This is a discussion paper meant for comment and reaction. Comments may be sent via e-mail to bhdesign@state.nm.us or in writing c/o Barbara Gay, Office of the Secretary, Human Services Department, P.O. Box 2348, Santa Fe, NM 87504-2348. There will also be public meetings held around the state to provide opportunity for reaction, questions and discussion about the issues this paper raises. A key public stakeholder meeting will be held on April 23, 2004, from 9:30 a.m. to 4:00 p.m. at Albuquerque High School, 800 Odelia N.E. in Albuquerque. Anyone interested is welcome to attend.
# NEW MEXICO

INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

CONCEPT PAPER: A WORK IN PROGRESS

April 19, 2004

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ACRONYMS USED IN THIS PAPER

ASD   Autism Spectrum Disorder
BBA   Balanced Budget Act
BHDWG Behavioral Health Design Work Group
BHITS Behavioral Health Interagency Implementation Teams
BI    Brain Injury
CDD   Childhood disintegrative disorder
CPT   Common Procedural Terminology
DD    Developmental Disability
DDMI  Developmental Disability/ Mental Illness and/or Substance Abuse
EPSTD Early and Periodic Screening, Diagnosis and Treatment
FINS  Families in Need of Services
HCPCS Health Care Common Procedural Coding System
HEDIS Information Set
IBHPC Interagency Behavioral Health Purchasing Collaborative
LSOC  Local System of Care
MCO   Managed Care Organization
MHSIP Mental Health Statistics Improvement Project
MOU   Memorandum of Understanding
NPDs  Neuropsychological Disorders
PCP   Primary Care Physician
PDD   Pervasive Developmental Disorders
PDL   Preferred Drug List
QM    Quality Management
RFP   Request for Proposals
RCC   Regional Care Coordinator
TANF  Temporary Assistance for Needy Families
UM    Utilization Management
UR    Utilization Review
ALTSD Aging and Long-Term Services Department
AOC   Administrative Office of the Courts
BHSD  Behavioral Health Services Division of the Department of Health
CYFD  Children, Youth and Families Department
DDPC  Developmental Disabilities Planning Council
DFA   Department of Finance and Administration
DIA   Department of Indian Affairs
DOC   Department of Corrections
DOH   Department of Health
DOL   Department of Labor
DOT   Department of Transportation
DVR   Vocational Rehabilitation Division of the Public Education Department
GCD   Governor’s Committee on Disabilities
GSD   General Services Department
HPC   Health Policy Commission
HIS   Indian Health Services
HSD   Human Services Department
MFA   Mortgage Finance Authority
PED   Public Education Department
I. PURPOSE OF THIS PAPER

This paper describes a process and a concept about improving the design and delivery of publicly funded behavioral health care services in New Mexico. The paper is written to communicate to stakeholders, funders, and decisionmakers much of the work that has occurred since September 2003 by staff of involved state agencies and by stakeholder Advisors selected to represent various perspectives about behavioral health care in New Mexico.

This paper also represents a commitment made in October of 2003 to behavioral health stakeholders in New Mexico: to provide periodic opportunities for anyone interested to provide input into the design of this new system of service delivery. In addition to an e-mail address for comments, various public meetings, and a website with posted materials, this paper is submitted to the public for reaction, questions and suggestions.

This paper was written by the Behavioral Health Design Work Group (BHDWG), a group of staff from the state agencies that make up the Behavioral Health Purchasing Collaborative (see Section IV). However, the content comes from hours of work by a variety of subgroups described later in this paper. These subgroups were attended by and work was done by BHDWG’s selected Advisors and members of a variety of stakeholder groups. Notes and concept papers from these subgroups can be found on the Human Services Department’s website at www.state.nm.us/hsd/home.html.

This paper represents a work in progress. We encourage interested persons to read and critique the concepts in this paper. The paper includes some areas where decisions have been finalized and many other areas where decisions are still in process. Comments are welcome and encouraged to form our thinking as we continue the difficult process of creating a single behavioral health service delivery system throughout New Mexico. Once comments are received and considered, the paper will be revised and will serve as the basis for development of a collaborative request for proposals (RFP) and for further development of the single behavioral health system described in this paper.

The term “behavioral health”, as used in this paper and in the law creating the Interagency Behavioral Health Purchasing Collaborative, includes mental health and substance abuse systems, services, and service recipients.
II. MISSION AND VISION OF THE INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE (IBHPC OR COLLABORATIVE)

Charge to and Goals of the Collaborative

The combination of tight government budgets and the growing demand for coordinated services for consumers and families encouraged New Mexico to seek a better behavioral health care delivery system, one which would foster creativity and increased responsiveness to the needs of New Mexico behavioral health care consumers and their families. On September 12, 2003, Governor Bill Richardson directed all agencies tasked with the delivery, funding, or oversight of behavioral health care services (defined as mental health and substance abuse services and treatment) in New Mexico, to work collaboratively to create and purchase a single behavioral health service delivery system throughout New Mexico, focused on the improvement and coordination of service provision and delivery. Governor Richardson wants to make behavioral health care a priority in New Mexico. His goals are to have better access, better services, and better use of taxpayers’ dollars. (See Appendix A)

In the 2004 session of the New Mexico Legislature, a bill was sponsored by Rep. Ed Sandoval and Senator Steve Komadina. This bill passed and was signed into law by Governor Richardson, thereby creating an Interdepartmental Behavioral Health Purchasing Collaborative (referred to in this paper as the Collaborative). The charge to (or mission of) the Collaborative in the law is as follows:

1) identify behavioral health needs statewide, with an emphasis on that hiatus between the needs and services set forth in the department of health’s gap analysis and in ongoing needs assessments, and develop a master plan for statewide delivery of services;
2) give special attention to regional differences, including cultural, rural, frontier, urban and border issues;
3) inventory all expenditures for behavioral health, mental health and substance abuse services;
4) plan, design and direct a statewide behavioral health system, ensuring both availability of services and efficient use of all behavioral health funding, taking into consideration funding appropriated to specific affected departments; and
5) contract for operation of one or more behavioral health entities to ensure availability of services throughout the state. (HB 271, page 11; Section 9-7-6.4 NMSA 1978).

One key goal of this effort is to replace the currently fragmented multiple behavioral health care delivery systems in New Mexico with a single behavioral health care delivery system that will minimize confusion for providers and for customers and their families.

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2 The words “consumer” and “customer” are used synonymously throughout this paper to mean those who currently, have in the past or will in the future receive services for a mental illness or substance abuse disorder or for the prevention or remediation of the effects of such disorders. At times, these words incorporate the families and significant others involved in the lives and/or care of such individuals.
families, and that will minimize ineffective or duplicative administrative costs throughout the system to stretch limited dollars for services. The result will be the creation of better, more efficient and more effective services and improved access to care for consumers, as well as better use of taxpayers’ money.

Planning Requirements

In fulfilling its charge to plan, the law directs specific content, process and principles (Subsections C, D and E of Section 9-7-6.4 NMSA 1978). Specifically, the plan must include “specific service plans to address the needs of infants, children, adolescents, adults and seniors as well as to address workforce development and retention and quality improvement issues.” Pursuant to the statute, the plan “shall be revised every two years and shall be adopted by the department of health as part of the statewide health plan.” This statewide health plan is now required as a result of other legislation proposed by Governor Richardson and passed in February during this legislative session.

The plan for behavioral health services must take into consideration, to the extent practicable and within available resources, core principles listed in Subsection D of Section 9-7-6.4 NMSA 1978. These principles have been incorporated into the values and principles section of this paper (see Section III below).

In fulfilling its planning functions, the Collaborative is required to “seek and consider suggestions of Native American representatives from Indian nations, tribes, pueblos and the urban Indian population, located wholly or partially within New Mexico, in the development of the plan for delivery of behavioral health services” (Subsection E).

This behavioral health planning process has just begun. An initial outline of the plan is attached as Appendix B. The Department of Health’s Behavioral Health Services Division, working with an interagency team and with stakeholder input, is leading this effort of the Purchasing Collaborative. An initial plan will be completed in time to be included with the Request for Proposals, scheduled to be released October 1, 2004 (see Section VIII in this paper).

Previous and Current Studies, Plans, Reports and Work Groups

The Governor’s directive and the subsequent law had their origins in several recent studies and reports concerning the delivery of behavioral health care services throughout the country and within New Mexico. It is critical to note that the findings of each study included a recommendation to improve the delivery of behavioral health care services through a coordinated approach. Each of these studies or reports can be found on the HSD website at www.state.nm.us/hsd. They include:

- 2001 – “Final Recommendations of the Behavioral Health Advisory Committee.”
• 2002 – “Comprehensive Needs Assessment and Gap Analysis of New Mexico’s Behavioral Health Services and Systems.”

• 2002 – CYFD’s “Infant Mental Health Plan.”

• 2003 – “Report and Recommendations on Medicaid Behavioral Health Redesign.”


• 2003 – “Achieving the Promise: Transforming Mental Health Care in America” by the President’s New Freedom Commission on Mental Health.


Each of these studies and reports serves as background leading up to the decision by the Governor and the legislature to require all state agencies funding, providing or overseeing behavioral health care services to do so as one.

_Purpose And Vision Of The Collaborative_

The new law indicates the purpose is to:

develop a statewide system of behavioral health care that promotes behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.

This statutory purpose, as well as the statutory charge to the Collaborative (see Section II), makes it clear that reducing duplication and fragmentation, creating a single behavioral health service delivery system throughout New Mexico, and staying true to the values and goals of prevention, early intervention, recovery and resiliency form the basis of the Collaborative’s mission.

The bottom line for the Collaborative is, as Governor Richardson directed, to improve access, improve services, and make better use of taxpayers’ dollars. The values that guide the development of this single system of behavioral health care (see Section III), lead us to frame the vision of the Collaborative is as follows:

A single behavioral health service delivery system in New Mexico in which available funds are managed effectively and efficiently; the support of recovery and development of resiliency are expected; mental health is promoted; the adverse effects of substance abuse and mental illness are prevented or reduced; and behavioral health customers are assisted in participating fully in the life of their communities.
III. VALUES AND PRINCIPLES – A COMMITMENT TO RECOVERY AND RESILIENCE

Philosophy

During the process of developing the concepts in this paper (see Section V), the Member Services subgroup looked at the principles set forth in HB 271 (Section 9-7-6.4 NMSA 1978, Subsection D) and also at the values and principles developed by various advisory and consumer/family groups in New Mexico and nationally. From that effort, the following statement of philosophy was developed and will guide the work of the Collaborative.

• Services will be individually centered and family-focused based on principles of individual capacity for recovery and resiliency:
  o Recovery is defined as “the process in which people are able to live, work, learn, and participate fully in their communities”; and
  o Resilience is defined as “the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses – and to go on with life with a sense of mastery, competence, and hope.”

• Care must focus on increasing consumers’/families’ abilities to successfully manage life challenges, on facilitating recovery, and on building resilience.

• Services will be delivered in a culturally responsive and respectful manner in the most appropriate, least restrictive mode (appropriate to their legal status), including home- and community-based settings wherever possible.

• Service planning and management will utilize individual and family abilities and strengths and, where appropriate, will be conducted in consultation with family, caregivers, and other persons critical to an individual’s life and well-being.

• Services will be coordinated, accessible, accountable, and of high quality.

• Each individual or family will direct his/her/their services to the extent possible.

• Services, where appropriate, will be individual/family-driven and –operated, and when operated or delivered by a consumer or family member, will be compensated commensurate equal to that of other professionals with similar experience and credentials.

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3 Achieving the Promise, Final Report of the President’s New Freedom Commission on Mental Health, April 2003, p.5. The report further explains the recovery concept as follows: “For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery.” While recovery is often associated with adults with mental illness or substance abuse disorders, it can also be a useful concept for children and families experiencing the impacts of a severe emotional disorder.

4 Ibid, p. 5. The report further explains the concept of resilience as follows: “We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits such as optimism, good problem-solving skills, and treatments. Closely knit communities and neighborhoods are also resilient, providing supports for their members.” Development of resilience is sometimes described in other works as a combination of developing protective factors and reducing risk factors in individuals, families and communities. While resilience is often associated with children and families, it is also a useful concept for adults experiencing the impacts of a serious mental illness or a substance abuse disorder.
• Services will include behavioral health promotion, prevention, early intervention, treatment, community support, and activities that further recovery and resiliency.
• The highest quality of care and information will be available to individuals, regardless of their race, gender, disability, sexual identity, ethnicity, language, literacy level, age, or place of residence.
• Mechanisms will be in place to ensure continuous quality improvement.
• Treatment and services will be based on effectiveness and individual preferences.

It is important to note that not all systems included in the Collaborative are currently guided by this philosophy. In some cases, the individual goal of services provided is secondary to or co-existing with the system or community goals of preventing incarceration or re-incarceration or preventing behaviors that are inconsistent with community safety. While recognizing and embracing the importance of these additional goals, the Collaborative as a whole will focus first on the best outcomes for the individual and family served and believes that by doing so, the additional system and community goals can also be met.

Principles and Values

The Member Services subgroup also identified several principles and values that should be the basis of action within New Mexico’s behavioral health service system. To the extent possible, these principles and values will guide the Collaborative’s work. In the spirit of continuing improvement, these will be ongoing goals rather than absolute requirements of the newly procured behavioral health service delivery system. These principles and values include:

• Use of “person first” and “people who” language.\(^5\)
• Sensitivity to and respect for diversity, including age, gender, physical disability, culture, ethnicity, spirituality, sexual identity, literacy level, and/or primary language.
• Meaningful involvement of individuals, family members, and customer-run organizations in all levels of decisionmaking processes concerning operations and oversight of the behavioral health service system.
• Five percent of state-controlled behavioral health resources utilized for consumer- and family-operated services, with a baseline and targets increasing annually until this amount is reached.
• A consistent standardized glossary of behavioral health terms and concepts.

Desired System Results

In order to accomplish its mission and vision, the Purchasing Collaborative will be committed over time to achieving the following system results:
• “Braided” (or in some cases “blended” or “coordinated”) funding that will be sufficiently flexible to promote a more efficient system of services and supports,

\(^5\) For example: “a person with mental health and/or substance abuse issues” or “a person who has schizophrenia,” rather than “the mentally ill” or “a schizophrenic.”
including but not limited to a single billing process and consistent data collection, management and reporting systems, while meeting state and federal requirements;

- Development and use of a common age-appropriate assessment process and tool, and a single service plan for each individual and/or family receiving services, sufficient for all funding sources and used in all service settings;
- Transition from the current multiple systems to the new single behavioral health delivery system in a careful and smooth manner so that neither consumers nor providers experience undue disruption
- Local systems of care in which local providers and practitioners coordinate care with one another and with other systems and community leaders in addition to representatives of customers and families;
- Uniform program standards, including common service definitions, utilization management measurements/criteria, quality requirements, system performance expectations, and consumer/family outcomes;
- Creation of an adequate number and distribution of appropriately credentialed behavioral health care providers;
- Attention to the special needs of various populations, including: children and adolescents; elders; Native Americans; persons with disabilities; persons who are gay, lesbian, bi-sexual or transgender; and other populations that are particularly at risk or have special service or access needs; and
- As comprehensive a benefit package as possible, within available funding, to support recovery and resilience, including prevention and early intervention services, an emphasis on evidence-based and best practice service approaches and thinking, and special consideration of service delivery to rural and frontier areas.

In summary, the Collaborative is seeking a behavioral health delivery system that is customer and family directed, committed to recovery and resilience, able to integrate services across multiple systems, and community-based. The Collaborative will focus on these goals as it designs and contracts for services and as it plans for the behavioral health needs of New Mexico.

IV. DESCRIPTION OF CURRENT SYSTEMS

The existing behavioral health care delivery systems in New Mexico present a fragmented and uncoordinated array of services, via multiple funding streams and offering varying degrees of accessibility and quality of service delivery. Within managed care and across New Mexico’s multiple behavioral health care systems as a whole, there has been a decrease in three critical service provision areas: (1) the number of child psychiatrists; (2) overall capacity of behavioral management services; and (3) case management services. The promise of an array of community- and home-based alternatives to institutional care has also not materialized even though planned in several ways. At the very least, it is cumbersome and confusing for consumers and families to navigate the multiplicity of systems, which may often be under funded, inadequate and not cost effective.
Publicly-funded behavioral health care services in New Mexico, which include both treatment and prevention mental health and substance abuse services, are delivered, funded or influenced through a myriad of state departments, including the Department of Health (DOH) for non-Medicaid adult mental health and substance abuse services; the Human Services Department (HSD) for Medicaid-funded behavioral health services for children, adults, and seniors; the Children, Youth and Families Department (CYFD) for non-Medicaid services for children, youth and families; the Aging and Long-Term Care Services Department (ALTSD) for seniors; the Department of Finance and Administration (DFA) for DWI services; the Department of Transportation (DOT) for certain substance abuse prevention services; the Department of Corrections (DOC) for services for adults in prison and on probation or parole; and the Public Education Department (PED) for children in schools. Additionally, critical support services assisting individuals with jobs and housing are funded or overseen by the Vocational Rehabilitation Division of PED (DVR), the Department of Labor (DOL), and the Mortgage Finance Authority (MFA). The Administrative Office of the Courts (AOC) plays a role with funding and oversight of some drug courts in New Mexico.

In addition to these funding and oversight agencies, several New Mexico state agencies have responsibility or interest in health care planning or delivery of behavioral health services to specific populations within New Mexico. These include the Health Policy Commission (HPC) for health planning and studies; the Developmental Disabilities Planning Council (DDPC) for individuals with developmental disabilities; the Governor’s Committee on Disabilities (GCD); and the Department of Indian Affairs (DIA) for Native American tribes and pueblos. Finally, the Governor’s health policy coordinator has a role in assuring the consistent delivery of behavioral health care services pursuant to the Governor’s direction and in keeping with the Governor’s broader health care policy goals.

Representatives of each of these departments, agencies, and individuals make up the new Interagency Behavioral Health Purchasing Collaborative, as described in this paper and in HB 271, Section 9-7-6.4 NMSA 1978, Subsection A. The following chart depicts the confusing array of agencies and intermediaries currently involved in New Mexico’s behavioral health services delivery systems and helps explain the importance of collaborative purchasing of a single behavioral health service delivery system across these multiple agencies.

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6 Each state department or agency has a website that describes their current activities and services. These websites may be accessed through the New Mexico State Government home page at [www.state.nm.us](http://www.state.nm.us).
Interdepartmental Behavioral Health Purchasing Collaborative (IBHPC)

State Agencies Currently Purchasing Behavioral Health Services

DOC (COM COR)  DOH (BHSD) (OSH)  CYFD  ALTCD  HSD (MAD) (TANF)  PED (SpEd Hlth Svc Voc Rehab)  DFA (DWI)  DOT

Governor's Office
HPC
IAD
DDPC

5 RCCs
AAAs
3 MCOs
Schools
Counties

Providers

State Facilities

New Mexico Human Services Department
V. PROCESS TO DATE AND NEXT STEPS

Behavioral Health Design Work Group (BHDWG)

Shortly after the Governor’s announcement in September 2003 (see Appendix A), a Behavioral Health Design Work Group (BHDWG) was formed, consisting of representatives of the agencies that will be affected by the development of the purchasing collaborative concept (see Section V). BHDWG will guide the development of the new behavioral health system until the formal Interagency Behavioral Health Purchasing Collaborative (IBHPC) is appointed and functioning, and will continue to guide the staff work for this initiative.

BHDWG, chaired by the Secretary of HSD, began meeting in September of 2003 and convened a statewide stakeholder meeting on October 21, 2003, to gather initial stakeholder input on key design issues such as the values and principles, behavioral health care model, services, state department governance, the role of consumers and families, impact on Native American communities, advisory structure, regional presence, and the procurement or selection process.

The Behavioral Health Design Work Group also sought advice and input from a variety of advocates and consumers. Advisors were nominated and selected from three existing advisory groups: the Governor’s Mental Health Planning Council, the Medicaid Behavioral Health Steering Committee, and the Children's Behavioral Health Re-Design Committee. Input was also sought from the Indian Behavioral Health Council and other stakeholder groups in order to assure a balance that included consideration of behavioral health and substance abuse program needs for both children and adults. Each of the advisory groups nominated individuals from their membership to serve as Advisors to BHDWG. BHDWG selected Advisors from these nominations and added other representatives to assure that all perspectives were represented.

Over 35 Advisors were selected to participate in subgroups of BHDWG developing concepts important to the new system and for this paper. Advisors include a managed care organization (MCO) representative, a representative of the DOH Regional Care Coordinators (RCC) system, consumers, families, Indian tribes and pueblos, providers, and advocates. These Advisors will serve until the formal Behavioral Health Planning Council that is created by HB 271 (pages 1-7, Section 2), is appointed and functioning.

Shortly after the selection of Advisors, BHDWG hosted a national consultants meeting in December 2003. Twelve national behavioral health consultants and federal officials came to New Mexico or participated by telephone in a day-long public meeting of stakeholders to obtain the best thinking available about the efforts New Mexico was about to undertake. Most of these consultants met the following day with BHDWG to discuss how the Collaborative might operate and to prioritize its efforts.

To reach out and collaborate with New Mexico’s Native Americans, on March 4, 2004, the BHDWG hosted its first tribal input meeting. The purpose of the meeting was to
inform the tribal leaders of the twenty-two New Mexico Indian Tribes and Pueblos about the Purchasing Collaborative and the work that had been conducted to date by the BHDWG, the Advisor group, which includes five Native American Advisors, and various subgroups. The meeting provided an opportunity for state agencies and Native American Tribes/Pueblos to discuss Native American behavioral health needs, exchange information, and engage in a meaningful dialogue about Native Americans served by the Indian Health Service or 638-programs. The meeting also provided information and raised questions about funding of behavioral health services for Native Americans, including Medicaid and non-Medicaid, state General Fund, Indian Health Service resources, and tribal funds. A second tribal input meeting is being planned for spring 2004.

Subgroups

Beginning in January 2004, BHDWG identified several areas requiring design and definition. Six subgroups were formed initially and a seventh formed later. Each was given a specific charge. Each had a series of meetings between January and March that were open to the public. The subgroups developed recommendations for the behavioral health care service delivery system reflected in this paper. The charges to the subgroups, as well as meeting minutes and/or papers emanating from the subgroups, can be found on the Human Services Department website at [http://www.state.nm.us/hsd/bhdwg.html](http://www.state.nm.us/hsd/bhdwg.html). Members of BHDWG and the names of stakeholder Advisors and their affiliations can also be found on this website.

The six subgroups charged by BHDWG and the agency providing the staff leads are as follows:

1. Structural Requirements, Regional Presence, and Financing Mechanisms (HSD);
2. Services/Benefit Package and Populations Descriptions and Priorities (CYFD);
3. Quality, Performance and Outcomes (HSD);
4. Pharmacy and Transportation (HSD);
5. Utilization Review (UR), Utilization Management (UM), Care Coordination and Coordination with Primary Care (HSD);
6. Member Services and Consumer Involvement (DOH); and

BHDWG also committed to the development of a subgroup on transition issues and on other topics that may arise as the design process continues.

A special e-mail address for anyone to use to provide input to BHDWG or the subgroups or to make comments about subgroup topics or products was established early in the process. That e-mail address (bhdesign@state.nm.us) is reviewed regularly and all comments are shared with all BHDWG members. Sometimes, a commenter is contacted directly by a BHDWG member if the e-mail includes a question or comment that requires specific reaction to that individual.
In addition to the six content subgroups, BHDWG has formed several state staff working groups charged with the following tasks:

1. RFP (Request for Proposal): led by HSD to research the various requirements and formats necessary for a multi-agency RFP.
2. Funding Inventory: led by DOH to identify existing resources available from the involved state agencies for behavioral health services.
3. Services Inventory: led by DOC to identify services provided by each involved agency.
4. Provider Inventory: led by DOH to list and post on DOH’s new website, www.nmcares.org.
5. Service Definitions: led by DOH to catalogue and create common definitions of behavioral health services provided by CYFD, DOH, and HSD, and to cross walk these definitions to various billing codes (including newly required HIPAA codes); these definitions will be refined based on the input of the other agencies and will serve as the basis for developing common service requirements.
6. Data Requirements: led by HSD and DOH to identify the types and sources of data necessary to manage the individual funding streams and the collaborative approach to purchasing.
7. Justice Issues: led by DOC to determine how best to interface with legal issues;
8. Statewide Behavioral Health Plan Development: led by DOH to begin the process of developing this plan and determine the best way to involve stakeholders.
9. Local Systems of Care Criteria: led by CYFD to determine criteria for local systems of care for public comment and eventually inclusion in the request for proposals.
10. Transition Issues: led by DOH to identify and plan for issues that will need to be addressed before the new statewide entity begins its role on July 1, 2005.

Many of these state-led groups will include stakeholders as the process unfolds.

Timelines

The Collaborative is committed to having a single behavioral health service delivery system in place, through a partnership with a procured statewide entity, by July 1, 2005. (See Section VIII for a description of the structure that will be utilized by the Collaborative and for a description of the statewide entity’s duties, functions and required capacities.) In order to meet this commitment, a final Request for Proposals will need to be released by fall 2004. Vendor selection will need to occur before the end of winter 2005, with contracting and transition plans completed by spring 2005. Federal approvals will be sought during the spring and summer of CY 2004.

This is an aggressive timeline, especially given the necessity to seek federal approval for some of the funding that will be included in this new system. The transition to a new, collaborative behavioral health care model of care that incorporates a variety of services, populations and funding streams began with the identification and recognition
of the differences, similarities and overlap within the current behavioral health care systems in New Mexico. The initial challenge to meeting that goal was the identification and understanding of the complexities in the delivery of current behavioral health care services funded by federal, state and local dollars. Although three agencies (DOH, HSD and CYFD) share primary responsibility for behavioral health care in New Mexico, several other agencies have independent programs that fill in some gaps, particularly in the provision of substance abuse-related services.

Combining and/or coordinating all these services, funds and resources into a single behavioral health service delivery system will be challenging, especially on this time frame. However, if services and structures were to continue in the current manner, DOH’s Regional Care Coordinator system must be re-bid in the fall or winter of 2004-2005. Likewise, HSD’s managed care organizations (MCOs) that currently manage the vast majority of Medicaid behavioral health services must also be re-bid in the fall of 2004 to be in effect July 1, 2005. Given this convergence of timing, CY 2004 is a good time for this critical system design and procurement process to be undertaken, and July 1, 2005 is perfect timing for the beginning of the new system of behavioral health services in New Mexico.

It is important to understand that July 1, 2005 is just the beginning of a much longer process. System change of this magnitude is not something accomplished with the flip of a switch or on a particular day. Rather, on July 1, 2005, a new system begins. It will take a number of years beyond that time to evolve the partnerships, relationships, and expectations of this new behavioral health service system to become what the stakeholders and state leadership want the single behavioral health service delivery system to be in New Mexico. As a consequence, the evolution of this new system will be considered in phases.

Phases of the Behavioral Health System’s Development

BHDWG anticipates a transition phase and at least three implementation phases in the evolution of this new single behavioral health delivery system.

- **Pre-Planning and Transition** is already underway. Conceptualizing and planning for the new behavioral health delivery system began as soon as the Governor announced the behavioral health initiative in September 2003. Planning continues with the work of the BHDWG and its Advisors, and the development of this concept paper. The transition process includes the changes that have to be made in the various funding streams (e.g., Medicaid, federal block grants and others), the development of the request for proposals for the statewide entity, and specific strategies for informing customers (especially those with ongoing service needs), their families and providers about how the system will change on July 1, 2005. This pre-planning and transition phase also includes developing the formal Purchasing Collaborative (Section V) and the Behavioral Health Planning Council (Section VI).
• Phase One will begin July 1, 2005, with a contract with a single statewide entity selected through a competitive procurement process during the fall of 2004 and the winter of 2005. This phase will cover the time period from July 1, 2005 through June 30, 2006 (FY 2006). During this phase, the Collaborative will work with the statewide entity to make sure services continue to be delivered and providers are paid for the services they deliver. During this phase, the “kinks” will be worked out of the changed system, transitional issues will continue to be addressed, and goals for Phase Two will be developed. Initial data requirements will be implemented, and a process will be developed for evolution of these data requirements throughout Phases One, Two and Three.

Also during this phase, expectations for the development of local systems of care (see Section VIII) will be created, and such local systems will begin to develop with the help of teams of state and statewide entity staff. With the help of the statewide entity and the Behavioral Health Planning Council (see Section VI), the Collaborative will complete the first comprehensive statewide plan for behavioral health.

• During Phase Two, lasting up to two years (July 1, 2006 through June 30, 2008), the statewide entity will work with the Collaborative to identify more effective ways of combining multiple funding sources and funding mechanisms to support local systems of care and the outcomes the Collaborative desires. Performance objectives and deliverables will be developed for each phase so that clear progress toward the behavioral health system the Collaborative envisions is accomplished. Local systems of care will be formed and effectively operating. Additional resources will be sought collectively by the Collaborative agencies and the statewide entity to address unmet needs and identified priorities for service expansions. Phase Two may also see the inclusion of additional funding streams and other resources not included in the initial RFP.

• Phase Three is anticipated to begin no later than July 1, 2008. By this time, the system should be maturing, performance and outcomes should be clear, and adjustments to the system can be undertaken based on those results. Any final funding streams planned to be included in the responsibilities of the statewide entity will be included and all coordination with other related resources will have been accomplished. The initial behavioral health plan will be revised according to the needs identified by local systems of care, the statewide entity and the Collaborative. New funding streams will continue to be sought to meet these needs.

VI. CREATION OF THE BEHAVIORAL HEALTH PLANNING COUNCIL

HB271, Section A, creates the Behavioral Health Planning Council to meet federal advisory council requirements and to provide consistent, coordinated input to the behavioral health service delivery system in New Mexico. The membership of the Council includes representatives of the following five groups: consumers/families; providers; state agencies responsible for behavioral health, education and vocational services, housing and corrections/justice; individuals necessary to assure appropriate geographic and cultural representation; and advocates. No more than 49 percent may
be persons who are providers or state agency representatives. Pursuant to federal law, all members will be appointed by the Governor, and the chair of the Council will be selected by the appointed members.

The charge to the Council in HB271 fulfills federal requirements for such councils in addition to the needs of New Mexico. This charge (or mission) is to:

- Advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;
- Report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;
- Encourage the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
- Advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 9-7-6.4 NMSA 1978 [the purchasing collaborative]; and
- Review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for Medicaid services and any other plan or application for federal or foundation funding for behavioral health services.

In addition to these duties, the law directs the Council to meet regularly, replace the currently existing Governor’s Mental Health Planning Council, and form subcommittees on Medicaid, children and adolescents, adults with serious mental illness, substance abuse, and other issues as may be needed. These subcommittees will meet at least quarterly. It is likely that the Council will be asked to form a subcommittee specifically to address the needs of Native Americans. The Council itself will be staffed by DOH, and the subcommittees will be staffed by various state agencies. All state agencies that are members of the Collaborative will be represented on this important advisory council.

The Council will be the single advisory structure for the single behavioral health service delivery system developed by the Purchasing Collaborative. This Council will advise the Collaborative and through that relationship will directly impact the statewide entity with whom the Collaborative will contract. Some consumer and family representatives on the Council may play a role in the process of selecting the vendor who will be the statewide entity to partner with the Collaborative in development of the single behavioral health delivery system (see Section VII). The Collaborative will assure that the statewide entity provides information to and considers the advice of the Council and its subcommittees as it works with the Collaborative.

Over 100 applications for appointment to the Council were received by the Behavioral Health Design Work Group in April 2004. Recommendations will be sent to the
Governor by May 1, 2004, with appointments expected to be finalized by the end of May. The first meeting of the Council is planned for sometime in June.

VII. SERVICES AND RESOURCES TO BE INCLUDED IN THE PURCHASING COLLABORATIVE PROCESS

Types of Available Resources

As BHDWG began to consider what services are currently being provided (see Appendix B) and how the Collaborative might work together, the group realized that there are three critical types of resources that need to be brought together and either jointly purchased or coordinated through this process. These include funding, human resources and agency service capacity.

Examples of the first type of resource include funds of each agency given or paid to providers or local governmental entities to plan, coordinate or deliver behavioral health services. The second type of resource includes staff of each of the Collaborative agencies whose responsibility is to plan, coordinate, contract for or oversee the quality of behavioral health services. The third type of resource includes those behavioral health services currently provided directly by state agencies such as Las Vegas Medical Center and Turquoise Lodge, and services in state-operated correctional facilities such as CYFD’s juvenile justice facilities and DOC’s prisons. All of these resources must be “braided” together through a common statewide entity or must be carefully coordinated through the work of the Purchasing Collaborative.

At this time, it is not anticipated that prison-based behavioral health services operated or contracted by DOC will be included in the responsibilities of the statewide entity. Due to separation of powers, the statewide entity will not be asked to administer funds flowing to drug or mental health courts and/or family drug courts through the Administrative Office of the Courts (AOC). However, the Collaborative will work to develop explicit guidelines to govern how any other state-controlled funding or other resources that are not within the statewide entity’s administrative responsibilities will work with the statewide entity to make a consistent, and to the extent possible, seamless behavioral health delivery system.

It is also not contemplated that state-operated facilities will be administered by the statewide entity. These facilities will remain state-operated, with state employees staffing these facilities. However, these services must be coordinated closely with the services and funds administered by the statewide entity. Referral processes and discharge planning must be carefully coordinated. Decisions regarding admission and discharge of persons in state-operated treatment facilities may become the responsibility of the statewide entity with financial impacts regarding utilization of these facilities built into the statewide entity’s contract during Phase Two or Phase Three described elsewhere in this paper.
Resources to be Purchased Collaboratively

This new way of developing and managing a single behavioral health service delivery system will not occur overnight. It will take time to mature and grow. It is important to distinguish what services and capacities the Collaborative will attempt to purchase together as of July 1, 2005, and what will need to come later. It is also important to think about how those resources that are not initially purchased together will be coordinated to create a single system of behavioral health services as contemplated by Governor Richardson and HB 271.

The Collaborative will release a single request for proposals (RFP) in the fall of 2004 (see Section V). This RFP will solicit proposals for a statewide entity (see Section VIII) to partner with the Collaborative in developing the single behavioral health delivery system. BHDWG anticipates that this RFP may include at least the following funds, services and programs during Phase One:

- HSD’s Medicaid-funded mental health and substance abuse services for children and adults (all managed care and most fee-for-service);
- DOH’s Federal mental health and substance abuse block grant funds and General Fund monies for treatment services for adults and adolescents;
- HSD’s TANF funds for substance abuse for TANF eligible individuals;
- DOC monies utilized for behavioral health services for adults on probation and parole and in the community corrections program;
- CYFD General Fund and federal monies for community-based behavioral health services for children, youth and families;
- School-based mental health services funded through the General Fund, Medicaid, federal or foundation sources administered by DOH, HSD or CYFD;
- CYFD and HSD TANF funds for behavioral health services for victims of domestic violence;
- ALTSD General Fund monies flowing to Area Agencies on Aging for behavioral health related services for seniors;
- MFA General Fund and federal monies for housing support services for persons who are homeless and mentally ill or substance abusing; and
- Possibly deployed state staff to work with the statewide entity to begin the establishment of local systems of care throughout New Mexico.

The RFP may indicate that during Phase Two, utilization of additional services and funding will be added to the statewide entity’s responsibilities. Services and funding being considered for inclusion in the statewide entities’ responsibilities to coordinate or administer beginning in Phase Two include but are not limited to:

- Admission and utilization of DOH’s state-operated behavioral health and substance abuse facility-based services (e.g., Las Vegas Medical Center, Turquoise Lodge, etc.);
- Access to vocational rehabilitation and supported employment funding and services for adolescents and adults with behavioral health diagnoses;
• Access to housing resources for low-income individuals or persons with mental illness or substance abuse disorders;

• CYFD funds for in-facility behavioral health services for youth;

• DOH forensic evaluation funds;

• DOH sexual assault services funding;

• Funds or services provided through federal or foundation grants;

• State and federally-funded services to address IEP needs for children with mental or behavioral disorders;

• Safe and Drug Free Schools funds for substance abuse prevention or intervention services;

• Federal and foundation funding for prevention, early intervention, treatment or rehabilitation services, including housing and employment-related services for persons with mental illness and/or substance abuse, and their families;

• DOH, CYFD and other substance abuse and mental health prevention dollars and services;

• Behavioral health funds and services provided through DOH public health clinics; and

• DOH funds for transitional reporting centers.

Any services provided through the state must be coordinated with the services and funding that are the responsibility of the statewide entity, whether the funding for those services are contracted to the statewide entity to administer or retained to be administered by state agencies. This means service definitions, service requirements, performance expectations, referral and follow-up, participation in and utilization of a single joint assessment and service planning process, early transition planning and coordination of transition from one service setting to another, data sharing, etc., must all be consistent or the same and/or shared throughout the behavioral health service delivery system.

For example, local DWI Grant Fund monies flowing to counties for services for persons charged or convicted of driving while intoxicated (DWI) must be coordinated with substance abuse prevention and treatment services administered through the statewide entity. How this coordination will occur and the role of the statewide entity, the counties, the local DWI councils, and DWI providers in that process needs to be determined by the Collaborative before the RFP is released. Similarly, how the statewide entity will coordinate with courts operating drug or mental health courts needs further discussion to make sure roles are respected while services are coordinated to accomplish the best outcomes and the best use of taxpayers dollars.

Financing Mechanisms

Because there are multiple funding streams and multiple types of populations (some of which are entitled to certain services and some of which are not), there will need to be multiple funding mechanisms for the statewide entity. Some of the funding contracted to the statewide entity will be financially risk-based, most likely a capitation amount or per-member, per-month payment for each eligible and enrolled individual. In other cases, the funds provided will be based on a budget or rate for specific deliverables or
activities. In other cases, there may be a global or program budget to serve particular populations for particular services or programs, with specification of amounts of services to be provided or numbers of persons to be served. In some cases, funds may be paid on a fee-for-service basis. Some of the populations covered by these fund sources are entitled to certain services once made eligible (e.g., Medicaid). This will result in different services being available to different groups of people, some as an insurance payment and some on a program-funding basis.

Throughout this process, the Collaborative will examine rates and funding mechanisms to help assure that the system is incentivized to move toward those services that promote recovery and resiliency and move away from those services that do not produce adequate outcomes for customers and their families. These decisions will have to take into account available resources and funding stream constraints. However, the Collaborative will work with the statewide entity, local systems of care, behavioral health service providers, the Behavioral Health Planning Council and other stakeholders to make the most of these available resources and use financial incentives to keep the system moving toward our consumer outcome and system performance goals.

However the individual funding streams are provided to the statewide entity, the Collaborative will work initially and over time to make the dollars as flexible and as interchangeable as possible, within the constraints of the state or federal funds involved. The Collaborative and the statewide entity will work together to identify state and federal constraints that preclude more efficient use of funds or better services or access. These constraints will be the basis of joint advocacy as this initiative unfolds. They will also be the basis of a requirement for community reinvestment of some of the funds managed by the statewide entity to encourage and incentivize cutting edge or alternative service delivery. These community reinvestment dollars will come from limitations on non-direct care costs and limitations on percentage of revenue over expenditures that can be retained by the statewide entity.

Roles and Responsibilities of the Purchasing Collaborative

In order to fulfill its mission and charge and realize its vision, the Purchasing Collaborative must have a structure of its own by which to make decisions and resolve conflicts; jointly manage projects; relate to the statewide entity and to each other; relate to the Behavioral Health Planning Council (BHPC) and other stakeholders; oversee the statewide entity's performance; and provide consistent leadership and technical assistance for the development of local systems of care. While each of the agencies in the Collaborative are used to doing these functions for the programs and funds for which they are responsible, they are not used to doing these functions for an entire behavioral health service delivery system. The Collaborative will have to begin to function as one, with equal concern and responsibility for all aspects of the behavioral health delivery system and for all populations, services and funding streams, regardless of originating state agency. This process will evolve over time, as the Collaborative
learns to work together and learns the best ways to put resources together to create an improved behavioral health delivery system for New Mexico.

Each state agency will retain responsibility for the reporting, accounting and oversight of the funds, staff and services that are in its budget. However, the collective whole will be concerned with what those funds and resources can produce – services and outcomes. The Collaborative as a whole will need to make decisions about how funds, staff and service capacities are deployed to achieve commonly desired performance and outcomes.

In order to operate collectively, the Collaborative will organize itself similar to a working board of directors, with lead agencies for some responsibilities (e.g., staffing the BHPC and staffing subcommittees of that Council) and cross-agency teams for others (e.g., overseeing the activities of the statewide entity, monitoring the quality of services, and working with communities to develop local systems of care). A Memorandum of Understanding (MOU) among the agencies will be developed and signed before the beginning of FY 2005.

The Collaborative will have “by-laws” or a working agreement about how the Collaborative will function, including what standing subcommittees might be needed to do business. Decisions will be made by consensus when possible and by vote of the member agencies when not. Methods for resolving differences will be built into the working mechanism of the Collaborative. Opportunities to hear and seek input from and interact with the BHPC will be built into meetings throughout the year. Opportunities to hear from the public will also be built into meetings where possible.

In addition to the formal Collaborative itself, BHDWG will continue as a multi-agency coordinating group to conduct the day-to-day business of the Collaborative and develop recommendations for policy and financial decisions for the Collaborative. BHDWG will consist of key staff from each of the agencies involved in the Collaborative. The Collaborative will meet at least quarterly and whenever major policy or financial decisions are needed. Pursuant to HB 271, the co-chairs will call these meetings, and they will be open to the public to observe, except when executive sessions are legitimately called to consider legal or personnel issues. BHDWG will meet more regularly to assure assignments are made, staff groups are working and effective, and issues are identified for the Collaborative’s consideration. BHDWG will also provide the day-to-day contact with the statewide entity and with BHPC. BHDWG meetings will be working staff meetings, not open to public observation except when meetings with stakeholders are scheduled.
VIII. STRUCTURE FOR COLLABORATIVE PURCHASING OF A SINGLE BEHAVIORAL HEALTH SERVICE DELIVERY SYSTEM

Principles for Structural and Financial Decisions

The following principles were considered as structural decisions were made. Some of these principles are the same as the general principles guiding the development of the Interagency Behavioral Health Purchasing Collaborative initiative; others are specific to the structural and financial issues.

- Decrease administrative layers and costs;
- Be consumer friendly and consumer/family driven;
- Be culturally proficient;
- Have flexibility in funding and offering of services;
- Utilize the most cost effective treatments;
- Maximize ease of access and be seamless for recipients;
- Maximize service capacity;
- Balance cost and outcomes;
- Be of the highest possible quality;
- Be recovery/resiliency oriented;
- Be directed toward priority populations/define the populations;
- Utilize New Mexico knowledge and experience;
- Have ability to respond quickly;
- Make clinical decisions as far as possible from monetary decisions; and
- Follow “first do no harm” and have no less services or effectiveness than is occurring today.

Functions at State and Local Levels

The subgroup considering functions that should occur at the Collaborative, statewide entity and local/regional levels resulted in the following initial thoughts:

- **Collaborative:** Develop and maintain the statewide behavioral health plan, grant writing and management (large grants), ombudspersons, single statewide planning, state and federal requirements planning, assuring visible services and funding for Native Americans, data management, performance and outcome indicator oversight, leadership for development of behavioral health systems of care/continuum of care, “keeper of values,” rate setting, service definitions, assuring consumer/family/citizen input, planning and oversight of training, clinical and evidence-based practice leadership, fraud and abuse monitoring, and licensing and certification oversight.

- **Statewide Entity:** Financial management and oversight, regional compliance, delivery of training, contracting with providers and establishing local systems of care, client outcomes, assuring consumer/family/citizen input, determining client eligibility, enrollment of recipients, service development, coding and configuration, legal issues, single client identifier for data, grant writing and management (smaller
grants), rate setting, utilization management (UM), trending UM data, utilization
criteria, predictive modeling/disease management guidelines, prior authorization (for
“high end” services), quality management and improvement, provider services,
member services (including formal grievances and appeals), claims
management/billing/payment, underwriting and actuarial functions, data
management, fraud and abuse, regulatory compliance, and implementation and
maintenance of provider credentialing.

- Local: Identifying unique barriers and solutions, planning and developing local
  systems of care and infrastructure, client outcomes, assuring consumer/family/citizen input, individual service planning including ability to do creative “wrap-around,” care coordination including coordination with physical health, program development of flexible (“non-treatment”) services and assurance of some resources to do this, clinical and/or psychosocial assessments, informal complaints, training, service delivery, quality assurance managers for providers, regional advisory groups/councils, and ability to function as community engagers.

This initial set of thoughts has been refined as discussions about structure have continued. Additionally, other subgroups considering care coordination, services and other issues identified other ideas that affect decisions about structure. At this point, a statewide entity to partner with the Collaborative, local systems of care, and regional planning teams of state and statewide entity staff are the approaches to be used to assure statewide consistency and regional and local presence. These approaches are described below.

**A Statewide Entity to Partner with the Collaborative**

In order to provide a mechanism for the multiple state agencies to work and purchase collaboratively, a single statewide entity will be jointly procured to receive multiple funding streams from multiple state agencies. With direction and oversight from the Collaborative, this statewide entity will implement the philosophy, principles and values, and service requirements directed by the Collaborative. The statewide entity will be the agent of the Collaborative and will “braid” the funding, human resources and service capacity available from the various state agencies to make a seamless single behavioral health service delivery system for New Mexico.

The Collaborative is looking for a partner as much as an administrator or management entity. The statewide entity will have to be flexible, able to work with multiple agencies and competing demands, and change as the system and the Collaborative evolve.

At the same time, the statewide entity will be responsible for contracting with individual providers or provider networks and developing local systems of care to serve the specific needs of different geographic areas within New Mexico, considering cultural, rural/frontier, border, and other differences. The Collaborative will seek to establish the right balance between local variations that address local needs and common approaches statewide that assure consistent quality, accountability, and access; that
avoids duplication of effort at local levels; and that avoids confusion by creating uniformity in billing, contracting, infrastructure and processes.

There must be a strong local presence, to address the necessary buy-in of local stakeholders and to address the unique characteristics of various geographic areas within New Mexico. Creating this balance will be difficult and will take time as the system evolves.

In preparing a Request for Proposal (RFP) for the statewide entity, consideration will be given to those elements that support systems of care and that are dynamic and incorporate long-term planning to address the gap between what is needed and what is provided. At a minimum, the RFP will need to include the following requirements:

- **Stakeholder engagement** – Clients, families and advocates engaged and involved in all aspects of the public behavioral health care system, from governance and policy development through planning and program development to quality management and system evaluation. Stakeholders in these systems have become the most effective advocates for the vision and mission of the public behavioral health care system. They have also provided the motivation and momentum for the change process.

- **Data for decision-making** – Accurate, timely and consistent data gleaned from a variety of sources used to drive system planning, budgeting, and quality management and performance evaluation, with decisions made at all levels based on consistent analyses and interpretations of accurate and timely data. Included in the information analyzed is literature describing evidence-based and best practices from other jurisdictions as well as information generated from within the state’s own systems.

- **Incentives and Rewards** – Formal and informal incentives to “do the right thing” consistent with the vision of the system; these could include resources, recognition, attention, mentoring and sanctions to encourage the system and its components to perform in the desired way.

- **Quality improvement culture** – An organizational and system-wide culture that fosters and supports constant learning, change, challenging of sacred principles, and trying out new ideas throughout the public behavioral health care system. The system knows and can articulate how it is performing and the outcomes it is achieving compared to goals it has set for itself, taking into account customer, funder and public expectations.

In order to assure program development, implementation and management consistent with the defined goals of the Collaborative, the state will require interested parties to provide information about their specific abilities and experience in planning, implementation, and monitoring of mental health and substance abuse services including coordination of care procedures. (See Appendix H for a list of desired characteristics and functions of a statewide entity in partnership with the Purchasing Collaborative.) The key functions of the statewide entity can be summarized as:
• Contracting and paying providers;
• Developing and implementing a regional service plan (see below) in conjunction with all the LSOCs in each regional area;
• Utilization review and utilization management;
• Assuring care coordination;
• Evaluation and monitoring of providers and services;
• Quality review and improvement – achieving system performance and consumer outcomes; and
• Collecting, managing and reporting data required by fund sources and for quality management purposes.

Not only must the statewide entity be able to manage all covered behavioral health services (including both Medicaid and non-Medicaid individuals) as listed for mental health and for substance abuse services, it must also manage and account for funding and other requirements of state agencies within the Purchasing Collaborative. At a minimum, the statewide entity must be able to identify, track and report allowable and non-allowable expenses and utilization for required state and federal reporting.

The Purchasing Collaborative will establish an interagency staff to oversee the work of the statewide entity. The RFP and contract will include specific deliverables including service and administrative requirements. The contract will also include specific system performance and consumer outcomes that must be met and consequences if they are not. These will form the basis of contract oversight of the statewide entity by the Collaborative.

Contracting with Providers

The statewide entity will contract with behavioral health providers or groups of providers for the delivery of behavioral health services. In the process of developing contracts with providers to assure services are delivered according to local community needs, certain providers will be considered essential. That means the statewide entity will need to maintain a contract or method of payment with these providers for the appropriate clients. These include (but are not limited to) Indian Health Services (IHS), 638 tribal programs and providers serving a particular linguistic or cultural group.

For at least Phase One, in order to maintain continuity of care and system stability, the statewide entity will be expected to maintain a contract or method for paying all providers who meet requirements and who receive state-controlled funds as of June 30, 2005. After that time, the statewide entity will not be required to contract with any willing provider and will be free to develop contracts with providers or groups of providers as needed to accomplish the goals of the Collaborative. However, any decision-making process about providers or groups of providers who will receive contracts will be based on the desire to create the best services and access to services possible within available resources. The process should represent a fair selection among willing providers rather than arbitrary decisions based on existing business partnerships.
Decisions by the statewide entity regarding what providers it will contract with in addition to existing providers in Phase One and in addition to essential providers ongoing will be guided by input from local systems of care and by quality guidelines and requirements established by the Collaborative with the statewide entity. The Behavioral Health Planning Council will play a role in reviewing and making suggestions about these guidelines and requirements.

**How the Statewide Entity Will Be Chosen**

The Governor indicated in his September press release (Appendix A) that the statewide entity would be selected through an open, competitive procurement process. The Collaborative will follow state procurement laws in selecting this entity. The process described here for selecting the statewide entity is only a proposed process and is subject to change based on legal, financial and other required reviews.

The intent is to release a draft request for proposals (RFP) for public review and comment before finalizing and letting the final RFP. However, concerns about the legal implications of such an approach have been raised by the state’s procurement agent. If these concerns cannot be resolved, the Collaborative will release for public comment further information about the proposed and potential requirements of the statewide entity and potential types of work and required outcomes that may be part of the RFP when released. BHDWG will develop the proposed content of the RFP for consideration by the Collaborative.

Once approved, the state’s General Services Department (GSD) will be asked to release the RFP on behalf of the Collaborative, with one agency designated as the lead or point of contact for GSD. At least one BHDWG representative from each agency that will have funds or resources administered by the statewide entity will be asked to review all proposals and participate in the proposal review team. To the extent permitted by law, some consumer and family representatives on the BHPC will be asked to read and comment on the proposals during proposal review process. The Collaborative proposal review team will score proposals based on criteria identified in the RFP and will make recommendations to the Collaborative about which bidders should be called for an oral interview.

The interviews will be conducted by a subgroup of the proposal review team and any of the Collaborative agency heads who wish to participate. From these interviews, a recommendation will be taken to the Collaborative for final selection of the successful bidder. Contract negotiations with the successful bidder will be conducted with one agency leading and providing lead legal counsel. A small interagency group, with assistance from all Collaborative agencies’ legal counsels, will negotiate the contract (much like the collective bargaining process) with single legal boilerplate language, and individual sections representing the particular requirements of each agency or funding stream. The single contract will serve to tie the Collaborative together and to the statewide entity. All agency heads whose funding, staff or service capacity is affected by the contract will be signatories on the contract.
Local Systems Of Care

After much consideration and input from stakeholders, BHDWG has determined that local systems of care should be developed in New Mexico’s local communities. In addition, several of the Collaborative agencies are attempting to standardize their regional boundaries for planning and state service delivery. These two geographic areas and concepts are important in the development of the single behavioral health delivery system for New Mexico. They are each described in this section of the concept paper.

The system of care concept is described in Appendix F. In New Mexico, local systems of care (LSOCs) should reflect the local area in which they develop and should include consumers (youth and adults), families, advocates, providers, tribes, community health improvement councils, area agencies on aging, local DWI councils, juvenile and adult corrections representatives, representatives of the faith community, schools, vocational programs, law enforcement, housing representatives, child welfare representatives, tribal representatives, local elected officials, representatives of other health and social services entities, and any other interested system representative. No system or stakeholder group that is interested should be excluded from some form of participation in the functions of the LSOC.

Since many of the Collaborative agencies work with courts and judicial districts, the current 13 judicial districts in New Mexico will be used as a guide for the geographic areas in which LSOCs should be developed, although some LSOCs may cover a smaller area or multiple judicial districts. LSOCs will not be allowed to cover a geographic area that is inconsistent with judicial district boundaries. (See Appendix D for a map of the state’s judicial districts). These LSOCs will be asked to be responsible for:

- Identifying gaps and needs/service array recommendations;
- Planning to address those needs;
- Capacity building and program development;
- Developing common proposals to the state, federal government, foundations and/or the statewide entity for funding for services or programs;
- Evaluating the quality of services provided;
- Agreeing on common protocols for referral and follow-up of persons in need of services across multiple local systems; and
- Coordinating care for multi-system service recipients.

The Purchasing Collaborative will release guidelines at the time the RFP is released that will be used to define and develop LSOCs. These guidelines will include components such as the following:

- Number and types of collaborative partners that must be involved (including local city and county governments);
- Diversity of collaborative partners (reflection of community profile);
• Expertise with culture/ethnic/frontier/rural populations represented in the geographic area;
• Governance structure including organizational capability (e.g., by-laws, decisionmaking authority, etc.);
• Fiscal capacity for LSOCs interested in becoming a limited service provider, including ability to receive and allocate funds, e.g., grants, to meet community needs (i.e., systems development);
• Relationship to local providers, including ability to communicate and coordinate planning and systems development with local service providers; and
• Capacity to:
  o Provide for direct consumer/family involvement in all areas of program development, evaluation, and decision-making;
  o Conduct needs assessments and planning;
  o Develop collaborative funding proposals;
  o Develop protocols for referral and follow-up;
  o Coordinate care and services across multiple systems;
  o Ability to use and interpret data and use it for quality improvement and resource management;
  o Ability to organize and conduct service and provider quality reviews; and
  o Ability to provide training, technical assistance and capacity building within designated region.

The guidelines will be used to encourage local communities to begin the process of organizing and developing the LSOC. Interagency staff teams working with regional staff from the statewide entity will provide training and technical assistance for any geographic area that would like to prepare to become an LSOC. If more than one entity expresses interest or intent, these Behavioral Health Interagency Implementation Teams (BHIITs) will work with local stakeholders to achieve the most input and the best possible collaboration so that only one single LSOC is designated for any particular area of the state. The BHIITs, including regional staff from the statewide entity, will assist in the organizing and development of each LSOC. Some areas of the state will need more assistance than others in their formation of the LSOC. If an LSOC is not coalescing in a timely fashion, the BHIIT for that area will work to facilitate the process. Ultimately, the Purchasing Collaborative will designate each LSOC.

Since the geography and culture of different areas of New Mexico are very different, the approaches to developing LSOCs will be different. In some places, a lead provider or a provider network will provide leadership to develop these LSOCs. In other places, local health planning councils, local tribal leaders, or consumer or family groups may lead this effort. In all cases, staff from state agencies and the statewide entity will need to provide technical assistance in developing these LSOCs. This local organizing entity will convene, plan, develop, mobilize, implement and continuously evaluate, in partnership with individual consumers and families, the services in that particular community. It will receive support from the BHIIT and be responsible to the statewide entity. While not receiving any service dollars initially, it could eventually be responsible for and paid by the statewide entity for case management, direct service support or
other similar functions. The decision to become a limited service provider will be up to each LSOC, and the decision to contract with an LSOC as a provider will be up to the statewide entity after consultation with the Purchasing Collaborative.

LSOCs will not be responsible for determining the specific providers or provider groups the statewide entity will contract with, or for directing specific dollars to specific programs. However, LSOCs will be critical partners, and will be important sources of information about the needs of that local community, about the processes that are most likely to work there, and about the quality of services experienced by service recipients in the area from specific providers. This information will be utilized by the statewide entity in contracting with and credentialing of providers and by the Collaborative in its quality oversight and accountability role.
Regional Behavioral Health Interagency Implementation Teams (BHIITs)

Many state agencies have four to six regional areas used for planning and state-operated service delivery. In some cases, a single agency has different regional boundaries for different programs within the same agency. Recently, the health and human services agencies have agreed to develop common regional boundaries for the behavioral health purchasing collaborative initiative and for other health and human services planning and service delivery purposes. Appendix E represents the proposed boundaries for these regional geographic areas.

Within each regional area, the Collaborative will organize Behavioral Health Interagency Implementation Teams (BHIITs) to be responsible for the quality of services, system performance and consumer outcomes in that geographic area. BHIITs will include regional staff of the statewide entity who will live and work in that part of the state. BHIITs will provide assistance to local groups in the development of local systems of care. BHIITs will meet regularly with the LSOCs to discuss service priorities, area needs, and operation and quality of behavioral health services and programs in that geographic area.

The primary functions of the BHIITs and the Collaborative as a whole will be:

- Philosophy and Values;
- Support for consumer/family involvement at all levels;
- Final resolution of consumer/family complaints and grievances;
- Resource management;
- Assuring consistency for the single statewide delivery system;
- Needs assessment and planning;
- Quality improvement (using UR/UM, QM and complaint/grievance data);
- Case and systemic advocacy;
- Training/Technical assistance;
- Program development; and
- Outreach development.

The Collaborative will look to the statewide entity to determine how to organize and fund service delivery initially and to work with the Collaborative to determine the best funding mechanisms for different types of populations and funding streams (e.g., case rates, fee-for-service, sub-capitation, program budgets, etc.) To the extent LSOCs are in place, the statewide entity will utilize their input in this process. The statewide entity will also be asked to assure that providers that serve the entire state are available, and that services needed statewide rather than in one particular community are developed and funded.

The statewide entity will be asked to provide a service delivery plan for each of the five geographic regions, and perhaps one non-geographical region covering Native American populations. The statewide entity will be required to incorporate all the LSOCs within each region into the regional service delivery plan.
In all these efforts, the goal will be common performance expectations and common client outcomes statewide (see Section VI). These will be the mark of the statewide entity’s success. Each LSOC may have its own outcomes it wants to achieve in addition to those required for the system as a whole across the state.

IX. PERSONS TO BE SERVED AND SERVICES TO BE OFFERED

Persons Served

It will be a goal of the new behavioral health system to emphasize wellness and provide incentives for prevention and early intervention with services provided in home, school, and other community-based settings. The Collaborative will work toward purchasing services that are culturally and linguistically proficient and able to be accessed by populations who live in rural and frontier areas of the state.

Other than universal prevention services, a needs-based approach to the planning and purchasing of services will be the goal, with a recognition that behavioral health services will continue to be available to people in New Mexico based on a combination of financial eligibility, federal and state mandates and individual/family need. The Collaborative will work to utilize current resources more efficiently so that services and persons served will not be reduced due to the development of the Collaborative (except to the extent affirmative choices are made to change some current services into other services).

Determining persons eligible to receive services is complicated by the combination and braiding of fund sources in the Collaborative process. Generally, each fund source has a specific population group in mind (e.g., CYFD’s community funds) or has specific eligibility criteria for the persons who have access to those funds (e.g., Medicaid). The statewide entity will have to assure that all mandatory or entitled populations are served and all mandated services are available. Those eligible to receive services are those who are:

- Federally- or state-mandated to receive services with targeted funds;
- meet categorical criteria associated with individual fund sources; and
- are in need of services as determined by medical necessity definition or other criteria used to make judgments about the utilization of services.

Within these eligibility criteria, persons who are “covered” for certain services the Collaborative will be purchasing include, but are not limited to:

- Individuals whose current insurance combined with income is insufficient to meet their identified clinical/service needs; or
- Children and their families referred by or involved with the Children, Youth and Families Department (Protective Services and Juvenile Justice) and/or tribal social services; or
• Families in Need of Services (FINS) as defined by the NMSA Article 3, Family in Need of Services Act, Section 32-A3A-2; or
• Children under the age of eighteen and their families at high risk for entry into CYFD’s Protective Services or Juvenile Justice Services;
• People under the supervision of the Department of Corrections (DOC) who meet criteria established by DOC; and
• People who meet age criteria for services from the ALTSD.

In addition to these populations, the Collaborative will work with the statewide entity and local systems of care to determine priorities within these groups or other populations designated by the Purchasing Collaborative to receive services, depending on available funding. There are not enough funds to serve everyone in need. This difficult process of setting priorities will be made easier by having the Collaborative work together and work with the statewide and local partners as the planning and implementation proceed.

The ultimate goal is to have each eligible person or family screened and assessed using a common age-appropriate instrument and/or process to determine the need for services.

Native American Issues

Home to twenty-two federally recognized Indian Tribes and Pueblos, New Mexico has the fifth largest Native American population of any state in the nation, including nineteen pueblos, two Apache tribes, and part of the Navajo Nation. According to the 2000 U.S. Census, the total American Indian and Alaska Native population in New Mexico was 191,475, slightly over 10% of the population. In addition to the population of the pueblos and tribes, the state’s urban Indian population, which is primarily centralized in the Albuquerque area, totals 22,047. Urban Indians face particular and unique obstacles and lack of access to health care services. In general, Native Americans in New Mexico are poorer and less educated than other populations, thus more prone to health risks than any other racial or ethnic group.

In proportion to other racial and ethnic groups in New Mexico, Native Americans have greater behavioral health needs. One of the most common challenges that New Mexico’s Native Americans face is substance abuse. More than six times as many Native Americans (13 percent) as Anglos (two percent), and more than twice as many Native Americans as Hispanics (six percent), die because of alcohol-related motor vehicle crashes in the state of New Mexico. Native American youth are also more than twice as likely to commit suicide, and nearly 70 percent of suicidal acts in Indian Country involve alcohol.

Pursuant to the tribal Input meeting held on March 4, 2004, the statewide entity will be asked to do the following to address the needs of native people:

• Encourage the use of culturally appropriate and traditional healing services for Native Americans under the new statewide entity that may serve as a best practice
approach;

- Include IHS, tribal and urban Indian behavioral health programs as providers, including under Medicaid;
- Assure that behavioral health services, including prevention services, for Indian people will not be reduced under the new behavioral health system;
- Establish partnerships with tribal and non-tribal entities to develop local tribal systems of care that encompass entities such as the New Mexico Indian Tribes and Pueblos, Indian Health Service, the Bureau of Indian Affairs, Native American traditional healers or medicine men, and urban Indian organizations;
- Be flexible to meet the needs of the diverse cultural and regional differences of the state, including Native Americans; and
- Retain special funding specifically for programs operated by and for Native American populations and communities.

The Purchasing Collaborative plans to create a special Subcommittee of the Behavioral Health Planning Council specifically to address the behavioral health needs of Native American communities and urban Indians.

The unique government-to-government relationship between the State of New Mexico and the twenty-two New Mexico Indian tribes and pueblos established by Governor Richardson in partnership with the tribes and pueblos will continue as it is today. State agencies will work directly with tribes on formal tribal consultations. The Purchasing Collaborative will hold the statewide entity accountable for providing culturally appropriate behavioral health services to Native Americans statewide.

**Persons with Complex Needs**

Neuropsychological Disorders (NPDs) consist of several complex disorders, which often involve significant physical, behavioral, social and educational issues and problems. Persons with certain of these disorders may need to be addressed by the Purchasing Collaborative. These disorders include Autism Spectrum Disorders (ASD), which include Autistic Disorder, Pervasive Developmental Disorder (PDD) Not Otherwise Specified, and Asperger’s Disorder; Developmental Disorders with mental illness and/or substance abuse (DDMI), and Brain Injury (BI) with mental illness and/or substance abuse.

In New Mexico, several state agencies provide or pay for physical and behavioral health care and services, educational services, community-based services, and/or job training for persons with NPDs and thereby maximize the benefit of treatments. These agencies include HSD (especially Medicaid), DOH (especially Long Term Services), ALTSD (especially services for persons with traumatic brain injury), CYFD, PED, and DVR.

Currently, many individuals with NPDs in New Mexico do not receive adequate assessment and diagnosis. As a result, services for which they may be eligible are not made available to them through New Mexico’s publicly-funded programs. Adequate,
timely neuropsychological and educational assessments are essential to begin planning services for individuals with NPDs. The type, frequency and duration of physical health, behavioral health and educational care and services must be individually tailored to meet the person’s needs.

The Purchasing Collaborative is not charged with and is not funded to purchase all needed services for individuals with NPDs. However, behavioral health needs for any New Mexican should be part of the Collaborative’s concern. The Collaborative may be able to serve as a forum for addressing some of the interagency service issues for individuals with complex needs.

Specifically, the Collaborative may be able to bring together the agencies with responsibilities to address the needs of individuals with NPDs to establish criteria for defining physical, behavioral and educational needs for services, and for determining which entities should be responsible for service delivery and seeking funding to meet those needs. The Collaborative will work with the statewide entity and stakeholders to include neuropsychological and behavioral health assessments, as indicated, to diagnose or rule out NPDs for those who may need such assessments. Uniform diagnostic and assessment criteria will be developed to assist in this process. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screens for all children and youth eligible for Medicaid need to be completed, and appropriate referrals need to be made when ASD, DD, or BI are suspected. Community outreach and screening of high-risk populations under age 21 should be conducted to insure early identification and treatment for persons with NPDs.

The Collaborative will need to work with the statewide entity and other state agencies to determine the best approach to addressing the multiple needs of individuals with NPDs, especially to assure that services and treatment plans (including individualized educational plans) are coordinated; adequate communication takes place among involved agencies; a comprehensive treatment record is available to all providers involved in treatment; and, differences are resolved between physical health, behavioral health and educational and developmental services entities regarding care coordination, services coordination and responsibility for payment of care and services.

The Purchasing Collaborative will require that the statewide entity to work closely with existing centers of excellence, such as the CDD at UNM and other in-state resources, where individuals may receive proper assessment and diagnosis, and also where medical, behavioral and educational professionals and programs involved in treatment of persons with NPDs may receive technical assistance, clinical consultation, current information and research. The Collaborative will also work with the Behavioral Health Planning Council to determine the best role for seeking input about the behavioral health needs of persons with NPDs. The state comprehensive behavioral health plan will include attention to the needs of individuals with NPDs so that a dialogue about addressing these needs can begin.
Services

Currently, each agency provides services that are defined differently with different methods of billing and accounting for these services. The implementation of the Health Insurance Portability and Accountability Act (HIPAA) has required a common approach to the coding, and therefore the definitions, of services that are essentially the same activity. Several agencies that pay for services subject to HIPAA requirements are working together to make sure their data systems and service definitions are consistent.

HIPAA requires the use of certain standardized codes and service definition sources, including Common Procedural Terminology (CPT) codes and Health Care Common Procedure Coding System (HCPCS) codes. While these codes and service definitions may not be familiar to many behavioral health providers, HIPAA requirements and the implementation of the Purchasing Collaborative are coinciding to make these changes necessary. This offers an opportunity for Collaborative agencies to create a common service taxonomy, common service definitions and common service billing codes for all behavioral health services to be funded by state-controlled dollars.

An interagency work group has completed considerable research and developed a draft of service definitions for all possible services. These services have been organized into a service taxonomy that groups services by categories, including prevention/early intervention, outpatient services, intensive outpatient services, residential services, and inpatient/inpatient detoxification services. Each service has been cross-walked to the list of services currently provided by Collaborative agencies and with the list of services developed by the Services and Populations subgroup. This taxonomy and crosswalk are included as Appendix C.

The Collaborative expects to finalize the taxonomy, service definitions and related service requirements before the RFP for the statewide entity is released. Service requirements will be the basis of a provider service manual and will be a tool for moving toward consistency and quality in service delivery. Service requirements will include the following for each service in the taxonomy:

- Service definition;
- Billing code;
- Target population;
- Service exclusions;
- Program requirements;
- Staffing requirements;
- Specific documentation requirements;
- Admission criteria (that is, who will receive the service);
- Continuing service criteria;
- Discharge criteria;
- Service authorization periods;
- Service authorization units; and
- Benefit limits.
The Collaborative will work with the statewide entity to begin training providers on how to use the new service definitions and requirements and how to bill for each service they are contracted to provide.

Not all services will be available to everyone. Some services will only be available for certain types of individuals. Services will only be available for any given individual if that individual is eligible for the service due to financial or clinical criteria and an assessment indicates a need for that service at that time (in some cases based on “medical necessity;” and in some cases based on program criteria. Priorities for access to services may include diagnostic criteria such as:

- Adults with severe and persistent mental illness;
- Children with serious emotional disturbance;
- Individuals with a neurobiological disorder;
- Individuals with co-occurring disorders (substance abuse and mental illness) or who are dually or multiply diagnosed (developmental disabilities and mental illness); and
- Individuals with substance use disorders.

Some behavioral health services will be prioritized for persons who meet identified characteristics, e.g.:

- Individuals who are enrolled in Medicaid;
- Children in the protective services or juvenile justice service systems;
- Adults who are incarcerated in jail;
- Juveniles who are incarcerated in detention facilities;
- Individuals covered by waivers who also have behavioral health diagnoses (e.g., developmentally disabled, disabled and elderly, HIV/AIDS, medically fragile children);
- Individuals with behavioral health diagnoses who have traumatic brain injury;
- Children with special health care needs as defined by Medicaid;
- Individuals who are in transition (all age transitions);
- Children placed out of home such as those in foster care/adoption;
- Individuals who are homeless;
- Individuals who are on probation and parole;
- Individuals in community corrections programs; and
- Women (especially those with substance abuse disorders) who are pregnant;

Even with these priorities, there are not enough resources to provide needed services for everyone in these groups. After meeting federal and state fund source requirements, other criteria will be used to prioritize who will have access to services. These criteria will be set by the Collaborative and the statewide entity with significant input by the Behavioral Health Planning Council. Some of the risk factors that may be considered for these criteria include:

- Use of multiple behavioral health services;
• Intensive use of behavioral health services;
• At risk of developing severe emotional/behavioral/neurobiological problems/disorders;
• Intention/plan to hurt self or other(s);
• Suicide attempt during the past year (adult, child or parent);
• Substance abusing behaviors;
• Infants, toddlers and preschoolers exhibiting difficulty in relationships, attachments, self-regulation or behavior problems;
• Multiple delinquent acts or law enforcement contacts by child;
• Multiple school problems, including suspension or expulsion from school during last year;
• Runaways/throwaways;
• Children whose parent(s) have mental illness;
• Children whose parents are incarcerated, involved with the criminal justice system, or on parole or probation;
• Physical, sexual, emotional abuse or neglect;
• Multi-generational history of familial maltreatment, neglect or abuse;
• Teen pregnancy during past year (or) a teen parent;
• Child/youth experiencing cultural, sexual and/or gender identity issues;
• Witness (or participant) to violence, school, or community;
• New or shifting family situations/environments that cause psychological distress, stressful family situations, individual/family challenges;
• Death of a family member or close friend during the past year;
• Families in Need of Services (FINS) as defined by New Mexico State Statute, Children’s Code, Article 3, Family in Need of Services Act, Section 32A-3A-2;
• Parents and families of 0-6-year-old youth, referred by a human services or related agency;
• Youth in K-6th grade exhibiting behavior problems and referred by school personnel, child care centers, etc.; and
• Youth ages 12-17 exhibiting behavior problems referred by juvenile probation officers, school personnel, parents, etc.

Certain core services should be available to everyone, depending on the individual’s eligibility category (i.e., income level, Medicaid eligibility, etc.). Core services include things such as screening and evaluation as well as a variety of outpatient and day or rehabilitation-oriented services. Specialty services include those services that are facility based and for persons with intense or acute care needs that cannot otherwise be served in a community setting. Unique services are those that are specialized (and in many cases manualized) for a limited number of individuals who meet very specific clinical criteria. Examples of these services include assertive community treatment (ACT) or specialized residential services for female adolescent sex offenders. Unfortunately, not all core, specialty or unique services that should be available are currently funded in New Mexico.
The Collaborative will have as its goal to make available over time a complete array of services using a knowledge-based approach to the service requirements and the identification of individuals who would benefit from those services. To the extent possible, the Collaborative will look for existing General Fund dollars being spent on behavioral health services for adults or children to increase the Medicaid benefit package of behavioral health services.

**Prevention Services**

Evidence-based prevention services are critical in New Mexico in order to stop the destruction caused by substance abuse. Such services have been successfully adapted, implemented and evaluated in various New Mexico communities. These prevention programs have strong evaluation components and have consistently shown positive outcomes. Several New Mexico prevention programs have received national awards as exemplary programs.

Alcohol, tobacco and other drug abuse prevention is an active process that promotes the personal, physical and social well-being of individuals and families not in need of treatment services. The goal of prevention services has been to prevent substance abuse through the reduction or abatement of risk factors and the strengthening of protective or resiliency factors. Prevention activities include various strategies aimed at educating the community at large and selective strategies for individuals and families who are at greatest risk for substance abuse but are not in need of treatment. These activities also include reducing environmental and normative conditions that encourage the use of substances, and strengthening or creating pro-social norms or regulations that decrease the likelihood of illegal or inappropriate use and abuse.

Prevention services for persons at risk of mental health issues are also needed. While the concepts of recovery and resilience have aspects of prevention – preventing relapse and preventing need for higher levels of services – prevention services for those who are not yet diagnosed or in need of treatment is critical for New Mexico. A significant portion of prevention dollars should be spent on people not yet in need of treatment for either substance abuse or mental illness.

The Collaborative is committed to providing prevention services that are universal (targeting the general population), selective (targeting those at higher-than-average risk for substance abuse or mental illness) and indicated (targeting those already using or engaging in other high-risk behaviors to prevent chronic substance use and those who will experience adverse impacts of mental illness without intervention). Screening and early intervention for at risk populations is important for indicated prevention services. In addition, services that help those with diagnosable disorders to prevent relapse and to live a productive life in the community will be priorities in the new behavioral health system.

The focus of current prevention programs has been preventing the onset of behavioral health disorders, in particular substance abuse and mental/emotional disorders. In
2003, DOH provided services to over 100,000; 81 percent of those served received universal prevention programming, 13 percent received selective prevention programming, and six percent received indicated prevention programming.

**Pharmacy**

The ultimate goal of the behavioral health system is that all customers should have access to the same medications, regardless of their eligibility for Medicaid, in order to assure seamless access to treatment for consumers and families. Co-payments, deductibles and other requirements, particularly for non-Medicaid eligible consumers, would likely be necessary to address cost containment issues. Coordination with the new Medicare prescription drug benefit for individuals who are both Medicaid and Medicare eligible will also be critical. It is not likely that all these goals can be reached by July 2005.

Currently, most behavioral health related medications paid for by state agencies in New Mexico are paid for by Medicaid, and are managed together with medications for all other health-related purposes within the Medicaid program. A few atypical psychotropic medications for non-Medicaid eligible adults are paid for by a special General Fund appropriation to BHSD in DOH. Other consumers do not receive medications at all, receive them only in an emergency and only from programs serving indigent individuals or those without any health care coverage, or receive them only while institutionalized or incarcerated.

The pharmacy program within Medicaid is changing. HSD is moving toward use of a preferred drug list in which use of generics is encouraged and the least expensive “best in therapeutic class” medication is offered with the lowest co-pay and the least prior authorization. Given these changes and the difficulty of managing the costs of and access to medications when they are not in the behavioral health system, the Collaborative is likely to include the management of behavioral health medications within the responsibilities of the statewide entity and health related medications within the responsibility of the MCOs. This would be managed by determining who the prescriber is and using the type of prescriber as the determinant of where the medication cost is charged.

The following principles will guide medication management in the new system:

- At least one type of each class of behavioral health medication should be available without prior authorization for Medicaid eligible clients. The list of such medications should be regularly reviewed and updated as needed.
- Consumers with a history of positive response to a behavioral health medication should be allowed to remain on the medication regardless of prior authorization requirements. For example, those individuals coming out of facilities on a medication that is working for them should not have to change that medication just because the PDL or formulary outside the facility is different than the one inside the facility.
• Criteria for approval of medications requiring prior authorization should be simple and available to the public. Medically appropriate use of generic medications should be encouraged.

• Medicaid should work to include as a benefit medications to treat substance abuse, including medically assisted treatment for substance abuse disorders to the extent resources are available. Some such medications are currently available for Medicaid enrollees, but information about how to access these medications is not readily available to consumers and providers.

• Appropriate coordination should be required between physical health and behavioral health entities and providers regarding prescribing practices for shared clients.

• The statewide entity should describe its methods of assuring high quality pharmacy services and maximizing access to behavioral health medications for non-Medicaid consumers to the extent resources are available, especially for those individuals for whom medication could mean prevention of the use of higher cost, more restrictive services. Such methods may include but are not limited to monitoring of prescribing practices, investigation of suspected fraud or abuse, best price purchasing arrangements, 340B participation, drug rebates, use of tribal, Indian Health Service and Veterans Administration resources, use of generic medications and samples and patient assistance programs.

Transportation

Many state agencies are working together to rethink the way transportation services are delivered. Human services, health care and transportation agencies are developing a pilot in a New Mexico community to test collaboration to increase the effectiveness of state and local transportation resources – vehicles, funding, and personnel. These agencies are also determining how they might work together at the state level to make the most of limited transportation resources. Fund sources involved in this process include Medicaid, TANF, DOT resources, and resources from ALTSD, DOH, CYFD, and other state agencies. This process may change the way the Purchasing Collaborative approaches transportation for individuals and families served through this behavioral health collaborative process.

The ultimate goal is that all consumers and families in the behavioral health system will have access to transportation services, regardless of their eligibility for Medicaid, in order to assure easy access to services. Co-payments, deductibles and other requirements would likely be necessary to address cost containment issues. However, to achieve the best possible transition to the new behavioral health system, there may be minimal change to behavioral health transportation services in July 2005. Medicaid will continue to be a large source of payment for this service. Incentives and disincentives will be utilized to encourage use of the least expensive forms of transportation consistent with consumer and family needs.

The statewide entity will be required to work closely and proactively with MCOs and with transportation and local behavioral health providers to maximize the availability of transportation services for Medicaid and non-Medicaid eligible behavioral health
consumers. The Collaborative will work to try to prevent reduction of access to existing transportation benefits or services.

Provision of and reimbursement for behavioral health services via telehealth approaches is one way to increase consumer access to behavioral health services, save professional time and be cost effective. Agencies within the Collaborative are working with UNM to increase the availability of this approach to service delivery, especially for rural areas. The use of additional telehealth, or tele-behavioral health modalities, will be expected as the single behavioral health delivery system is implemented.

School-Based Services

The integration of school-based behavioral health services as critical components of the New Mexico behavioral health care delivery system is one of the goals of the Collaborative. Schools are where our children spend each day. It makes sense to link scarce resources and supports such as mental health programs to the community sites where our children can be found. Schools are accessible community settings that are comfortable for families, minimize stigma, and ease transportation issues. Having services in the neighborhood minimizes transportation issues.

School-based providers are able to observe students in a variety of settings including the classroom, the lunchroom and the playground, and thereby have more information for making appropriate clinical interventions. Partnerships between families, school personnel and mental health providers are enhanced when all can come together easily to support the individual student. Those providing mental health supports in schools are more often able to identify those youth with “internalizing” disorders, such as depression, anxiety, and post-traumatic stress, in addition to the more obvious disruptive behaviors most often recognized by school personnel.

Critical components for school behavioral health services success include:

- Integration of the services into the school culture;
- Collaboration of the school behavioral health with community health care systems;
- Improvement of the school behavioral health services sustainability through diversification of funding and by the development of community partnerships;
- Increased capacity of School Behavioral Health Services to access Medicaid reimbursement;
- Development of other third party billing and reimbursement mechanisms;
- Financial and in-kind support from the served school district(s);
- Integration of behavioral health services with primary physical health services in the schools;
- A full continuum of school behavioral health services including training, prevention programs, screening, direct services, case management services, and enhanced school behavioral health interventions; and
- Strong linkages with physical and behavioral health systems in the community.
Local systems of care will include local school officials. The statewide entity will work with the Collaborative and the Public Education Department (PED) to increase access to behavioral health services for children in schools and their families.

X. MEMBER SERVICES AND CONSUMER/FAMILY INVOLVEMENT

“Members” refers to those individuals who are enrolled in the new behavioral health system, whether as a person who is entitled to certain services, or as a person who has been accepted into services after requested or being referred for services. How the new system provides information and resolution of customer concerns will be a key quality indicator for the Collaborative. Federal and state requirements guide some of the expectations for Member Services. The Collaborative’s philosophy, values and principles (see Section III of this paper) also guide expectations in the areas of education, assistance in member enrollment, outreach, customer representatives/services, and complaints, grievances and appeals processes.

As the Collaborative is formed and the new system is designed and begins operating, the state agencies are committed to consumer and family involvement in the new system at all levels. Consumer and family roles and mechanisms for consumers and advocates to have meaningful avenues of participation in the system design and operations must be varied. Ideas about this participation were developed by the Member Services subgroup and are described below. These ideas will guide the Collaborative’s and the statewide entity’s activities to address customer needs, although actual requirements for the statewide entity will be determined through the RFP and the contracting process. Actual required services and activities will be developed within available resources and the constraints of available fund sources.

Education of Customers, Families and Providers

The statewide entity, together with the Collaborative, will be responsible for providing education, training and technical assistance to customers, providers and key stakeholders. Preliminary topics for these activities include:

- Scheduling region-specific education and assistance to customers and providers regarding the state’s publicly funded behavioral health system;
- Developing an educational/training curriculum in collaboration with individuals and families and approved by the state at least 90 days prior to implementation of the new behavioral health care system;
- Providing ongoing training and education regarding a benefit package of services, including: behavioral health and substance abuse information; provider education; and billing codes, processes and procedures;
- Disseminating the principles and core values of the new behavioral health system, particularly the concepts of recovery, resiliency and empowerment;
- Developing educational materials that include ways those consumers and their families may access information and services;
• Providing clearly written, culturally and linguistically appropriate, informational materials designed and distributed with consumers and families in mind;
• Implementing a toll-free, 24-hour bilingual telephone bank staffed by customer-friendly staff to assist customers and providers with identifying and locating appropriate services and/or answering questions;
• Disseminating policies and procedures to customers and providers regarding the complaint, grievance and appeals processes that are compliant with federal and state laws, regulations and guidelines; and
• Standardizing the complaint, grievance, and appeals process so that it is the same regardless of payer source or funding stream (i.e., a baseline process such as that defined in BBA).

Assistance with Enrolling/Registration

• The statewide entity and providers should establish a uniform, well-coordinated intake process that, in addition to keeping the intake streamlined and user friendly, will also assess the customer’s need for guardianship, treatment guardianship, advanced medical directives and living wills/powers of attorney, and make appropriate referrals.
• The statewide entity and providers will incorporate the consumer’s and family’s cultural and linguistic realities into their care.
• The statewide entity and providers will disseminate clear policies regarding the individual’s right for self-determination.
• The statewide entity and providers will assist individuals and families with identifying the spectrum of available services, their payer source(s), and eligibility requirements.
• The statewide entity and providers will provide the individual with basic care coordination and/or case management to ensure that unmet psychosocial or medical needs are identified and, if so, appropriate referrals will be made.

Outreach

• The statewide entity will be required to perform ongoing, time-efficient customer education initiatives targeting special, historically underserved, and at-risk groups of individuals. These shall include, but not be limited to:
  o Native Americans;
  o Frail and elderly individuals;
  o Individuals who are incarcerated;
  o Individuals who are entering the probation/parole system;
  o Individuals in transition, especially youth and young adults from 16 to 21 years old;
  o Individuals who are experiencing or are at risk for homelessness; and
  o Individuals with co-occurring disorders/dual diagnoses.
• The statewide entity shall establish and properly staff an individual/family-friendly presence in all areas of the state to perform outreach and education.
• The statewide entity will develop avenues and mechanisms for individual and family input and include that input in educational materials.
• The statewide entity shall conduct an advertising “blitz” of public service announcements in various media, beginning 90 days in advance of the new system’s implementation, to inform those individuals and families affected as well as stakeholders of forthcoming changes to the behavioral health care delivery system.
• The entity shall disseminate information instructing the public where to call if problems are experienced, where or how to have questions or concerns addressed.
• The entity shall reassure individuals and families that any services they are now receiving will not be interrupted after implementation of the new system.
• The entity shall conduct focus groups to determine the best approaches and methodologies for marketing to and educating special populations.

Complaints, Grievances and Appeals

• To avoid confusion, the state shall establish clearly defined policies and procedures for complaints, grievances and appeals, so that individual and family concerns are addressed promptly and uniformly without regard to payer source or funding stream (Medicaid or any other program or service).
• Individuals receiving mental health and substance abuse treatment while in the justice system shall be afforded a mechanism whereby they may access the complaint, grievance and appeals processes without threat of retaliation or negative impact on their adjudicated status.
• An early warning system shall be designed and utilized for tracking trends or patterns in complaints, grievances, appeals, service denials, access issues and/or other pertinent monitoring mechanisms.
• Identified trends or recurrent customer or provider complaints, grievances and/or appeals shall be subject to sanctions.
• Individuals and families shall play significant roles in providing monitoring, oversight and feedback to the statewide entity and providers regarding performance and/or room for improvement.
• The state shall establish a tracking and data collection system that will capture all payer sources. The appropriate state oversight entity shall document, track and resolve issues and provide reports that ensure and enforce compliance.
• The state shall use as its baseline for the complaint/grievance and appeal process the proposed Medicaid Regulation MAD-MR: 8.305.12 (Member Grievance Resolution).

Statewide Entity and Provider Accountability

• The state shall include in the contract with the statewide entity and shall require the statewide entity to include in its contract(s) with providers clearly defined, contractually enforceable sanctions so that if the statewide entity and providers does/do not perform according to agreed-upon standards and expectations, correction or remedy will be possible.
• The statewide entity shall be subject to oversight by interagency teams or individuals directed by the Collaborative to evaluate or review performance and shall make available such data and individuals necessary to determine whether the entity is meeting contract requirements.

• Negative trends or poor performance by the statewide entity and providers shall receive prompt attention and response that includes specific, enforceable timeframes for resolution of identified problems; and the possibility of monetary withholding or penalties.

• Consumers and their families shall have specific meaningful roles in assessing quality of services and in reviewing quality and utilization review data, including aggregate data about consumer complaints, grievances and appeals.

**Customer Involvement/Customer Services**

• Based upon nationally accepted curricula and practices, the state shall develop a consumer/family peer provider certification program, similar to those found in the states of Georgia or New Jersey. Following proper education and training, an interested consumer/family may be credentialed and seek employment as a peer support staff. Her/his services will be billable to any/all funding source as per medical necessity.

• The state shall develop and maintain a committee comprised of consumers, family members and advocates that may offer support to consumer leaders, families, and advocates across the state through a toll-free number.

• The state shall have a single, coordinated behavioral health ombudsperson team of state agency and statewide entity staff.

• The state shall strengthen and expand its current behavioral health ombudsperson activities to ensure that collaboration, timely and efficient communication and non-duplication of efforts occurs among ombudspersons in various state departments.

• According to the individual ombudsperson’s purview, uniform guidelines, expectations and procedures that empower the ombudsperson to identify and, whenever possible, expeditiously resolve issues shall be followed.

• Each individual — including children, youth, adults, the elderly and people with developmental disabilities — and, where appropriate, their families, shall have opportunities to have an equal voice in and be actively involved in, educated about and/or included in his/her care plan.

• Inclusion of culturally relevant rituals and practices as viable treatment or healing modalities shall be encouraged and billable through the new statewide entity and providers. For example: sweat lodge, medicine wo/man services, prayer circle and/or curandera/o.

• Specialized, culturally relevant, effective therapeutic modalities shall be offered through enhanced service codes.

• On an ongoing basis, the statewide entity and providers shall work collaboratively with the state and advocacy groups to cultivate, identify and strengthen consumer and family initiatives and activities.
• On an ongoing basis, the statewide entity and providers shall work collaboratively with the state and advocacy groups to identify and provide evidence-based and promising practices and treatment modalities.

XI. UTILIZATION REVIEW, UTILIZATION MANAGEMENT AND CARE COORDINATION (INCLUDING COORDINATION WITH PRIMARY CARE)

Care Coordination

Care coordination is a service to assist consumers with special behavioral health care needs on an as-needed basis. It is consumer-centered and consumer-directed, family-focused when appropriate, culturally competent, strength-based and recovery oriented. Care coordination can help to ensure that medical and behavioral health needs are identified and services are provided and coordinated with the consumer, and family if appropriate.

Aspects of care coordination can operate within the statewide entity with a dedicated care coordination staff functioning independently but structurally linked to other systems, such as quality assurance, consumer services and grievances. These clinical decisions should be based on criteria for determining medically necessary covered services, not other financial or administrative criteria.

The statewide entity may determine that structuring care coordination to occur at the regional or local system of care level is the best way to provide this service for particular geographic areas or for particular populations. If both physical and behavioral health conditions exist, the statewide entity will be required to make proactive attempts to coordinate with physical health entities.

Activities provided through care coordination at the statewide entity level will differ from case management activities provided at the community level. The statewide entity will be asked to implement the following primary elements of care coordination:

• Identify proactively those individuals for whose care they are responsible who need care coordination assistance;
• Identify proactively the behavioral health needs of Medicaid eligible populations;
• Develop and implement policies and procedures to ensure access to care coordination for all Medicaid eligible Individuals with special health care needs, as required by federal regulation;
• Identify a designated person (either within a provider or within the statewide entity) as primarily responsible for coordinating behavioral health services furnished and to serve as the single point of contact for the consumer;
• Communicate to the consumer the care coordinator’s name and how to contact him/her;
• Ensure access to a qualified provider who is responsible for developing and implementing a comprehensive treatment plan;
• Ensure the provision of necessary behavioral health services and actively assist consumers and providers in obtaining such services;
• Work proactively to achieve appropriate coordination between physical and behavioral health services, including social support services;
• Coordinate with designated case managers and/or medical/behavioral health care service providers;
• Monitor progress of consumers to ensure that services are received, assist in resolving identified problems, and prevent duplication of services; and
• Be responsible for linking consumers to case management when needed if a local case manager/designated provider is not available.

All consumers should have access to care coordination services, as needed, regardless of funding source. However, given the limited resources for this service, the statewide entity, in conjunction with the Collaborative, will develop criteria for determining which high priority consumers will be provided with care coordination services. Criteria will include such issues as acuity of need, need for multiple services and/or systems, past high use of BH services, and high risk of needing intensive behavioral health services. The criteria will be approved by the Purchasing Collaborative, published and widely distributed, and utilized as standard criteria throughout the state.

Utilization Review and Utilization Management

Given the wide spectrum of how the Collaborative state agencies are conducting utilization review and management (UR/UM) currently, the “strictest” utilization management requirements set forth for federal and state funding may be the place the Collaborative has to start to develop UR/UM criteria and processes. UR/UM is an often-used term in managed care. However, UR/UM concepts are not as often used in other systems of health or behavioral health care delivery. Yet, in all systems, some processes are used to determine who gets what services and how much of those services they get. These processes are more or less formal. The Collaborative will ask the statewide entity to propose a process for determining what criteria will be used to determine who gets what services and how much and in what order; what processes will be used to make these decisions; and will make sure that providers are paid for those services for those individuals that are directed by the Collaborative. The Collaborative will ask the statewide entity also to maintain data and conduct analyses of that data to better manage individual and family services as well as to make or suggest adjustments in the system as a whole.

A single administrative centralized file with comprehensive behavioral health information should be maintained for all persons receiving services through the Collaborative process. This mirrors the requirement that a single service plan be developed in conjunction with the customer and family to govern the services received. A process for resolving differences between physical and behavioral health care entities with regard to care coordination, coordination of services, and responsibility and payment for care will be developed and implemented by the Purchasing Collaborative and required by contract.
Uniform definitions, clinical criteria, processes and procedures will be used throughout the state for determination of what individuals and families are priorities to receive services and for authorization or review of specific services for an individual or family, whether before or after the fact. Some populations and some services may be reviewed only retrospectively (i.e., after the service is delivered) as part of a quality management process, while other services (especially out-of-home or extremely costly services) are likely to require authorization prior to service delivery.

UR/UM can be a way of assuring that limited dollars are used most effectively but, more importantly, done right, UR/UM can help assure the individuals and families get their needs met and that services are the right ones for those individuals and families. UR/UM can also be a way to identify groups or types of individuals who are not receiving the appropriate services and, as a result, are not having their needs adequately met. For example, high priority federally-defined populations and populations transitioning between levels of care (i.e., between residential treatment centers and inpatient care to the community), from one age group to another (i.e., adolescents to adulthood) and from one setting to another (i.e., from jails, prisons or detention to the community), should receive special attention. Service interventions targeted to these specific individuals/families can improve care, satisfaction and outcomes.

**Coordination with Primary Care**

Physical and behavioral health services must be coordinated. Both physical and behavioral health care providers need access to relevant medical records of mutually served individuals to ensure maximum benefits of services for that person. Confidentiality and HIPAA laws apply during this coordination process, so procedures for sharing information will need to be developed by the statewide entity in conjunction with the Collaborative.

The statewide entity will implement policies and procedures designed to maximize the coordination of physical and behavioral health services and address the medical and behavioral health needs of individuals served. Similar mechanisms for coordination with behavioral health providers will be required of Medicaid physical health providers. Some of these mechanisms include, but are not limited to the following:

- Behavioral health providers will be encouraged to assist the member in accessing physical health services.
- A written report of the outcome of any referral containing sufficient information to coordinate the individual’s care will be forwarded to the primary care provider by the behavioral health provider and vice versa, within seven calendar days after screening and evaluation.
- The statewide entity will be required to educate and assist behavioral health providers to make appropriate referrals for physical health consultation and treatment. Agencies that provide or fund health care (e.g., HSD/Medicaid,
DOH/Public Health) will require the same education and referral assistance at the health care provider level.

• A process for assuring a clinical home for each mental health or substance abuse client will be adopted, along with a process for development of a single assessment and plan of care (or individual services or treatment plan), will be developed to assure consistent care across providers and involved systems. The responsibility for developing and implementing the behavioral health plan of care will be a provider’s, in coordination with the individual, parent and/or legal guardian and other providers when clinically indicated. A process needs to be developed for determining who is the lead provider (or clinical home) and for sharing the services plan across providers to provide optimum care and communication. Care coordinators and case managers will be responsible for monitoring the coordination of the plan of care and information-sharing for members receiving behavioral health care from multiple providers.

• Either with the individual’s written permission or as part of a HIPAA business associate agreement, behavioral health providers will be required to keep the individual’s primary care physician (PCP) or other health care practitioner informed of the following:
  o drug therapy;
  o laboratory and radiology results;
  o sentinel events such as hospitalization, emergencies, and incarceration;
  o discharge from a psychiatric hospital or from behavioral health services;
  o transitions in level of care; and
  o progress in meeting individual service or life goals that affect physical health care.

The state agencies in the Collaborative that fund or provide health care will work to require PCPs or other health care practitioners to keep behavioral health providers informed about these same issues.

• Behavioral health providers will be encouraged to obtain consultations and assistance with psychopharmacotherapy and diagnostic evaluations from a psychiatrist or other behavioral health specialist with prescribing authority when clinically appropriate.

• Protocols for sharing information between mental health providers and substance abuse providers for those individuals with co-occurring disorders who are being served by separate providers.

XII. QUALITY – EXPECTED PERFORMANCE AND OUTCOMES

First and foremost, the commitment to recovery and resilience will drive the outcomes the Collaborative seeks from the services it funds. Services are not the end being sought; they are the means to that end. The end for individuals and families with mental illness or substance abuse disorder, just as for anyone, is a satisfying productive life in the community. Mostly, persons with mental illness or substance abuse disorder need a place to live, a job to do or a successful school or developmental experience, sufficient income to meet basic needs and socializing opportunities with friends or relationships.
Society (taxpayers, community leaders, legislators) want to make sure that people with mental illness and/or substance abuse disorders are not disruptive to the community, the costs of providing care are reasonable and funds are not spent on ineffective services or activities. Service providers want to be assured they are being paid quickly, that the result of doing business is worth the cost and the outcomes are meeting the demands of funders and service users.

The Collaborative will need to develop system performance measures and consumer/family outcome measures that satisfy different audiences or different purposes. The Collaborative will also need to incorporate a quality improvement process into the new system to assure that data is used to monitor both system performance and consumer/family outcomes, consumers and family members have meaningful roles in that monitoring and that this monitoring is used to make changes to improve the system designed and purchased. The statewide entity will have a critical role in helping to track and monitor the system and to guide the changes that need to be made. The Collaborative will include specific deliverables and performance requirements in the contract with the statewide entity as well as monetary and other sanctions to assure accountability. The Collaborative will have a quality management and improvement subgroup whose role will be specific oversight of the contract with the statewide entity.

Core values and indicators endorsed by the American College of Mental Health Administration are important guides for developing system performance and consumer/family outcomes. There are also existing performance measures and consumer outcomes in other processes that must be taken into account. For example, each state agency has performance indicators set through the legislative process that must be tracked and reported. Performance and outcome indicators exist in MHSIP, HEDIS, evidence-based practices and other data collection mechanisms that should be considered. Specific concepts/interests that Advisors believed important to measure by either system performance or clinical/provider expectations/outcomes include employment, quality improvement at the provider level, CYFD measures of client functioning, linkages to services, consumer safety and access to care. National benchmarks and state experience will be used in the creation of the performance measures and acceptable outcomes.

Overall concepts being discussed are regulatory and statutory performance requirements, access to care, appropriateness of care, functional outcomes, prevention services, special populations, transitions of care, care coordination, credentialing and licensing, data collection and required reports, complaints and grievances, behavioral health clinical criteria, fraud and abuse, behavioral health encounter data and quality management and improvement. Final measures will be developed based upon the specific structure and components of the overall design.

A matrix of sources of information for the possible development and tracking of performance and outcomes measures is attached as Appendix G.
XIII. CONCLUSION

This paper provides some preliminary thoughts about the single behavioral health delivery system to be purchased collaboratively among multiple state agencies pursuant to HB 271. The paper recognizes that while the current way of providing and funding services will change on July 1, 2005, that date is only the beginning. This change is an evolution. It will take many years, much stakeholder involvement, continuing efforts to improve and a lot of patience to reach our state’s goals.

This change will be a difficult one to put into place. There will be growing pains as we learn together how to design, implement and oversee a single behavioral health delivery system for children, adults and seniors, regardless of ethnicity, location or degree of need. However, this change has the potential to significantly improve the delivery of behavioral health services within New Mexico.

Transitional issues need to be identified and addressed, especially for persons with complex or ongoing needs and for the provider infrastructure upon which customers with mental health or substance abuse needs rely. A transition work group has begun to identify some of these transition issues, and will soon begin to develop transition activities. These transitions will not end on July 1, 2005. Rather, they will continue or just begin. We will succeed if we keep our focus on recovery and resilience, and if we keep the interests of consumers, families and communities uppermost in our minds.

This process will require everyone in New Mexico who is involved in behavioral health to think about all the affected people and the available services and resources, not just those in a particular agency or funding stream. We must think of behavioral health as a single system for which we are all responsible. This process will not likely increase resources; however, it can make the resources we do have go a lot further to assure better lives for those with mental illness and substance abuse disorders and their families, and for New Mexico’s communities.
GOVERNOR RICHARDSON’S SEPTEMBER 12, 2003 PRESS RELEASE

For immediate release                                                                 Contact: Gilbert
Gallegos                                                                                                                                   505.476.2217
9/12/03

Governor Bill Richardson announces plan to Consolidate mental health care and behavioral health care services.

SANTA FE – Governor Bill Richardson today directed several state agencies to consolidate mental health care and behavioral health care services.

Governor Bill Richardson delivered the following prepared remarks:

Today, I am making mental health care a priority in New Mexico. Mental health is as important as physical health. For too long, we have placed mental health care in an inferior position. Those days are gone. We have had a policy of confusion and duplication that is neither cost efficient or effective for our people. I want all mental health care programs, behavioral programs to be better coordinated so that New Mexicans can receive the best care in the most cost effective way. We must revamp our program to meet the current challenges. We will move away from multiple HMOs and multiple state agencies to a single provider under a single administrator. It’s time for the right hand to know what the left hand is doing.

I am officially announcing a new direction to place mental health care under one roof. I have ordered a mental health care, behavioral health care carve out from, not just the Medicaid program, but across all state agencies for all programs.

Over the past eight months I have had many discussions with all four health and human services secretaries to determine whether or not we should blend behavioral health services for New Mexicans. We all agree it is time to do it. You will hear from them shortly.

The new policy impacts all state agencies that receive state or federal funds for substance abuse and mental health services: the Human Services Department, the Department of Health, the Children Youth and Families Department, the Aging and Long-term Care Department, the department of Finance and Administration’s DWI programs, the department of Corrections and the state Department of Education.
We will establish a single entity to administer behavioral health services. This policy change will mean -- better services, better access for consumers and providers, and better use of taxpayers money.

I know it means change. I know it means re-structuring the way we currently provide services, but that is ok. It is time to do what is best for all New Mexicans who need these services. And, that is -- by coordinating behavioral health services from all state agencies across the state -- better programs, better and simpler access and better use of our money.

Planning and design of this collaborative purchasing approach has already begun. All four health and human services secretaries are talking to the four behavioral health committees to announce this decision and to begin discussions on how this will look.

I have directed the secretaries to make this an open process – anyone who wants input into the design of this approach will be heard.

This is what I can tell you today in terms of what the single behavioral health program will look like:

- A working group has been formed that includes the top people from the state that currently administer behavioral health programs and services;
- This working group will be lead by Human Services Department Secretary Pamela Hyde;
- No decision has been made about what single entity will administer and oversee behavioral health services for the State.
- There will be a competitive RFP process and everyone is encouraged and welcome to apply.

I'd like to digress for one minute to say something to the MCOs (Presbyterian Health Plan, Lovelace Health Plan & Cimarron Health Plan) that have currently been providing behavioral health services in our Medicaid program.

I know the MCOs are the one's who will be affected the most by this new decision. Thank you for the work you have done. I know 8 years ago you were asked to integrate behavioral health services into your health plans for Medicaid clients. You worked very hard to make it happen and you have done a wonderful job.

My decision today has nothing to do with you or the services you have been providing. Instead, it has to do with making a decision that probably should have been made 8 years ago – a decision that will allow the state to use our behavioral health money better.
Executive Summary

I. History, Background and Context

- Brief history of Behavioral Health in New Mexico
- Identification of critical gaps and needs
- Interagency Behavioral Health Purchasing Collaborative
- Alignment with key documents:
  Behavioral Health Needs and Gaps in New Mexico 2002
  Surgeon General’s Report
  President’s New Freedom Commission Report
  Healthy People 2010
  Other documents to be added

II. Principles and Vision

III. Behavioral Health Planning Council

- Purpose
- Organization
- Goals and Objectives
- Sub-Committees

IV. Systems/Infrastructure

- Workforce
- Licensing and Certification
- Information Management and Data systems
- Finances and Funding
- Using Technology

V. Insuring Quality

- Performance Indicators: Federal and State Requirements
- Departmental strategic plans
- Quality Programs
- Quality Plans
- Evidence Based Practice
- Recovery Models

VI. Prevention
• History
• Services
• Goals
• Five year plan

VII. Treatment Service System: All Ages: Services, Gaps/Needs, Plans/Goals

• Mental Health Services
• Substance Abuse Services
• Co-occurring Disorders
• Employment
• Housing
• Education
• Corrections/Judicial Systems

Inpatient and Residential Facilities
• Public Facilities
• Private Facilities

In addition, for Children and Adolescents
• Transition Services to adult system
• School Mental Health
• Juvenile Justice
• Protective Services

VIII. Special Populations: Services, Gaps and Needs, Plans and Goals

• Ex-Offenders
• Infants and Children with Developmental Delay
• Native Americans
• Offenders
• Person who are Transgender/Transsexual or have any gender issue
• Persons covered by Waivers (HIV/AIDS, Medically Fragile, DD, D and E)
• Persons who are Gay/Lesbian
• Persons who are Homeless or Near-Homeless
• Persons who are Immigrants
• Persons who are Migrants
• Persons who are Victims of Domestic Violence
• Persons who are Victims of Other Trauma
• Persons who are Victims of Sexual Assault
• Persons who have HIV/AIDS
• Persons with any Physical Disabilities
• Persons with Developmental Disabilities
• Persons with Hearing Impairment
• Persons with Special Health Needs
• Persons with Traumatic Brain Injury (TBI)
• Persons with Visual Impairment
• Others to be added

IX. Special Topics

• Acculturation Issues
• Ancillary/Collateral Services
• Bi-National Border Issues
• Consumer Affairs/Recovery Focus
• Cultural Competency
• Disaster and Emergency Preparedness
• Drug Courts
• Faith based providers and treatment
• Family Courts
• Forensic Evaluations
• Homeless Courts
• Integration with Primary Care/Specialty Care
• Jail Diversion
• Mental Health Courts
• Mental Health Courts
• Native American behavioral health service system
• Olmstead Decision
• Oral Health
• Rural/Frontier Issues
• Seclusion and Restraint
• Stigma
• Suicide
• TANF
• Telehealth
• Trauma and Violence
• Vocational Rehabilitation
• Others to be added

X. Summary, Conclusions and Recommendations for 3-5 Year Plan

XI. Appendix

• Descriptions and Organizational chart for each Department
• List of Federal Grants
• Links to state resources

XIII. Bibliography
## APPENDIX C
### DRAFT PRELIMINARY SERVICES INVENTORY MATRIX

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| Group Psychotherapy OR Interactive Group Psychotherapy | 98057 or 98057 | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |

| Substance Abuse Services | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |
| Other Group Psychotherapy | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x | x |

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<td>Acute - Resid. Techr Serv</td>
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<tr>
<td></td>
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<td>HD018</td>
<td>Treatment Foster Care &amp; II</td>
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<td>HD041</td>
<td>Therapeutic Foster Care</td>
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<tr>
<td></td>
<td>Respite Care, Unskilled or Respite Care Services</td>
<td>SS151, SS151 or T1005</td>
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<td>HD013</td>
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<tr>
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<td>Supportive Housing</td>
<td>HD042</td>
<td>Adolescent Shelter</td>
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<tr>
<td><strong>BH Inpatient and Inpatient Detoxification</strong></td>
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<td>Initial Input Consultation / Follow-Up Input Consultation</td>
<td>96251, 96252, 96253, 96254, 96255</td>
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<td></td>
<td>Inpatient Treatment and Evaluation</td>
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<td>* Individual psychotherapy, inpatient</td>
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<td>* Individual psychotherapy, inpatient w/med evaluation</td>
<td>08817, 08819, 08822</td>
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<td>* Individual psychotherapy, interactive, inpt</td>
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<td>* Initial hospital care, new or established pt w/E&amp;M</td>
<td>08242, 08247, 08250</td>
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<td>* Subsequent hospital care w/E&amp;M</td>
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<td></td>
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<tr>
<td>Inpatient Mental Health</td>
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<td>Acute Psychiatric Hospital</td>
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<td>Alcohol and/or Drug</td>
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<tr>
<td>Inpatient Mental Health</td>
<td>Rev Code 0124, 0134, 0154</td>
<td>Inpatient Hosp Psychiatric Services</td>
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<tr>
<td>BH Treatment Servs - Partial Hospitalization - Less Intensive</td>
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<td>PROGRAMS, SERVICE SETTINGS AND SERVICES NOT YET CATEGORIZED</td>
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<td>Alcohol and/or substance abuse services not otherwise classified</td>
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<td>Jail Diversion - Co-Occurring</td>
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<td>Juvenile Diversion - Co-Occurring</td>
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<td>Compliance Monitoring / Tracking</td>
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<td>Life Maintenance Issues</td>
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<td>Tx Svcs - “gaps in services”</td>
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<td>Insight Seminars</td>
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APPENDIX D

JUDICIAL DISTRICTS IN NEW MEXICO FOR INITIAL STARTING PLACES FOR DEVELOPMENT OF LOCAL SYSTEMS OF CARE

Judicial District Map
APPENDIX E

GEOGRAPHIC AREAS FOR INTERAGENCY STAFF TEAM ASSIGNMENTS

<table>
<thead>
<tr>
<th>Population</th>
<th>1 370,254</th>
<th>2 277,153</th>
<th>3 556,678</th>
<th>4 244,828</th>
<th>5 370,143</th>
<th>6 167,640*</th>
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</thead>
<tbody>
<tr>
<td>Native Americans</td>
<td>6 167,640*</td>
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* American Indian and Alaska Native Alone, Not Hispanic or Latino Origin
APPENDIX F

CONCEPT OF SYSTEM OF CARE

A System of Care is a range of treatment services and supports supported by an infrastructure and guided by a philosophy. It is a comprehensive spectrum of behavioral health and other necessary social services and supports that are organized into a coordinated network to meet the multiple and changing needs of individuals, children and their families.

Systems of care are meant to improve access, availability and coordination of care, and to reduce fragmentation.

Systems of care emphasize the importance of local ownership of the system. The more “local” a system is, the more likely it will reflect community strengths, needs, values and day-to-day realities. However, system-building at local levels cannot sustain itself without state-level commitment.

Building a system of care involves structures and processes. Structure is “something arranged in a definite pattern of organization” that distributes power and responsibility; shapes and is shaped by values; and affects practice and outcomes and subjective experiences. Process has to do with: who is involved in a system-building effort; the roles, rights and responsibilities each is accorded or assumes; how these various players communicate, negotiate and collaborate with one another; and being strategic.”

Community Level: At the community or local level, a system of care is the infrastructure unique to that community whose goal it is to support/serve the individual and family. Structurally, the individual and family are at the hub of the wheel.

The spokes of the wheel, or the community partners, are the behavioral health services providers (aka the provider network); social services; educational services; health services; vocational services; recreational services; operational services; housing services; employment services; and community helping agencies (e.g. United Way, service clubs, chambers of commerce, Boys and Girls Clubs, faith community, mentoring agencies, MCH Councils, health councils, peer supports, community councils, advocacy groups, businesses, private foundations, and other similar organizations) that support and play important and diverse roles in the life of an individual or family and their community.

A community can be defined as a cultural, geographic, population or commerce center that has a set of needs that could be met reasonably by aligning itself into one local organizing entity or community infrastructure. It may be a city, a county, a set of

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7 These paragraphs are from Pires, Sheila (2002). Building systems of care: A primer. National Technical Assistance Center for Children’s Mental Health, Center for Child Health and Mental Health Policy. Georgetown University Child Development Center.
counties, a tribe or another grouping that is reasonably self-defined and has systems or goals in common.

The community infrastructure or local organizing entity is the flexible mechanism that is established by the community partners and may evolve and develop further over time. In the analogy of the wheel, it holds the spokes of the wheel together (the rim of the wheel). This local organizing entity is the community partners that function as the mechanism to maintain the integrity, cohesiveness and structure of the locally designed system of care. This local organizing entity may be the provider network or the local MCH Council or the local Health Council or any other entity that espouses and supports the values and principles of this approach and is qualified, willing and able to be the organizing entity for a particular community.

The local organizing entity would convene, plan, develop, mobilize, implement and continuously evaluate, in partnership with individual consumers and families, the system of care service/support delivery for that particular community. It would receive support from and be responsible to the statewide entity. It would not be responsible for utilization review, claims payment, credentialing or any other similar administrative functions that the statewide entity would perform. It could be responsible for care coordination, case management, direct service/support delivery and other similar functions.

Individual/Child/Family Level: A System of Care for an individual and family is based on the following values: individual/child centered, family focused (for a child), community-based and culturally competent. A system of care approach relies on an individualized treatment plan; services and programs that are provided in the least restrictive setting, as appropriate, and are accessible for persons with physical disabilities; individuals and families, as appropriate, being full participants in all aspect of care planning and delivery; integrated, linked and coordinated service/support delivery; easily accessible mechanisms for early identification and intervention; smooth transitions for individuals; and responsiveness to cultural differences.

A system of care approach utilizes natural supports as much as possible to reduce the reliance of institutional or congregate care. One process that is widely used in individualized systems of care is “Wraparound.” It is described as “a definable planning process involving the individual and family that results in a unique set of community services and natural supports individualized for that individual and family to achieve a positive set of outcomes.” It is based on using an individual’s strengths and building upon them. A team approach is used to design and implement the Wraparound plan, with the individual and family being partners and collaborators and driving the decisionmaking process wherever possible. Services and supports are created and tailored to meet the needs. The entire community is relied upon to respond to the varied needs of the individual and family, i.e. “community ownership.” It relies on flexible or braided funding from multiple funding streams that is not reliant solely on categorical funding.
## APPENDIX G

### Quality/Performance Measures/Outcomes Subgroup

<table>
<thead>
<tr>
<th>Subgroup Issue</th>
<th>Client-Driven Measures</th>
<th>Service-Delivery Measures</th>
<th>Provider Measures</th>
<th>Subgroup Recommended Measure</th>
</tr>
</thead>
</table>
| **Regulatory & Statutory Performance Requirements** | 1) Mental Health Statistical Improvement Project (MHSIP) Adult & Children’s surveys  
   • Medicaid requirement  
   • BHSD requirement  
   2) [CSAT & CSAP requirements]  
   3) [HIPAA requirements]  
   4) CYFD requirements: [CFARS, the Children’s Functional Assessment Rating Scale]  
   • CFARS/ Improve individual indexes in relationship, emotionality, and safety.  
   • NCFAS /Improve the functioning level of the family.  
   • Client Satisfaction Survey/Improve client satisfaction with services. | 1) EWS (Early Warning System) Medicaid requirements (Includes Clean Claims requirements from BBA/1997)  
   2) HEDIS (Health Plan Employer Data and Information Set) (CMS)/Medicaid requirement | 1) Provider Annual Survey (Medicaid requirement)  
   2) (EWS) Early Warning System  
   • Centers for Medicaid & Medicare Services (CMS)/Medicaid requirement | • ACMHA Core Values: 1) Consumers and families are at the core of performance measurement; 2) Consumer/customer choice must be a driving value for design, delivery, evaluation and accreditation; 3) Issues of ethnicity, race, age, developmental status, gender, language, culture, spirituality, disability are consciously addressed in ensuring access and availability of services; 4) The delivery system must be accountable to both internal and external stakeholders for meeting the mental health needs of the people they serve in ways that are effective and efficient; accountability must be based on reliable, comparable data; 5) Access to services must be quick, easy and convenient, and outreach and follow-up must be seen as part of the access continuum; 6) A public health vision must drive outcomes measurement, which means that universal access and integrated primary and behavioral healthcare are the ultimate goal of effective systems; 7) Children who have mental health and substance abuse problems:  
   • should be able to receive effective services in their homes and schools without disruptive removals from either setting;  
   • should be able to remain safe and out of trouble with law enforcement;  
   • should remain connected to family and peers while in treatment;  
   • should receive services that are family |
<table>
<thead>
<tr>
<th>Subgroup Issue</th>
<th>Client-Driven Measures</th>
<th>Service-Delivery Measures</th>
<th>Provider Measures</th>
<th>Subgroup Recommended Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1) ACCESS to Care Standards/ 8.305.8.18 (Medicaid requirements for urban, rural &amp; frontier regions of state: (a) 90% of urban residents shall travel no farther than 30 miles; (b) 90% of rural residents shall travel no farther than 45 miles; and (c) 90% of frontier residents shall travel no farther than 60 miles.</td>
<td>1) Medicaid 8.305.6.9 GENERAL NETWORK REQUIREMENTS</td>
<td>focused and health centered. (8) Adults with mental health and substance abuse problems: • should be able to maintain a stable, comfortable and safe living environment; • should be able to engage in chosen, productive daily activity; • should be able to remain safe and out of trouble with law enforcement; • should receive treatment that is consumer-centered and which maximizes independence and self-care skills; • should receive services designed to enhance total health and maintain social connections and improved quality of life. <strong>Underlying data premise:</strong> The cost of data collection and reporting is justified by the potential improvements in service delivery and outcomes. <strong>Co-occurring activity:</strong> • How many people are assessed with MH/SA? (“Penetration Rate”) • Identification and linkages activity • % of funding that goes to the statewide entity has to go to consumer run facility • Discharge Implementation (Iowa model measures)</td>
</tr>
</tbody>
</table>

**Access to Care Requirements**

1) Mental Health Statistical Improvement Project (MHSIP) Adult & Children’s surveys (Medicaid requirement)  
   a. The rate of persons served reporting that they receive services they need  
   b. The rates of utilization of services as compared to the identified needs of the community.
<table>
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<tr>
<th>Subgroup Issue</th>
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<th>Provider Measures</th>
<th>Subgroup Recommended Measure</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>1) Follow up after acute psychiatric hospitalization within 7 days (Medicaid Requirement)</td>
<td></td>
<td>•Turnover rate of providers in agency and evidence of support/training in order to increase retention of front-line providers.</td>
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<td>2) Follow up after acute psychiatric emergency care within 3 days (Medicaid Requirement)</td>
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<td>•Require comprehensive provider training: Include Consumer/Family Based Services (5X5)</td>
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<td></td>
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<td></td>
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<td>•Penetration rate in rural/frontier areas</td>
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<tr>
<td>Appropriateness of Care Requirements</td>
<td>1) MHSIP Adult &amp; Children’s surveys (Medicaid Requirement)</td>
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<td>•MHSIP - consolidate into one? Be sure it contains Substance Abuse (SA) measures.</td>
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<td>Recovery oriented</td>
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<td>•Safety - Emotional and Physical - Client expression of sense of safety physically, in treatment relationships, emotionally, etc. Measured in Complaints &amp; Grievances (C&amp;Gs) and/or client surveys.</td>
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<td>•Another method of measurement may be:</td>
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<td></td>
<td>a. The rate of episodes of victimization reported at a standard interval following the termination of treatment</td>
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<td>b. For persons served who identify victimization or vulnerability as a concern at the initiation of treatment: the rate of perceived vulnerability reported at the termination of treatment and at a standard interval following the termination of treatment</td>
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<td>•Permanency/stability</td>
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<tr>
<td>Functional Outcome Requirements</td>
<td>1) MHSIP Adult &amp; Children’s surveys (Medicaid Requirement)</td>
<td>1) Performance Improvement Projects (PIPs) (Medicaid Requirement)</td>
<td></td>
<td>•Employment: Both for Mental Health (MH) and SA populations - How many people access/achieve employment. Days of employment (not related to job retention) Did they work more this year then last? (Example: a. For adults: the rate of employed/unemployed adults counted at the termination of treatment and at a standard interval following the termination of treatment</td>
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<td></td>
<td>2) CFARS, the Children’s Functional Assessment Rating Scale, is mandatory for agencies/contractors providing behavioral health services to one or more of the target groups</td>
<td>1) Decreased readmissions following discharge from RTCs; 2) Improved F/U after hospitalization at 7 days &amp; 30 days; 3) Improved utilization of anti-depressant medication.</td>
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<td>more of the target populations (CYFD requirement)</td>
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<td>b. For employed adults: the average number of days not worked counted at a standard interval following the termination of treatment</td>
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<td>• CYFD measures of client functioning based on resilience/recovery model - Cognitive ability, interpersonal relationships</td>
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<td>• Reductions in alcohol, tobacco and drug use</td>
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<td>• Measure related to jail diversion</td>
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<td>Prevention Services Requirements</td>
<td>1) BHSD requirements:</td>
<td>1) BHSD requirements:</td>
<td>1) BHSD requirements:</td>
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<tr>
<td>Special Populations/Transitions of care Considerations</td>
<td>• Adolescents aging to adult to elderly &lt;br&gt; • Social Needs: Housing, employment &lt;br&gt; • Incarcerated parents/child issues &lt;br&gt; • Dual diagnoses: DD/MI, SA/MI, others &lt;br&gt; • Infant Mental Health</td>
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<td>• Provision of transition planning - How well they accommodate/link, started early in care.</td>
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<td>• Monitor Discharge Plan Implementation (Iowa model)</td>
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<td>• CYFD/Early Intervention measures: For children under five years of age, the performance measure will be an instrument that is approved by CYFD and designed to assess functional changes for this population and age group.</td>
</tr>
<tr>
<td>Care Coordination Requirements</td>
<td>1) Individuals with special health care needs (ISHCN) proactive identification (Medicaid requirement)</td>
<td>1) COORDINATION OF SERVICES regulations 8.305.9.9 (Medicaid requirement)</td>
<td></td>
<td>• Coordination of Service Agreements</td>
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<tr>
<td>Credentialing/Licensing Requirements</td>
<td>1) 8.305.8.14 Standards for Credentializing and Recredentializing</td>
<td></td>
<td></td>
<td>Credentialing should include non-licensed practitioners such as PSR and peer providers (CPRP is nationally recognized). This should be phased in or only required in percentages so that it improves quality, but</td>
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<tr>
<td><strong>Data Requirements &amp; Reporting [Benchmark-able]</strong></td>
<td>[HIPAA requirements]</td>
<td>[HIPAA requirements]</td>
<td>1) 8.305.8.11 Encounter Data regulations [Medicaid requirement] [HIPAA requirements]</td>
<td>• <strong>Underlying data premise:</strong> The cost of data collection and reporting is justified by the potential improvements in service delivery and outcomes. • The collection of data for the measures should not violate any accepted standards of confidentiality. • Report findings available to providers, stakeholders, and consumers. CQI, TQM, etc.</td>
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<tr>
<td><strong>Complaints &amp; Grievances</strong></td>
<td>1) Client complaints &amp; grievance tracking (CMS)/Medicaid requirement</td>
<td></td>
<td>1) Provider complaints &amp; grievance tracking (CMS)/Medicaid requirement</td>
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<tr>
<td><strong>BH Clinical Criteria</strong></td>
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<td><strong>Salud! Standardized Level of Care Criteria for Medicaid BH-covered services (CMS)/Medicaid Requirements</strong></td>
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<td><strong>Fraud &amp; Abuse</strong></td>
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<td><strong>FRAUD AND ABUSE regulations (8.305.13.9) Medicaid Requirements</strong></td>
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<tr>
<td><strong>Behavioral Health Encounter Data</strong></td>
<td>[HIPAA requirements]</td>
<td>[HIPAA requirements]</td>
<td>1) 8.305.8.11 Encounter Data collection requirements for any behavioral health service delivery (including behavioral health case managers), regardless of setting or location. [Medicaid requirement]</td>
<td>• <strong>Underlying data premise:</strong> The cost of data collection and reporting is justified by the potential improvements in service delivery and outcomes. • The collection of data for the measures should not violate any accepted standards of confidentiality.</td>
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<tr>
<td>Quality Management and Improvement Processes</td>
<td>8.305.8.12 Quality Management and Improvement (QM/QI) regulations. [Medicaid requirement]</td>
<td></td>
<td>• Quality Improvement process at the provider level - Clinical chart audit; C&amp;G; Results of consumer surveys. • Provider Involvement – e.g. statewide provider Quality Council: All provider performance gap reports, monitoring, and corrective action plans include provider-training component.</td>
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<td>Other Considerations</td>
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<td>• Demonstrate client involvement at all levels, including administrative oversight activities • Measure related to housing. Example: a. The rate of domiciled/homeless persons at the termination of treatment and at a standard interval following the termination of treatment b. For adults who identify housing as a concern at the initiation of treatment: the rate who report improvement, worsening or no change in their satisfaction with housing at the termination of treatment and at a standard interval following the termination of treatment. c. For children: the rate of children at home at the termination of treatment and at a standard interval following the termination of treatment. • Continue with EQRO model of external evaluative entity • Training at provider level - meaningful information (was training used/applied?), connected to corrective action • Development and Use of a standardized, consistent initial assessment</td>
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</table>
APPENDIX H

DESIRABLE CHARACTERISTICS OF STATEWIDE ENTITY

Governance and Administrative Capacity
• Evidence of New Mexico experience, knowledge and in-state presence;
• Evidence of consumers and families as meaningful participants in decision-making, policy-setting and quality oversight;
• Evidence of ability to partner with the state and be flexible as the system evolves
and
• Ability to develop and implement a Cultural Competency Plan as directed by the Collaborative.

Consumer/Family-Based
• Ability to create and maintain Consumer/Family Advisory Boards, including Oversight Committees for service delivery;
• Ability to assure behavioral health recipient rights regarding advance directives, privacy and confidentiality, right to choose his provider and right to be part of treatment decisions;
• Ability to assure a smooth transition from the existing systems to the new behavioral health delivery system for consumers;
• Ability to develop and implement processes for handling complaints, grievances, appeals and hearings;
• Ability to develop culturally sensitive and geographically appropriate service delivery systems; and
• Ability to successfully collaborate with consumers and families.

Services and Providers
• Ability to establish and implement a plan to reinvest monies in behavioral health services and increase statewide access;
• Ability to develop agreements with behavioral health providers throughout the state to meet geo-access and telephone access standards and assure access to out-of-network providers;
• Ability to move all behavioral health providers to a common and universal credentialing process accepted for all systems, services and funding streams;
• Ability to develop and provide the array of services necessary and required by the various funding streams and priorities within the Collaborative, including but not limited to school-based behavioral health programs, specialty programs serving persons with corrections and justice system involvement (including DWI, defendants in drug and mental health courts, homeless individuals, adult probationers and parolees, and juvenile offenders), independent living programs for transitioning youth, and programs interfacing with other systems such as Aging, Development Disabilities, Child Welfare, and primary health care;
• Ability to coordinate with housing, employment and community educational programs necessary for quality community life;
Behavioral Health Concept Paper – May 10, 2004

- Ability to develop and establish methods of timely and effective communication of behavioral health and public health information between one another;
- Ability to develop and establish methods used to foster a collaborative atmosphere among state departments, agencies, and community providers;
- Ability to assure a smooth transition from the existing systems to the new behavioral health delivery system for providers;
- Ability to listen to and collaborate with providers while still providing the state with a vehicle for overseeing and improving quality of providers and services;
- Ability to provide community education and prevention programs;
- Ability to work collaboratively with courts, probation and parole officers, juvenile justice officers, protective services workers, etc. to address the needs of individuals in the justice system;
- Ability to coordinate with tribes and pueblo people;
- Ability to coordinate with schools to facilitate access to and payment of school-based services; and
- Evidence of ability to pay providers promptly and accurately.

Consumer/Family Education
- Ability to provide member and provider education and training;
- Ability to provide education about available services;
- Ability to provide 24 hour/7 day a week coverage for questions and complaint resolution; and
- Ability to resolve complaints and appeals in timely manner.

Data/Information Systems
- Ability to maintain and retain secure electronic and hard copy records, including clinical, data and financial;
- Ability to produce timely and required ad hoc reports;
- Ability to develop and implement management information systems (MIS), data collection systems, collection and production of encounter data, and use of standardized codes;
- Ability to develop a timely claims payment system;
- Ability to develop any necessary sliding-fee scale procedures;
- Ability to develop and establish mechanisms for monitoring sentinel/critical events, e.g., incarcerations, deaths, suicides, and involuntary hospitalizations;
- Ability to develop and implement systems for payment of last resort and third party liability (TPL);
- Ability to provide proof of financial stability;
- Ability to manage and account for funding and other requirements of state departments within the Purchasing Collaborative; and
- Ability to identify, track and report allowable and non-allowable expenses statewide and for any local systems of care, regional groups, and providers (individual and networks).
Regulations and Financial Capacity

- Ability to adhere to federal and state laws, regulations and standards;
- Ability to assure behavioral health staff requirements, including education, licensure, cultural competence, behavioral health experience and staff to client ratio;
- Ability to develop and implement uniform standards for provider credentialing
- Ability to develop standards and procedures to prevent fraud and abuse;
- Ability to establish a mechanism to handle court-ordered services, juvenile and adult, and parole-board ordered services for adults;
- Ability to specify policy and procedures regarding subcontractor performance and functions; and
- Capacity to establish and develop a community reinvestment account, held jointly with the Purchasing Collaborative to reinvest monies into the statewide and local system of care service system.

Utilization Management/Care Coordination

- Ability to develop, train for and implement a common assessment and service plan;
- Ability to conduct a behavioral health screen within 24 hours on every child/adolescent entering the CYFD system, and make appropriate referrals;
- Ability to assure coordination of care between physical health/primary care and behavioral health care, lab and x-ray, pharmacy, transportation, and emergency services;
- Ability to assure responsive and timely communication including the availability of electronic communication, web site access and on-line materials;
- Ability to assure follow-up for necessary behavioral health services identified through EPSDT screens;
- Ability to assure review of clinical denials;
- Ability to manage all covered behavioral health services listed specifically for mental health and listed specifically for substance abuse treatment, including both Medicaid and non-Medicaid as appropriate;
- Ability to develop and provide standardized utilization review (UR) and utilization management (UM) criteria and administration thereof, e.g., prior authorizations, no authorization, open access;
- Ability to facilitate development of local systems of care infrastructure at the community level;
- Ability to develop standardized level of care criteria;
- Ability to establish a Continuing Quality Improvement Program, including consumer, family and provider satisfaction surveys;
- Ability to establish formats for and implement the consistent and appropriate development of provider-created treatment plans, including comprehensive discharge planning;
- Evidence of ability to coordinate UR authorizations with state-owned, vendor-operated claims payment system; and
- Evidence of ability to analyze and make timely UR decisions.