INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE–
Toward a National Model

Presentation to Health and Human Services and Legislative Finance Committees
July 14, 2004
PURPOSE OF TODAY’S PRESENTATION

- Origins of BH Purchasing Collaborative
- Problems To Be Solved and Desired Results
- Roles of Various Entities
  - Collaborative
  - Behavioral Health Design Work Group
  - Statewide Entity
  - Local Systems of Care
  - Behavioral Health Planning Council
- Target Dates and Phasing
- Status of Activities to Date
BACKGROUND

Governor Richardson’s September 2003 press release announcing BH Purchasing Collaborative

– better services
– better access
– better use of taxpayer dollars

HB 271 (Rep Sandoval & Senator Komadina) – effective May 19, 2004

Goal is single behavioral health delivery system across multiple state agencies and multiple funding sources
PROBLEMS TO BE SOLVED

- Lack of common agreement about goals and outcomes – insufficient focus on recovery and resiliency

- “Fragmentation” (per President’s New Freedom Commission Report), i.e., multiple approaches, plans, service definitions, billing processes, reporting requirements for similar or related services
PROBLEMS TO BE SOLVED (cont’d)

- Duplication of effort and infrastructures at state and local levels, resulting in confusion for consumers, families, referral sources, providers

- Higher administrative costs for providers due to multiple state approaches and multiple contracting entities

- Insufficient or duplicative oversight of providers and services
Insufficient services; inappropriate services (not always evidence-based)

Not always maximizing resources across funding streams

Multiple disconnected advisory groups and processes working toward a different, sometimes disconnected goals
DESIRED RESULTS

- Recovery and resiliency as driving philosophies
- “Braided” flexible funding
- Single billing process and consistent data collection and management
- Common age-appropriate assessment process used in all service settings
- Smooth transition from current systems to single system
- Local community input and collaboration; attention to rural and frontier areas
- Attention to persons with unique service or access needs
DESIRMED RESULTS (cont’d)

Uniform program standards, including common:
- service definitions and requirements
- utilization management requirements/criteria
- system performance expectations
- consumer/family outcomes expectations

Sufficient number and distribution of providers

Best benefit package possible within available funding

Emphasis on evidence-based and promising practices and thinking
HB 271 STATUTORY PURPOSE

“... 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.”
PURCHASING COLLABORATIVE VISION

A single behavioral health 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.
17 Purchasing Collaborative Members

- Department of Health
- Children, Youth and Families Department
- Human Services Department
- Department of Corrections
- Aging and Long Term Services Department
- Public Education Department
- Department of Finance and Administration
- Department of Transportation
- Department of Labor
- Division of Vocational Rehabilitation
- Administrative Office of the Courts
- Mortgage Finance Authority
- Indian Affairs Department
- Health Policy Commission
- Developmental Disabilities Planning Council
- Governor’s Commission on Disability
- Governor’s Health Policy Coordinator
COLLABORATIVE STATUTORY DUTIES

- Identify behavioral health needs statewide
- Give special attention to regional differences, including cultural, rural, frontier, urban and border issues
- Inventory all expenditures for mental health and substance abuse services
- Plan, design and direct a statewide behavioral health system
COLLABORATIVE STATUTORY DUTIES (cont’d)

- Contract for operation of one or more behavioral health entities to ensure availability of services throughout the state
- Develop a comprehensive statewide behavioral health plan
- Seek and consider suggestions of Native Americans
ADDITIONAL COLLABORATIVE FUNCTIONS

“Keeper of the values and philosophy”

Collective oversight of statewide entity

Address system and individual problems that cannot be resolved at the local level

Assure consumer and family voice in governance, planning, implementation and evaluation
BEHAVIORAL HEALTH DESIGN WORK GROUP (BHDWG)

- Staff group from impacted departments & agencies to get the work done and report to the Collaborative (operating as a policy and decision-making body)

- Led by HSD and Co-Chair (DOH in FY 2005)

- Staffed by the Behavioral Health Manager appointed by the Governor to coordinate BH work across departments
STATEWIDE ENTITY RESPONSIBILITIES

- Contracting with and paying providers or provider groups
- Helping to “braid” “blend” or “coordinate” multiple funding streams – increasing flexibility and maximizing resources
- Credentialing and quality oversight of providers
- Utilization review (UR) and management (UM)
Assuring care coordination

Assisting the Collaborative in development and nurturing of local systems of care

Consumer/family relations

Collecting, managing and reporting data
PROCUREMENT PROCESS FOR STATEWIDE ENTITY

- Single RFP to select the statewide entity
- Open competitive procurement process pursuant to state law
- Draft implementation plan for stakeholder input
PROCUREMENT PROCESS FOR STATEWIDE ENTITY (cont’d)

- Consumer/family involvement in review of proposals
- Joint selection and negotiation by Collaborative agencies
- Single contract with multiple agencies
LOCAL SYSTEMS OF CARE

Local community groups developed in areas consistent with each of the 13 judicial districts

Consisting of consumers, families, providers, advocates, and other system representatives, such as courts, schools, churches, child welfare organizations, health improvement councils, tribes, vocational/employment providers, housing authorities, area agencies on aging, local DWI councils, civic organizations, primary care providers, local government officials, and other interested individuals or groups
LSOC RESPONSIBILITIES

- Identifying gaps and needs in local areas
- Recommending service array for local areas
- Capacity building and program development
- Proposals to funding bodies for local activities
- Evaluation of local area services; information for and from Collaborative and Statewide Entity
- Agreeing on common protocols for referrals and follow-up of persons in need of multiple services
- Assisting in coordinating care for multi-system service recipients
Single statewide advisory group with subcommittees on:
- adults (staffed by DOH)
- children/adolescents (staffed by CYFD)
- substance abuse, including DWI (staffed by DOH)
- Medicaid (staffed by HSD)

Likely other subgroups on Native Americans, prevention, specific grants, SE RFP, Block Grant, etc.

Replace existing behavioral health advisory councils and structures

Consistent with federal requirements
BHPC STATUTORY DUTIES

- Advocate for adults, children and adolescents with behavioral health needs
- Report annually to the Governor and Legislature
- Encourage development of a comprehensive, integrated, community-based behavioral health system
- Advise the Collaborative agencies (& statewide entity)
- Review and make recommendations for the comprehensive mental health plan, mental health and substance abuse block grant applications, Medicaid state plan, and other plans and applications
BHPC MEMBERSHIP

Members appointed by Governor

Five types of members – consumers, providers, advocates, state agency reps and others to balance geography and culture.

Providers and state agency representatives may not constitute more than 49% of the council membership (i.e., a majority of consumers/families and advocates)
2. State Agency Representatives
   – Adult MH and SA (DOH)
   – Children’s MH and SA (CYFD)
   – Education (PED)
   – Vocational Rehabilitation (PED)
   – Criminal Justice (NMCD and PD)
   – Juvenile Justice (CYFD)
   – Housing (MFA)
   – Medicaid and Social Services (HSD)
   – Health Policy Planning (HPC)
   – Developmental Disabilities Planning (DDPC)
   – Disabilities Issues and Advocacy (GCD)
DEVELOPMENT PROCESS TO DATE

Initial Subgroups with Stakeholder Advisors
- Services & Populations (CYFD)
- Transportation and Pharmacy (HSD)
- Care Coordination/UR/UM (HSD & CYFD)
- Member Services (DOH & PED)
- Structure and Financing (HSD)
- Quality & Outcomes (HSD)
- Persons with Complex Needs (HSD & DDPC)
- Justice Issues (NMCD)
- Financial Inventory (DOH)
Current Staff Subgroups

- Transitions (DOH)
- Comprehensive BH Plan (DOH)
- Legal Boilerplate (HSD, DOH, CYFD, NMCD)
- RFP Development (HSD)
- Data Requirements (HSD)
- Service Definitions/Requirements (DOH, CYFD, HSD & NMCD)
- BHPC Staffing (DOH & CYFD)
- School Based Services (DOH/OSH, PED & HSD)
- Ombuds Role (DOH & HSD)
- Process Evaluation (HSD & DOH)
- Local Systems of Care Requirements (CYFD & NMCD)
PHASES

Pre-planning and transition – September 2003 – July 1, 2005

- Designing
- Planning
- Public input
- Federal approvals sought
- Local systems of care criteria determined and development begun
- Releasing RFP and selecting partner
- Transition
TARGET DATES
(subject to change)

September 2003 – March 2004 – Organizing, Planning and Concept Paper Development
Spring/Summer 2004 – Public Stakeholder Meetings (including tribal meetings)
July 2004 – Draft Implementation Plan for RFP Out for Review
September 2004 – Request for Proposals Released
Winter 2005 – Vendor Selection
Spring 2005 – Contracting and Transition
July 1, 2005 – New System Begins Operating in Phase One
Public Input Venues

Public Meetings – Calendar on Web
- [www.state.nm.us/hsd/bhdbwg](http://www.state.nm.us/hsd/bhdbwg)
- July 23 – Service Definition and Requirements
- August 4 – Draft Implementation Plan and SE Requirements
- August 4 – Consumer Meeting
- August 5 – 3rd Tribal Input Meeting

Concept Paper & Other Resources – on Web

Collaborative Meetings – Open to Public
- June 11, August 5, September 3

E-mail address
- [bhdesign@state.nm.us](mailto:bhdesign@state.nm.us)
PHASE ONE
July 1, 2005 to June 30, 2006

- Services provided; providers paid; data reported
- Transition continued
- Expectations refined
- Data systems refined
- Identification of ways to maximize funding
- Local systems of care developed
- Implement statewide plan
- Goals for Phase Two set
PHASE TWO
July 1, 2006 to June 30, 2008

- More blending and flexibility of funding
- Additional funding streams added
- Local systems of care refined
- Development of additional evidence-based and promising practices
- Additional consumer/family operated services
- Performance expectations and consumer/family outcomes refined, measured and reported
- Additional resources sought (e.g., grants)
PHASE THREE
July 1, 2008 forward

- System matured
- Increased program and service development
- Increased performance and outcomes
- Increased coordination among local and statewide systems
TYPES OF RESOURCES

❖ State controlled funds – federal and state ($200-$400 million)

❖ State agency service delivery capacity, e.g.,
  − state treatment facilities

❖ State agency staff working on behavioral health issues
WHAT’S IN WHEN – Phase One

- Medicaid MH and SA services for children and adults
- Federal MH and SA block grants
- General fund for community based services for adults and children
- Funds for behavioral health services for adults on probation and parole
- School-based behavioral health services funded through multiple sources
- TANF funds for substance abuse and for behavioral health services for victims of domestic violence
- Funds for peer counseling for seniors
- General Fund and federal funds for housing support services
WHAT’S IN WHEN – Phase Two (under consideration)

- DOH forensic evaluation funds
- DOH federal/foundation grants
- DOH and DOT prevention funds/services
- DOH Transitional reporting centers funding
- Admission and utilization of DOH state facilities
- Access to DVR vocational rehabilitation and supported employment
- Access to MFA housing resources
- CYFD in-facility behavioral health services for incarcerated youth
- Safe and Drug Free Schools and other PED funds for behavioral health
- IEP services for school-age children
WHAT’S IN WHEN (cont’d)

Coordination

- In-facility behavioral health services for adult corrections
- AOC funding for drug or mental health courts
- DWI funding for counties
- Anything not directly included within SE responsibility
“It can’t be done overnight; it will take time.”

“System improvement is a process, not an event.”