HUMAN SERVICES DEPARTMENT

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Behavioral Health Update for the Legislative Finance Committee

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Throughout 2014, we have continued to collect key information about Centennial Care to monitor service utilization patterns, especially for behavioral health. The reporting template was structured like the previous BH utilization reporting template to provide tracking of pre- and post-Centennial Care utilization. The report examines utilization of over 200 BH services in five categories: Inpatient, Residential, Intensive Outpatient, Recovery, and Outpatient. It shows the unduplicated number of members receiving services by age group, as well as units of service and expenditures.

In addition to behavioral health utilization, this report includes an update on consumer satisfaction surveys, post-session behavioral health actions, and the Behavioral Health Collaborative's strategic plan

Behavioral Health Utilization

New Mexico continues to monitor utilization of BH services with the implementation of Centennial Care. For comparability, Centennial Care utilization in Calendar Year 2014 is compared to pre-Centennial Care utilization for SFY 2013. At that point in history, there was one managed care entity that managed all behavioral health funds (i.e., Medicaid Managed Care, Medicaid Fee for Services and non–Medicaid state and federal block grant funds.) This period of pre-Centennial Care utilization was chosen to reduce any potential impact to the utilization report due to the program integrity activities and pay holds implemented with fifteen behavioral health providers in Pre-Centennial Care, July-December, 2013.

Table 2. In 2014, 160,582 individuals received behavioral health services from all funds as compared to the Pre-Centennial SYF13 when 87,373 persons were served. This represents an 84% increase or, 73,209 additional persons served in these time periods

Table 2. Recipients Receiving BH Services by Age*				
	CY 2014			
Age Groups	Centennial Care Members	Medicaid FFS	Non-Medicaid	Total
Under 18	45,353	19,794	6,757	71,904
18-20	3,944	695	1,254	5,893
21 -64	47,434	9,401	21,565	78,400
65 and over	2,532	2,413	1,211	6,156
Total**	98,393	32,306	29,883	**160,582**

* Based on claims data

**Total will not equal sum of age groups as there will be some duplication

*** Unduplicated count, all funds, 12 months July, 2012-June, 2013

Table 3. Reflects all fund sources in 2014, in which $269,284,176 were expended on behavioral health services. This represents an 11% percent increase in funds (or, $26,757,143) expended on behavioral health services as compared to the Pre-Centennial SFY13 period. Centennial Care funds represented 76.7 percent of all funds expended in 2014.

Table 3. Expenditures for BH Services CY 2014*	
Presbyterian	$86,471,334
Molina	$76,669,799
United	$18,237,596
BCBS	$25,014,687
Subtotal Centennial Care	$206,393,416
Medicaid FFS	$37,646,711
Non Medicaid	$25,244,049
2014 Total	**$269,284,176**
Pre-CC SFY2013	**$242,507,033**

*Does not include pharmacy

Table 4. reflects the unduplicated counts of persons served by setting of service.

Data on Medicaid Fee-for-Services recipients, by setting of service and related expenditures were not available at the time of this report. So those data are excluded from the following observations.

Table 4. Unduplicated Count of Recipients Served By Level of Care*					
	CY 2014				Pre-CC SFY2013***
	Centennial Care members	Medicaid FFS	Non-Medicaid	Total	
Inpatient	6,280	Not available	809		5,030
Residential	1,610	Not available	2,113		3,971
Intensive Outpatient	1,760	Not available	896		2,296
Recovery	9,115	Not available	5,462		17,956
Outpatient	95,733	Not available	26,964		81,512
Value Added Services					1,264
Uncategorized					8,053
Unduplicated -All Services **	98,393	32,306	29,883	160,582	87,373

* Based on claims data

*Totals will not equal sum of levels of care as there will be some duplication

*** Unduplicated count, all funds, 12 months, July,2012-June,2013

Both Medicaid members and Non-Medicaid recipients were primarily served, during this reporting period, in outpatient services (97% and 90% respectively.) A higher proportion of Medicaid members (6.4%) received inpatient services than non-Medicaid recipients (2.7 %.) A notably higher percent of non-Medicaid recipients were served in recovery services (18.3% vs 9.3% for Medicaid members) and in residential services (7.1% vs. 1.6%). This is explained further in the discussion under Table 5.

Table 5. looks at expenditures by Setting of Service.

Table 5. Expenditures for BH Services *					
	CY 2014				Pre-CC SFY2013***
	Centennial Care members	Medicaid FFS**	Non-Medicaid	Total	
Inpatient	$17,555,674		$1,044,442		$22,037,112
Residential	$62,088,582		$9,208,685		$76,080,401
Intensive Outpatient	$5,831,418		$1,382,270		$12,182,971
Recovery	$26,436,794		$4,390,285		$40,427,251
Outpatient	$94,480,948		$9,198,368		$83,471,195
Value Added Services					$4,910,907
Outliers					$3,397,196
All Services	$206,393,416	$37,646,711	$25,224,049	**$269,264,176**	$242,507,033

* Based on claims data

**Data on the expenditures by setting of service not available at time of this report

*** Unduplicated count, all funds, 12 months, July,2012-June,2013

Almost forty percent (38.6%) of all Centennial Care funds ($79,644,256) were expended on high-end care (i.e., inpatient and residential services). In addition, 40.6% of the non-Medicaid funds were also expended on high end care; almost all of which were spent on residential care. This is not surprising considering that adult residential placement is not a Medicaid covered benefit. A further explanation is that over eighty percent of those non-Medicaid residential funds ($7,681,433) were spent on substance abuse residential services to adults which also are not part of the Centennial Care benefit. It should be noted however, that the total costs associated with inpatient and residential care have been significantly reduced in CY2014, from $98.1 million to $89.9 million. And outpatient (OP) service costs have simultaneously increased from $136.1 million to $141.7 million. This shift in costs from high-end services to outpatient community-based care is seen as a positive trend due in large part to Centennial Care.

Annual Consumer Family/Caregiver and Youth Satisfaction Surveys

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (C/F/YSP) is a yearly survey of the satisfaction of New Mexico Adults, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services. The C/F/YSP survey serves helps to inform a quality improvement process to strengthen services in New Mexico.

In 2014, New Mexico continued to score high in these surveys, and while there are performance areas that need improvement, New Mexico meets or exceeds the US averages in all indicators.

Table 6. Family/Caregivers of Children in Service: Their satisfaction in the following areas in 2013 Pre Centennial Care, 2014 and the comparison with the US Average (2013)

Scales Topic	Pre Centennial Care New Mexico 2013	New Mexico 2014	US Average 2013
Access	88%	89%	85%
Participation in Treatment	89%	92%	88%
Improved Functioning	84%	81%	69%
Social Connectedness	92%	93%	85%
Outcomes	85%	81%	68%
Cultural Sensitivity	96%	96%	93%
Satisfaction	86%	88%	86%

Table 7. Adults in Service: Their satisfaction in the following areas in 2013 Pre Centennial Care, 2014 and the comparison with the US Average (2013)

Scales Topic	Pre Centennial Care New Mexico 2013	New Mexico 2014	US Average 2013
Access	86%	85%	85%
Participation in Treatment	88%	87%	81%
Improved Functioning	81%	73%	70%
Social Connectedness	88%	83%	70%
Outcomes	85%	75%	71%
Quality & Appropriateness	91%	88%	88%
Satisfaction	88%	89%	88%

Crisis Triage, Investment Zones and Facilitating Medicaid Enrollment with Correctional Facilities

1. Crisis Stabilization Units (aka Crisis Triage Centers) provide services to individuals who are in behavioral health crisis and whose needs cannot be accommodated safely in residential service settings. The goal of the CSU is to stabilize the consumer and reintegrate him or her back into community services quickly. CSUs can provide an important service in the behavioral health system. In addition, CSUs can help law enforcement and hospitals by diverting individuals from jails and emergency rooms in to more appropriate service and care settings.
    - House Bill 212, sponsored by Representative McMillan and Senator Papen and signed by Governor Martinez, provides new licensing authority to DOH and
    - Dona Ana County has completed its facility and Bernalillo has identified a CSU as a priority need.
    - House Bill 2 provides $2.25 million from the general fund for Medicaid and non-Medicaid support of crisis stabilization services.

2. Investment zone funding strategies can be an effective way to target resources to higher-needs areas of the state. House Bill 2 includes $1 million for HSD to allocate to higher needs areas of the state through an investment zone strategy.

3. HSD has been working with counties and the Department of Corrections to develop a Medicaid enrollment process that provides for quicker access to Medicaid services for individuals released from incarceration and provides Medicaid reimbursement for inpatient hospital services for an otherwise incarcerated individual. Senate Bill 42 further supports these efforts, and we'll be working with counties and the DoC to refine our efforts to ease this enrollment. The goals of these projects include:
    a. Help reduce recidivism by connecting individuals more quickly to health care services, especially behavioral health services
    b. Leverage federal funding for county and DoC correctional health care budgets.

Behavioral Health Collaborative Strategic Initiatives to Strengthen the Behavioral Health System

Over the next year, the BH Collaborative will focus on three critical domains: Regulations, Finance, and Workforce. The Collaborative will be developing a two-year Strategic Plan, with the same critical foci, to strengthen the sustainability of the publically funded BH service system. These three domains have been consistently cited by various reports, workgroups, advisory bodies, and advocacy groups as critical to system improvement, and through the Collaborative, we will be working with these stakeholders to develop the short- and long-term actions for improving the system. For example:

- Regulatory Environment
    - Updating clinical supervision policies to enable non-independently licensed practitioners to be reimbursed for services under appropriation supervision
    - Improving and speeding the provider credentialing process
    - Reviewing the certification and licensure processes and requirements that support the Medicaid program.
- Finance
    - Develop provider-level payment reform pilot projects that promote and pay for improved health care outcomes, including health homes
    - Provide incentivize for the adoption of and Open Access Model to eliminate the need for waiting lists without need to increase provider capacity.
- Workforce
    - Like changes to non-independently licensed regulations, support the development of a workforce pipeline by support interns in agency practices.
    - Support development of peer specialist and peer support services
    - Where appropriate, promote the use of group psychotherapy
    - Collaborate with the BH Workforce Committee