenced, and are need of further research to prove the efficacy of the practice. The BHSD has implemented promising practices such as comprehensive community support services, using peer support in the service array and CSAs for care coordination.

Policymakers are becoming more aware of the benefits of evidenced-based practices and have taken actions to ensure public funding is directed to health interventions which have monetary and health benefits. In 2009-2011, the Oregon legislature directed state agencies to spend increasing shares of public dollars on evidenced-based practices culminating in 75 percent by the end of the budget period.

In the mid-1990's, the Washington state Legislature directed the Washington State Institute on Public Policy (WSIPP) to research interventions that have been shown to improve particular outcomes. With this information, policymakers can budget for better outcomes for service recipients and a more efficient use of taxpayer dollars. For each practice researched, the WSIPP produces two major findings: expected benefit-cost results (return on investment) and the odds that the policy will have at least greater benefit than costs. Benefits and costs are present-value per participant in 2011 dollars. The evidence-based practices appearing in **Table 12** are interventions which are or have been used in the New Mexico behavioral health system.

Table 12. Washington State Institute on Public Policy
Benefits and Costs of Evidence-Based Practices

EBP	Benefits Minus Cost	Benefit to Cost Ratio	Measured Risk (Odds of a positive net value)
Adult Drug Court	$11,255	$3.69	100%
Brief Alcohol Screening and Intervention	$2,883	$13.75	97%
Cognitive Behavioral Therapy	$9,283	$23.55	100%
Functional Family Therapy	$67,108	$21.57	100%
Multisystemic Therapy	$24,751	$4.36	98%

Source: Washington State Institute for Public Policy

The work of the WSIPP demonstrates the positive value of evidence-based practices when implemented in consideration of population to be served and with the fidelity prescribed by the research.

Over the past two years, the LFC staff has developed a cost benefit model known as the New Mexico Results First Model. This model was developed with assistance from the Pew-MacArthur Results First Initiative. The Results First Initiative is a project of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation.

The New Mexico Results First Model provides estimated monetary benefits, costs, measure of risk, and return on investment based on New Mexico data and over 27 thousand national studies. Through a better understanding of program effectiveness and cost benefit of investments, policy makers can use this approach to inform investment of funds toward strategies that result in increased savings and improved outcomes for New Mexicans.

Screening Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based, comprehensive, integrated public health approach that demonstrated positive results in New Mexico, but is no longer funded. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur. Screening quickly assesses the severity of substance use and identifies the appropriate level of treatment, brief intervention focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change, and referral to treatment provides those identified as needing more extensive treatment with access to specialty care.

An independent evaluation of the New Mexico SBIRT program demonstrated that participants decreased the number of days of alcohol use, the days of illegal drug use, and the rate of substance abuse caused by stress. SBIRT was available through community based primary health clinics, school-based health centers, and public health offices in New Mexico from 2004 to 2008. It targeted rural and underserved at-risk populations to increase access to integrated behavioral health services. The major clinical modules within the SBIRT program includes motivational interviewing and cognitive behavioral therapy for the brief interventions and assessments that precede referrals for more specialized behavioral health treatment from community behavioral health provided when needed.

Table 13. New Mexico SBIRT Patient Rate of Change as a Result of Receiving Services, 2003-2008

Government Performance and Results Act Measures	Percent at Intake	Percent at 6-Month Follow-Up	Rate of Change
Abstinence: did not use alcohol or illegal drugs	29%	46%	58%
Crime and Criminal Justice: had no past 30 day arrests	91%	95%	5%
Employment/Education: were currently employed or attending school	54%	83%	42%
Health/Behavioral/Social Consequences: experienced no alcohol or illegal drug related health, behavioral, social consequences	59%	83%	42%
Social Connectedness: were socially connected	72%	66%	-8%
Stability in Housing: had a permanent place to live in the community	62%	64%	2%

Source: CSAT Database 9/30/2008

The SAMHSA funded SBIRT in New Mexico for $3.2 million dollars per year for four years. The federal government expected New Mexico to sustain SBIRT efforts once federal funding expired. However, New Mexico did not allocate any state general funds for sustaining or continuing the SBIRT program after federal funding expired in 2008**.** The discontinuation of funding and inability to produce new funding resulted in the Sangre de Cristo Community Health Partnership, a non-profit corporation, administering and maintaining a downsized SBIRT program at a limited number of sites around New Mexico: from 32 locations offering services in 10 counties to nine sites operating in five counties, mostly in Bernalillo.

The Collaborative strategic plan to position behavioral health in New Mexico for health care reform for FY11-FY14 seeks to develop local systems of care in which primary care and behavioral health providers and practitioners are aligned and integrated with one another and with other community-based services and supports. One of the goals is to develop a training and technical assistance plan for primary care providers to incorporate behavioral health services in primary care settings, including topics such as: implementing SBIRT, use of motivational interviewing skills, administration of depressing screening instruments, appropriate prescribing practices, and treating opioid addiction in families.

New Mexico has made a FY13 application for a SAMHSA funded SBIRT grant available to states or tribes without requiring a funding match. Since 2003, the SAMHSA has funded 17 medical residency cooperative agreements, 15 state cooperative agreements, and 12 targeted capacity expansion campus screening and brief intervention grants, none of which were located in New Mexico. In FY11, SAMHSA requested applications from states and tribes for cooperative agreements to implement SBIRT at a funding level of $1.7 million per year for up to five years, but New Mexico was not among the applicants. In FY13, another request for proposal was released by SAMHSA at a funding level of $2 million per year for up to five years. The BHSD, through the joint efforts of Sangre de Cristo Community Health Partnership and the University of New Mexico's Center for Rural and Community Behavioral Health, responded to the request and proposes to expand and enhance the state and tribal continuum of care for substance misuse services and reduce alcohol and drug consumption and its negative health impact if awarded the grant.

Although reimbursement for screening and brief intervention is available through Medicaid *Healthcare Common Procedure Coding System* codes, these codes are not on the current OptumHealth reimbursement schedule. The SAMHSA is working with the Centers for Medicare and Medicaid Services to educate practitioners about the importance of SBIRT coverage and the Medicare billing rules around these services. A review of all services by provider funded by all the BHSD funding streams in FY12, reveals that no OptumHealth contracted behavioral health providers are using the Medicaid codes for alcohol and/or drug screening or alcohol and/or drug service, brief intervention, per 15 minutes because they cannot be reimbursed for these services. If New Mexico is awarded the SBIRT grant, these codes should be added to the Medicaid plan.

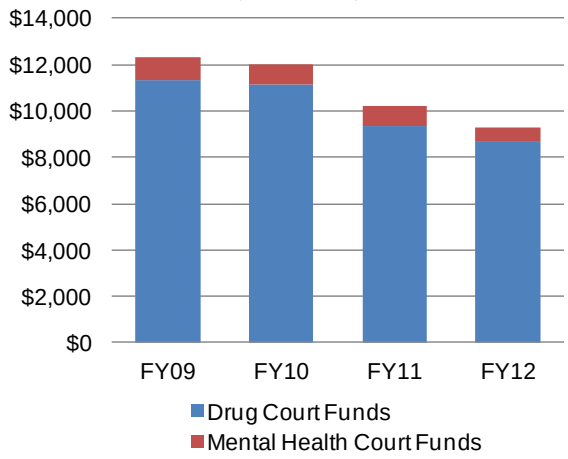
Evidence-based programs, like problem-solving courts, demonstrate positive outcomes and a return on public investment, but funding is being cut and is resulting in reduced program capacity. A drug court is a specially designed problem-solving court with a special docket, the purposes of which are to achieve a reduction in recidivism and substance abuse and to increase the participants' likelihood of successful rehabilitation. This is accomplished through mandatory periodic drug testing in combination with an ongoing treatment program along

with incentives and rewards for progress in the program or sanctions awarded by a judge. Mental health courts, also called treatment courts, are problem-solving courts that focus on people who have been charged with a crime and have a psychiatric disability. The purpose of the court is to deal with the crime in a way that addresses the person's mental health needs. Treatment, medical care and supervision, case management, and service referral are integral to problem-solving courts.

Data on drug courts both locally and nationally shows them to be effective at reducing the substance abuse and recidivism of drug-dependent offenders at a relatively low cost. The New Mexico Administrative Office of the Courts (AOC) collects performance measures on drug courts on a biannual basis, with a focus on the year-end compilation, which is available at the individual program level allowing each program to identify problems as well as accomplishments. In FY12, the drug court average cost-per-client-per-day was $19 compared to the average New Mexico daily cost of incarceration of $133 and the daily cost of detention at $65. The average state drug court graduation rate in FY12 was 65 percent, higher than the national average for drug court graduation of 57 percent in 2008.

All of New Mexico's drug court programs have resulted from local initiatives. As of October 2012, 25 counties in New Mexico have at least one drug court program, while eight counties do not have any problem-solving courts. There are five mental health courts in Aztec, Santa Fe, Bernalillo, and Albuquerque, where there are two locations. Recent closures of specialty courts have occurred in Taos, Hobbs, and Alamogordo because of budget cuts. From FY09 to FY12, federal and state funding for the drug courts and the problem-solving courts decreased by 24 percent, from $12.3 million to $9.3 million. Most of the reduction in funding was from the state general fund and the program absorbed those cuts in several ways, mostly by cutting their treatment contracts and reducing capacity.

Graph 17. Problem-Solving Court Total Funding, FY09-FY12



Source: AOC

Recommendations

The BHSD should

- Develop a minimum provider outcome data set for presentation to the legislature, display on public websites, or available to the public on request;
- Evaluate services and programs for duplication to ensure funding is spent in the best interest for consumers; and
- Investigate how evidenced-based practices, such as SBIRT and problem-solving courts, can be financially supported in the state to enhance the integration of physical and behavioral health and provide the opportunity for "warm hand offs" between the two.

New Mexico Human Services Department

Susana Martinez, Governor
Sidonie Squier, Secretary

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May 14, 2013

Mr. David Abbey, Director
Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, New Mexico 87501

Dear Mr. Abbey:

This correspondence serves as the Human Services Department (HSD) response to the Legislative Finance Committee's (LFC) program evaluation report "Cost and Outcomes of Selected Behavioral Health Grants and Spending".

HSD is committed to improving the health of people with serious mental illness and substance abuse disorders and demonstrates this throughout its statutory authority. The Behavioral Health Services Division within HSD serves as the mental health and substance abuse authority for the State of New Mexico. The New Mexico Behavioral Health Interagency Purchasing Collaborative (Collaborative) brings together 15 state agencies to plan services to meet the behavioral health needs of New Mexico. The Secretary of HSD is the standing chairperson of the Collaborative.

HSD is working on several key initiatives that will strengthen the behavioral health system and provide better outcomes for New Mexicans:

1. HSD is conducting audits of behavioral health providers who represent approximately 80% of the dollars spent on behavioral health services. This audit is being conducted by an independent firm, Public Consulting Group. We expect a final report within 4 weeks of the date of this letter. The results of the audit will assist HSD in identifying technical assistance needs across the provider network, as well as identify gaps in quality of service affecting consumer care.

2. The Collaborative adopted a substance abuse prevention strategy shared with the Legislature last Fall that identified working on strategic initiatives recommended by several task forces established by the Legislature, HM 17 – Crisis Memorial, HJM 21 – Substance Abuse, SM 18 Drug Policy Task Force, as well as the State Epidemiology Work Group, and the multi-agency Behavioral Health Promotion and Substance Abuse Prevention 5 year plan.

3. The Collaborative is working on developing a plan to monitor the progress of integrated care in the new Centennial Care program, specific to behavioral health outcomes at the Managed Care Organization level, as well as the provider level.

In addition to the three key initiatives above, this administration has embarked on several key programs that have immediate positive impact to the behavioral health of New Mexicans:

- Implemented Mental Health First Aid across the state – over 2,700 New Mexicans have been trained with a network of 58 instructors, to recognize the signs of mental illness, and assist individuals and families in getting the help they need;

- BHSD has worked closely with the Department of Veterans Services to provide veteran initiatives including the Second Judicial Veterans Court, Veteran & Families Support Services, statewide veteran conferences, and the governor's pro-bono counseling program for Veterans, which kicked off March 15, 2013;

- A statewide crisis line – 855-NMCRISIS – which is answered by licensed clinicians and stabilizes people or family members in crisis over the phone, and connects them to services in the community. A care coordinator with OptumHealth NM, follows up with the caller within 24-48 hours.

HSD is also working on a plan to structure the Collaborative so it can more readily make policy decisions that can be operationalized and monitored for outcomes. In its current structure, the Collaborative is unwieldy and the coordinated funding streams add a complexity to operations that make it difficult to identify the cause of weaknesses in programs. The proposed plan to restructure the Collaborative will address a more simplified structure, retain an advisory body, and reduce administrative burden on agency staff.

Regarding the key findings from the LFC program evaluation, HSD has summarized comments in the following matrix:

KEY FINDING	HSD COMMENT
The BHSD should report the results of the behavioral health provider audits to the LFC.	HSD agrees with this recommendation utilizing the guidance of HSD counsel.
The BHSD should require a sustainability plan be developed prior to the submission of grant applications.	HSD agrees with this recommendation in principle and agrees that details of a sustainability plan should be completed within the first year of a grant award if not already prepared.
The BHSD should clarify the role of the HSD Inspector General in the auditing process.	HSD agrees with this recommendation.
The BHSD should strengthen oversight of the statewide entity's monitoring of program integrity.	HSD agrees with this recommendation.

The BHSD should direct the process by which information will be exchanged between the statewide entity and the MCOs to ensure the BHSD has consistent data by which to administer the system and consumer services are efficient and timely.	HSD agrees with this recommendation. BHSD is working closely with MAD on the development and readiness activities for Centennial Care to address this change.
The BHSD should require the statewide entity and Centennial Care MCOs to provide more detailed analyses of financial, service utilization, and provider access information for monitoring of the behavioral health system performance and to target resources appropriately.	HSD agrees with this recommendation, though the word *more* does not point to specific operational changes. BHSD is working closely on the development and readiness activities for Centennial Care to address this change.
The BHSD should establish performance measures in MCO contracts which would aid in monitoring the level of provider oversight for program integrity by MCOs.	HSD agrees with this recommendation. BHSD is working closely with MAD on the development and readiness activities for Centennial Care to address this change.
The BHSD should develop a minimum provider outcome data set to present to the legislature, to display on public websites or to provide to the public on request.	HSD agrees with this recommendation.
The BHSD should prioritize service funding to evidence-based practices.	HSD agrees with this recommendation.

We look forward to keeping you abreast of our progress in the initiatives addressed above as we move toward addressing past problems and improving the behavioral health system for New Mexico. HSD recognizes the hard work of the LFC staff in producing this evaluation and in developing its recommendations. Thank you for the opportunity to review and respond to this report.

Sincerely,

Sidonie Squier
Cabinet Secretary

APPENDIX A: Program Evaluation Scope and Methodology

Evaluation Objectives.
This evaluation examines the state and federally funded adult behavioral health services in New Mexico under the purview of the Behavioral Health Collaborative and the Human Services Department. The evaluation also analyzes the adequacy of resources, the potential effect of national health care reform and state Medicaid expansion on future services, and the consumer outcomes being achieved through the behavioral health system.

Objective 1: Review spending on non-Medicaid mental health and substance abuse treatment programs and service capacity;
Objective 2: Evaluate the use and availability of evidence-based behavioral health programs and oversight of providers to ensure quality of care;
Objective 3: Analyze the cost and outcomes of selected behavioral health programs; and
Objective 4: Assess the relationship of the Behavioral Health Services Division funded services and programs with other state and federal funding, such as Medicaid.

Scope and Methodology.

- Interviewed key Behavioral Health Collaborative, Behavioral Health Services Division, and OptumHealth New Mexico staff to learn about the administration of federal and state funding for behavioral health services.
- Obtained and analyzed data from the Behavioral Health Services Division and OptumHealth regarding public spending, delivery of services, and outcomes of consumers of mental health and substance abuse services.
- Researched state and national reports relating to the grants currently funded in the state and how behavioral health funding and services could be impacted by the Affordable Care Act and Medicaid expansion.

Evaluation Team.
Valerie Crespin-Trujillo, Lead Program Evaluator
Pamela Galbraith, Program Evaluator

Authority for Evaluation. LFC is authorized under the provisions of 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 subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conferences. The contents of this report were discussed with the Human Services Department on May 10, 2013.

Report Distribution. This report is intended for the information of the Office of the Governor; the Human Services Department; 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.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: Performance Report Card Behavioral Health Collaborative-Second Quarter , Fiscal Year 2013

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

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

Comments: The collaborative has improved performance in providing follow-up services, with 43.6 percent of individuals receiving follow-up services at 7 days and 59.3 percent at 30 days. The percentage of individuals receiving alcohol and substance abuse treatment who show improvement in the addiction severity index slipped over FY12 actuals.

APPENDIX C: State and Federal Behavioral Health Funding, FY12

State Non-Medicaid Behavioral Health Funding, FY12

State Funds	Amount
BHSD Community Mental Health Services	$21 million
BHSD Community Substance Abuse Services	$18 million
BHC Transformation Grant	$66 thousand
Central NM Los Lunas Substance Abuse Operation	$597 thousand

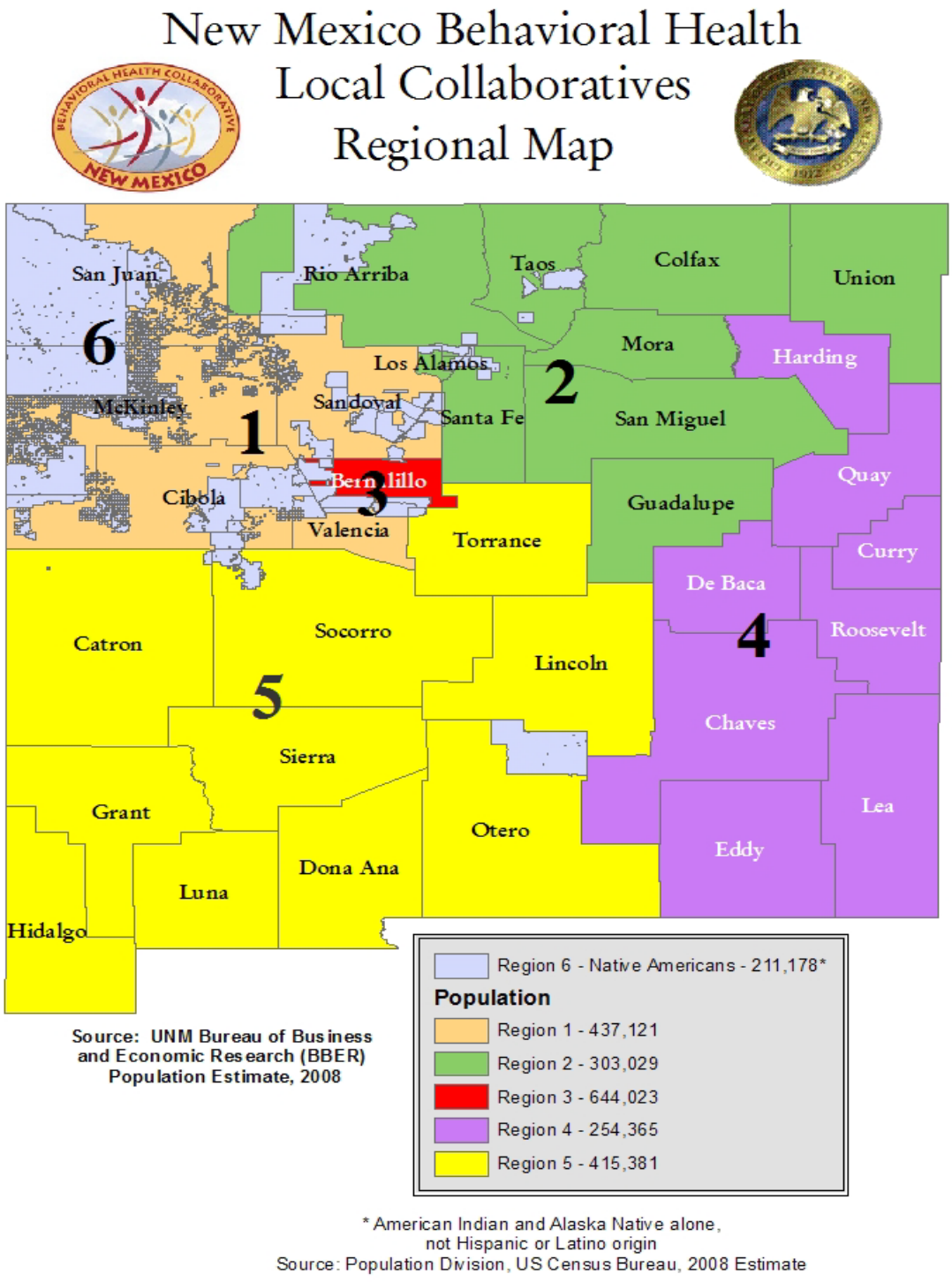
Source: HSD

New and Continuing Federal Behavioral Health Grants and Contracts, FY12

Federal Funds	Amount	Purpose
Access to Recovery III	$2.9 million	Funds a voucher-based, faith-based, clinical and recovery support service with a focus on services to members of the National Guard through provision of integrated recovery and treatment services.
Community Mental Health Services Block Grant	$1.4 million	Funds mental health services for adults with severe mental illness and children with serious emotional disturbance.
Jail Diversion Veterans First	$394 thousand	Funds jail diversion for veterans in Sandoval county with a focus on Native American veterans who experience traumatic spectrum disorders and who have had contact with law enforcement. The intent is to treat and not incarcerate under certain conditions.
Substance Abuse Prevention and Treatment Block Grant	$5.2 million	Funds substance abuse, treatment and primary prevention activities.
Data Infrastructure Grant	$13 thousand	Supports data collection and other reporting requirements related to the Community Mental health Services block grant.
Drug and Alcohol Information Services (DASIS)	$21 thousand	The primary source of national information on the services available for substance abuse treatment and the characteristics of individuals admitted to treatment. DASIS contains three data sets which are maintained with the cooperation and support of the States.
National Institute on Drug Abuse	$144 thousand	Designed to increase system capacity for evidence-based practice adoption and implementation through the Total Community Approach initiative.
Strategic Prevention Framework State Prevention Enhancement Grant	$600 thousand	Planning grant to build workforce capacity in all health arenas to implement effective prevention strategies.
Mental Health Transformation Grant-Healthy Homes	$670 thousand	Seeks to expand and enhance the capacity of the state's behavioral health system to provide evidence-based trauma-informed permanent supportive housing to adults with SMI and co-occurring substance use disorders who are homeless or at risk of homelessness.
Federal Drug and Administration (FDA) Tobacco Inspection Contract	Reimbursement	A cost reimbursement contract with the FDA in funding for tobacco retailer inspections statewide intended to decrease the use of tobacco products by minors and increase communities' awareness and responsibilities in this effort.
Pregnant and Postpartum Women-Crossroads Supporting Families	$392 thousand	Expands and enhances the capacity of the state's behavioral health system to provide evidence-based services to pregnant and postpartum women and their children with behavioral health needs in a residential treatment setting.
Projects for Assistance in Transition from Homeless	$295 thousand	Supports persons who are homeless with mental illness and/or co-occurring disorders.

Source: HSD

APPENDIX D: New Mexico BHC Local Collaboratives Regional Map



APPENDIX E: SAMHSA Formula and Discretionary Funding for NM, FY11-FY12

Formula Funding			FY11-FY12
Substance Abuse Prevention and Treatment Block Grant			$8,929,188
Community Mental Health Services Block Grant			$2,371,503
Projects for Assistance in Transition from Homelessness (PATH)			$300,000
Protection and Advocacy for Individuals with Mental Illness (PAIMI)			$660,200
Subtotal of Formula Funding			**$12,260,891**
Discretionary Funding	**Program**	**Project Period**	**FY12 Funding**
New Mexico Family Network		9/30/10-9/29/13	$70,000
University of New Mexico	Campus Suicide	8/1/11-7/31/14	$101,975
University of New Mexico Health Sciences Center	Community Treatment and Service Centers of the National Child Traumatic Stress Initiative	9/30/12-9/29/16	$399,706
Pueblo of Laguna	Linking Actions for Unmet Needs in Children's Health	9/30/12-9/29/17	$839,650
New Mexico State University-Las Cruces	Campus Suicide	8/1/11-7/31/14	$77,863
Mescalero Apache Tribal Council	Child Mental Health Initiative	9/30/10-9/29/16	$927,543
Region IX Education Cooperative	Prevention Practices in Schools	9/30/10-9/29/15	$299,442
New Mexico Department of Health	State/Tribal Suicide Prevention Grants	8/1/12-7/31/15	$472,063
Las Cumbres Community Services, Inc.	Community Treatment and Service Centers of the National Child Traumatic Stress Initiative	9/30/12-9/29/16	$399,906
Farmington Municipal Schools	Prevention Practices in Schools	9/30/10-9/29/15	$299,860
Community Area Resource Enterprise	Supportive Housing	5/1/10-4/30/15	$396,305
Pueblo of San Felipe	Child Mental Health Initiative	9/30/12-9/29/16	$1,000,000
New Mexico Department of Health	Linking Actions for Unmet Needs in Children's Health	9/30/08-9/29/13	$916,000
New Mexico Children, Youth, and Families Department	Child Mental Health Initiative	9/30/09-9/29/15	$2,000,000
Life Link	Supportive Housing	9/30/09-9/29/14	$398,532
New Mexico Department of Health	Jail Diversion	9/30/09-9/29/14	$393,741
New Mexico Human Services Department	State Data Infrastructure Grants	9/30/10-9/29/13	$130,600
New Mexico Human Services Department	Mental Health Transformation State Incentive Grants	9/30/10-9/29/15	$329,790
First Nations Community Healthsource	Strategic Prevention Framework State Incentive Grants	9/30/10-9/29/15	$1,568,479
County of Torrance	Drug Free Communities	9/30/04-9/29/14	$99,283
Carlsbad Community Anti-Drug/Gang Coalition	Drug Free Communities	9/30/04-9/29/14	$125,000
Pueblo of Laguna	Drug Free Communities	9/30/10-9/29/15	$125,000
Community Foundation of Southern NM	Drug Free Communities	9/30/08-9/29/13	$125,000
Pueblo of Acoma	Strategic Prevention Framework State Incentive Grants	9/30/10-9/29/15	$312,210
Five Sandoval Indian Pueblos, Inc.	Drug Free Communities	9/30/08-9/29/13	$106,188
County of Rio Arriba	Drug Free Communities	9/30/10-9/29/15	$125,000
San Juan County Partnership, Inc.	Drug Free Communities	9/30/08-9/29/13	$125,000
Teambuilders Counseling Services, Inc.	Drug Free Communities	9/30/10-9/29/15	$125,000
Santa Fe Public Schools	Drug Free Communities	9/30/12-9/29/17	$125,000
New Mexico Human Services Department	SPF-Partnership for Success II	9/30/12-9/29/15	$2,674,187
Albuquerque Healthcare for the Homeless	Treatment for Homeless	9/30/08-9/29/13	$400,000
City of Albuquerque	Co-op Agreement to Benefit Homeless Individuals	9/30/11-9/29/14	$500,000
New Mexico Human Services Department	Access to Recovery	9/30/10-9/29/14	$3,389,232
New Mexico Human Services Department	Pregnant/Post-Partum Women	9/30/11-9/29/14	$524,000
Subtotal Discretionary Funding			**$17,360,841**
Total SAMHSA Funds			**$29,621,732**

APPENDIX F: Core Service Agency (CSA) Designations

Core Service Agency (CSA) Designations

Local Collaborative	Provider Agency	Clients	Counties Served
Local Collaborative 1	Teambuilders	Youth	Los Alamos, Rio Arriba, Santa Fe
	PMS	Adult	
	Life Link	Adult	
Local Collaborative 2	YDI	Youth	Bernalillo
	Hogares	Youth	
	All Faith Receiving Home	Youth	
	UNM	Youth/Adult	
	St Martins	Adult	
Local Collaborative 3	Southern NM Human Development	Youth/Adult	Dona Ana
	Families and Youth, Inc	Youth	
Local Collaborative 4	Teambuilders	Youth	Guadalupe, Mora, Sam Miguel
Local Collaborative 5	Counseling Associates	Youth/Adult	Chavez, Eddy. Lea
	Lea County Guidance Center	Youth/Adult	
Local Collaborative 6	Border Area Mental Health	Youth/Adult	Grant, Luna, Hidalgo
Local Collaborative 7	PMS	Youth/Adult	Catron, Sierra, Torrance, Socorro
Local Collaborative 8	Teambuilders	Youth	Colfax, Taos, Union
Local Collaborative 9	Teambuilders	Youth	Roosevelt, Curry
	Mental Health Resources	Adult	
Local Collaborative 10	Teambuilders	Youth	DeBaca, Harding, Quay
	Mental Health Resources	Adult	
Local Collaborative 11	PMS	Youth/Adult	San Juan, McKinley
	Child Haven	Youth	
Local Collaborative 12	Teambuilders	Youth	Lincoln, Otero
Local Collaborative 13	PMS	Youth/Adult	Cibola, Sandoval, Valencia

Source: OHNM Website