1. **Welcome and Review of Agenda**
Secretary Pam Hyde called the meeting to order at approximately 10:30 am. She noted this was an open session and that a quorum was present.

**Attendees**

Sec. Pam Hyde, HSD  
Sec. Dorian Dodson, CYFD  
Cathy Kinney, DOH  
Jay Czar, MFA  
Director Pat Putnam, DDPC  
Linda Roebuck, BH CEO  
Sec. Deborah Armstrong, ALTSD  
Mary Beresford, GPC  
Jacqueline Cooper, PDO  
Ricardo Campos, DOT  
Dep. Secretary Erma Sedillo, NMCD

2. **Review and Approval of Minutes**
January 4, 2007 minutes will be approved at the March meeting.

3. **Community Reinvestment & Enhanced Services – Pam Galbraith, Chris Charson, VONM; Matt Onstott and Alana Reeves, Collaborative Oversight Cross Agency Team**
Enhanced services are required as part of the Medicaid managed care organizations’ and the statewide entity’s (SE’s) obligations but are by definition not part of the Medicaid state plan services and are not included in the Medicaid capitation rates paid to VONM. That means that ValueOptions (VONM) has been utilizing its own funding for enhanced services. Medicaid managed care regulations require MCOs and the SE to provide enhanced services, but no specific dollar amount and no specific services are required by the regulation. In addition to the contract language and the obligations, there were policies and processes that were put in place by the Collaborative for community reinvestment pursuant to the RFP that was used to select VONM as the SE and pursuant to the contract with VONM. Generally, the community reinvestment obligation is a specific description of all or part of the enhanced services requirement.

In FY05, the MCOs spent just under $9 million for enhanced services. The contract with VONM required VONM to continue those services for six months (through December 31, 2005) without change. VONM did not have information from the MCOs about what services were being provide where by what providers, so they allowed all the enhanced services codes to be utilized by any provider, thereby significantly increasing the availability of these.
services. VONM also continued these services through all of FY06 and into FY07 to the present, a total of over 18 months at this point.

In FY06 VONM expended $12.5 million on enhanced services, and in FY07 projections are that they will spend over $17 million without changes to control the growth of these expenditures. The state has not provided sufficient funding to continue this enhanced services growth and VONM cannot continue to fund these services out of its own funds beyond the extra 12 months plus it has already funded these services beyond the contract requirement.

Chris Carson, Chief Medical Officer for VONM, presented the following statement:

“On 1 July 2005 when VO became the statewide entity for BH, the situation was confusing and fragmented. VO was required, and agreed to continue all enhanced services initiated by the MCO’s until at least 31 Dec 2005 as part of Do No Harm. A list of enhanced benefits from each MCO, dated April 2005 was given to VO to direct us in this process. It quickly became apparent that there was no consistent understanding of even what services were considered “enhanced”. This led to a memo being sent to VO from Leslie Tremaine and Geri Cassidy, dated 12 August 2005 clarifying what services were enhanced and the time frames we had to continue them.

“Enhanced benefits were never subject to any kind of service definition process; they were created solely at the discretion of and under the direction of each individual MCO, and although there was overlap, each MCO had a unique enhanced benefit package. Because each MCO had created their own enhanced benefit package, our arrival greatly expanded the enhanced benefit access. MCO-A with 25% of the Salud! Population had Service A in their Enhanced benefit package and the other two did not: on 1 July 2005 100% of consumers became eligible for the service. We created ONE benefit package from 3 expanding the availability of enhanced benefits.

“An enhanced benefit service, while nominally the same, was often very different from MCO to MCO. An enhanced benefit, while available to all consumers in a given MCO, were frequently provider specific or specific to a small number of providers and we still see services provided entirely by one provider or mainly by one provider. Also, the focus from MCO to MCO was different. One MCO funded MST at one rate in the year before our arrival, while another funded it at a different rate. It was impossible to utilize enhanced benefits to further the system of care due to the fragmented nature of the system. Enhanced benefits were not subject to any of the usual oversight by HSD/MAD. This was probably most troubling because often these services used nomenclature that followed services provided by Medicaid or one of the other agency funding streams. For instance we found a “Residential Treatment center” funded entirely as an enhanced benefit by one of the MCO’s. However, it was not licensed; had absolutely no clinical staff (licensed or unlicensed), and indeed the children largely weren’t even involved with a clinical provider whatsoever. We had to have the children taken into a community mental health agency for a clinical evaluation in order to determine best clinical steps to take. In the case of transitional living, which I think most people intuitively believe to be a transition program, we found people in TLS continually for over a decade. Respite, a service championed by CYFD and
evidence-based, who trained providers etc., was often done by providers who were not part of the CYFD driven process.

“In all cases, except the most egregious, we continued all Enhanced benefits until today, over one year after our commitment to the state in this regard. In FY 2006 we funded over $12 million in Enhanced benefits. In FY 2007 we are on track to fund over $17 million and have already funded $8.6 million in this fiscal year.

“In October 2006 we presented to the oversight team a proposal to re-look at enhanced benefits and define them in a way that emphasized the system-change goals that we have been given by the purchasing collaborative. We recommended specifically that enhanced benefits be used strategically as a testing ground for promising and evidence-based practices that might eventually be added to the Medicaid State Plan as a regular benefit.

“By allowing such evidence-based services, i.e. MST, as enhanced benefits, the SE can begin capacity development among providers, look at outcomes, and assess whether a given service would be of benefit to the consumers of NM. As experience is gained with a given service, the data and outcomes could be presented to HSD and the Purchasing collaborative for a decision on next steps. HSD and the Collaborative could recommend that a service be included in the state plan or recommend that it not be added. If a decision is made to not add a service to the state plan, VONM would then reassess whether it should remain as an enhanced benefit. As new services are developed, identified, or needed, VONM would update the enhanced benefit plan to include those needed, but not covered services.

We also believe that all enhanced benefits should be subject to the service definition process in which they are described, standardized, and quality is assured. Enhanced benefits, while not a part of the regular benefit, should still be subject to the MAD regulations in respect to how they are provided and by whom. We further believe that as we begin to tackle “braided funding” it is important to distinguish different agency funding streams and further define the appropriate use of Medicaid as well as other state funding streams, to minimize redundancy between funding streams and to standardize the approach to care between funding streams.

Specifically, as we have looked at the Enhanced benefit package we are making recommendations to the Purchasing collaborative on both the current package as well as future use of enhanced benefits. You have been given information to follow as I discuss this.

“We are making one of 4 recommendations:

1. Keep a specific service as part of the enhanced services.
2. Remove a service from the enhanced services list.
3. Redefine a service more appropriately as a service already covered in the Medicaid benefit plan.
4. Remove the service from the enhanced services list, but continue to fund it through other agency funding streams, to the extent funding is available.

“We propose to continue the following enhanced services, at least through the end of FY07

A. Transitional Living Service (TLS)
This is a troubling service in the way it is often provided today. Again, there is variance in its provision but too often it is not “transition”, but rather supported housing for the mentally ill.
We are recommending keeping TLS as a benefit for now, while we also re-emphasize the need for the Collaborative to aggressively address the need in NM for housing availability. There is also a need for true TLS, especially in the aging-out population of adolescents. We want to work with the Collaborative on the TLS situation, and while doing so believe that to change TLS without a plan for the future would create unacceptable burdens for consumers.

B. Substance Abuse Intensive Outpatient (IOP)
While IOP is not a Medicaid benefit currently, in the arena of substance abuse and co-occurring disorders it is clearly an effective community-based treatment. We wish to keep it as an enhanced service, while working on outlining and standardizing the approach to substance abuse IOP statewide.

C. Psychiatric Emergency Room Service
This service exists at UNM only and is a specialty service that we believe serves consumers well and is an appropriately funded medical service, so we will be working with the MCOs on the appropriate split of payment for this service.

D. SA Residential Substance Abuse Service for Women at Milagro
Residential substance abuse program for women, one of the few gender-specific programs in the state for substance abuse. We believe that it is a vital and unduplicated service, so will continue it for now.

E. Inpatient and Ambulatory Detoxification
We believe these are medically necessary treatments that while not specifically part of the Medicaid plan currently, it frequently occurs must continue to be covered as an enhanced service in limited circumstances, pending the state’s addition of this service to the Medicaid state plan.

F. School-Based Enhanced Service
We believe this should be continued as part of the ongoing development of school-based healthcare in NM.

G. ECT
This is clearly an effective, if not the most effective, treatment for refractive depression. It will be continued in limited circumstances approved by the VONM CMO.

H. Telemedicine:
VONM has actually expanded the enhanced benefit in the area of telemedicine to allow for psychiatric billing. We believe this is an example of an area in which enhanced benefits can be used before a service is made part of the regular benefit. The state (HSD) is working on including this service in its state plan.

I. MST
Although not currently a regular benefit, it has been included in the latest amendment request and we expect its addition shortly, so will continue it until it is part of the regular Medicaid state plan, to the extent funding is available for this service.
I. Crisis services/non PSR
   This is a service that although rarely used, could be an effective crisis intervention service in the future.

   “We propose to eliminate the following enhanced services:
   A. Interpretation of results
      This should be a regular part of the therapeutic interaction that is already funded.

   B. Activity therapy
      This is largely equine therapy, provided by two providers in the state. While beneficial, is not necessary. It is currently funded by CYFD for kids who need this service, and will not be continued as an enhanced service paid for out of VONM funds.

   C. Days Awaiting Placement (DAP) for adults in freestanding hospitals.

   D. Environmental Interventions

   “We propose to move the following services to Medicaid billable services:
   A. Functional Family Therapy (FFT)
      We believe FFT is a specialized form of Family Therapy and therefore should be billed under the regular benefit for family therapy.

   B. PSR (under 18)
      Without getting too technical this is an array of services, all of which can be billed using codes that are part of the regular benefit plan.

   C. Psychiatric IOP
      As opposed to Substance abuse IOP, this is an ill-defined service that has great variability in this state in the way its being provided. There are options that are similar to Psychiatric IOP such as day treatment, PHP, and PSR programs that can serve needs currently served by IOP. This is a service that we believe should continue to be considered, in a most structured programmatic approach, for future addition.

   D. Family Stabilization
      This is another array of services, all of which can be billed using codes that are a part of the regular benefits plan.

   “We propose to continue the following two services, only if funded through other sources and to the extent resources are available:
   A. Infant Mental Health – to the extent fundable by CYFD funds or through regular Medicaid billings.

   B. Respite for Children – to the extent CYFD funds are available or through other state General Funds should such GF be appropriated for FY07 and beyond.

   “As has been discussed in this meeting, we also in FY06 funded over $5 million in community reinvestment. This was meant to capitalize and begin new services in regions
where they did not exist and fund capacity development. As I said in the last meeting of this
group, I am very proud of what was done in FY 2006 with reinvestment. We believe that
reinvestment and enhanced benefits are two valuable tools to effect system change and
should be dovetailed to do this. We are recommending that community reinvestment be used
specifically to capitalize and fund start-up costs for programs that are valued, and needed and
for which the start up costs are prohibitive for providers and to continue to fund consumer-
run and focused programs

“We further are recommending that $4.5 million of the funding for community reinvestment
be utilized to cover some of these enhanced services for FY07. We have not yet allocated
FY07 community reinvestment funds awaiting the outcome of this meeting and discussions
with the Collaborative on the funding mechanisms and amounts for these programs. We
have received about $12 million in community reinvestment projects to date.

“Conclusion:
VONM is committed to this process and to health and sustainability of the Behavioral Health
system in NM. Health and sustainability is predicated on fiscal and clinical soundness. My
role as Medical Director is to look at the system and attempt to change and evolve it
clinically so that consumers receive better care. I must do so within the confines of the
resources available. I don’t enjoy being the bearer of grim news, or being the messenger for
hard truths, but know from my long experience taking care of patients that I must be both if
health is to be realized. I know that the road to system health lies in looking at these issues
realistically. I believe we have laid forth a plan that has clinical integrity and more
importantly, creates a foundation that we can aggressively build upon to move into the future.
These recommendations only set a foundation. We must build on that foundation if we going
to accomplish what we want to accomplish. I want to emphasize that these recommendations
should only lead to a discussion tomorrow about what do we do next to continue down the
road towards better outcomes and recovery for consumers in NM.

4. ValueOptions Rate Equalization and Incentive Activities & Plans, Chris Charson,
Pam Galbraith, VONM; Matt Onstott, Collaborative
Pam Galbraith, CEO of VONM, presented VONM’s process to date in moving toward rate
equalization, including giving additional time for those providers whose rates were changing
this year and redoing rates for those providers where the impact was greater than the contract
allowed. Ms. Galbraith also indicated that VONM is working with Collaborative staff to
come up with a comprehensive rate equalization plan that will be implemented over the next
couple of years.

5. Public Input
Bill Damueller –
Has talked with providers and has done a formal survey with providers, 64% were losing
money; 57% serving more consumers; costs have gone up and rates have barely gone up,
providers have been making this case for years.

Gay Finalyson – Bernalillo Local Collaborative
Concerned about enhanced services, infant mental health are a great priority of the Bernalillo
LC, respite services outside of CYFD will allow kids to stay at home and not go out-of-state.
Peter Cubra
The steering team talked extensively about enhanced services back in 2002, put the services into the Medicaid state plan, now finally talking about in, has looked back at the minutes since 02 and believes it has only been mentioned once. Don’t radically change the system until there is a good plan. VONM is not spending enough money. The Collaborative has not asked for enough money. Ask for more dollars.

Border Area Mental Health Services
Reiterate, in favor of standardizing rates as long as they cover services. Providers are feeling the rate cuts, where are they losing money, services could start to be limited. Needs to be more money in the system for behavioral health services

Roque Garcia - Rio Grande Behavioral Health
Asks if there is justification for the reduction in DOH rates?

Donald Naranjo
He has been in the behavioral health field for over 30 years. Poorly funded system, there has not been and administration that has strongly backed behavioral health. In favor of accountability, asking the Collaborative to do the same. Work together towards a better system.

Robin Cash - Protection and Advocacy
Supports Peter Cubra. Very disturbing working in the trenches with adults and children, the sadness and hopelessness, people are getting hurt and dying in the streets, no beds no adequate transition services. The Collaborative needs to take a stand and ask for money for behavioral health.

Carlos Miera - Taos Colfax Community Services
Echo the issue of the rates, things are not cheaper in the country, the current rate structure does not allow for that. More direct input from providers.

Ben Tafoya
Providers have made a lot of good points, tend to talk about best practices, why does the problem continue to grow? All part of a machine, the gears are worn out and are going to break down; don’t have adequately trained staff, and the ones that are trained are hard to find.

Shari M
Lack of money, there are so many people that need services, VONM is completely cutting art therapy services. Facilities need help; addiction services need help. Not enough money to pay providers for what needs to be done.

David Rogers – President of Eddy County Local Collaborative
CYFD does the best job they can, but long term consequences can be devastating. Move CYFD services into other agencies. Eddy County cannot afford psychiatric professionals

Noel Clark
Negotiated a higher rate with VONM; has family stabilization, substance abuse residential treatment programs, and is representing clients and people that all of this affects. Don’t agree that the rates and prices are adequate.

Carolyn Thomas Morris - Navajo LC
Thank VONM and the Collaborative for allowing providers to speak today. Need more technical assistance from the state and VONM. Consider all consumers across the state for the transformation in New Mexico to take place. What about the Native American set aside dollars? Will they continue at the same level?

Nancy Jo Archer - Hogares
System of care is needed, and she would like to be part of the process. Her concern is that CYFD money has been capped for enhanced services. Changing the low end and denying on the high end will result in a crisis for a period of time. What is going to happen to the families and the kids when they don’t have services? We need more money. What are the time frames?

Richard Malcolm – Dessert Hills
The Collaborative holds the ultimate decision-making authority. Why do we have local collaboratives when decisions are made at the last minute in a small room in Santa Fe. Use the local collaborative system, need to hear from the people that are served.

Pat Lincoln
If the Collaborative allows the diversion or the absolute withdrawal of $9 mil dollars from the system, it is going to cause a crisis. Ask the Collaborative to keep the services, find additional funding, and/or re-examine the allocation of funds for community reinvestment.

6. Discussion and Next Steps
It was recognized that this decision is ultimately VONM’s to make. However, in its consultation requirement with the Collaborative, the Collaborative felt it was necessary to provide some guidance about those decisions and to allow additional time for public input. It was also recognized that VONM cannot continue services for which no funding or no contractual obligation is available beyond the extra effort VONM has done already to continue enhanced services.

It was agreed that the public would be given an additional week to comment via e-mail and that VONM would consider those e-mail comments and today’s discussion before making any final decisions.

Secretary Armstrong made a motion that VONM consider the following principles for dealing with enhanced services:

1. Up to $4.5 million in community reinvestment dollars could be used to pay for part of the enhanced services expenditures during FY07;
2. VONM should consider the impact on specific providers in making its decisions;
3. VONM should either move services to other Medicaid billing codes, other fund sources where they exist or continue services through at least the end of FY07 if those services are being moved to Medicaid state plan services; and
4. VONM should consider the importance of the service to the system, either as evidence-based or as a vehicle to move the system toward the goal of recovery and resiliency.

Secretary Hyde seconded, and the motion passed with Director Pat Putnam opposing.

It was also agreed that the Collaborative would talk with the Governor’s office and the Legislature about additional resources, especially for respite and early childhood services, even though the budget process is already well underway for FY07 supplementals and FY08 funding. The Co-chairs will carry that message to the Governor’s office and legislative budget leaders.

There being no further business, the meeting adjourned at 1:45 p.m.