It's Never Too Late to Do It Right: Lessons From Behavioral Health Reform in New Mexico

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This column describes an initiative to reform the public behavioral health system in New Mexico, which has placed publicly funded services under the management of a single for-profit private corporation. The authors discuss problems that they attribute to the state's "top-down model of planning and implementation": complex documentation requirements that increase administrative burden on providers, unrealistically high expectations for a comprehensive information technology system, inadequate monitoring that hampers assessment of reform, and insufficient attention to the rural safety net. They call on other states to better incorporate experiences of those delivering and receiving services into the design and timing of reform initiatives. (*Psychiatric Services* 61:646–648, 2010)

In September 2003 Governor Bill Richardson announced a major transformation of the public behavioral health system within the predominantly rural state of New Mexico. Central features of this reform included increased accountability and the braiding and blending of service funds from 15 state agencies to manage these monies better and leverage them in new ways. The consolidation of funding streams was intended to reduce service fragmentation and contribute to the development of a unified set of administrative practices that, in turn, would decrease duplicative and costly paperwork requirements for behavioral health care providers who traditionally contracted with multiple state agencies. The broader vision and aspirations of this reform are described elsewhere (1).

The revamped system was officially brought online in July 2005, when the state government placed the lion's share of its publicly funded behavioral health services under the management of a single for-profit private corporation, ValueOptions New Mexico (VONM), referred to locally as the "Statewide Entity" (SE). The corporation was awarded its four-year contract through a competitive bidding process. Four years later, this same process led OptumHealth New Mexico (OHNM), a subsidiary of the UnitedHealth Group, to assume the reins of the SE in July 2009.

In September 2009 the Interagency Behavioral Health Purchasing Collaborative (IBHPC), a partnership of state government agencies that direct system transformation and oversee the performance of the SE, began investigating complaints from providers who had yet to receive payment for services from OHNM. Provider agencies throughout New Mexico, particularly those in rural areas, were facing cash flow problems because of delays in claims processing. In October and November 2009, the state legislature held two hearings to determine the origin and extent of this problem. At the close of this period, OHNM was subjected to a corrective action plan, was assigned an external monitor to ensure compliance with the plan, and faced sanctions and fines totaling more than $1 million.

In January 2010, just seven months into the four-year contract with OHNM, Governor Richardson directed state officials "to issue a request for proposals for more efficient, effective and quality driven services" (2). This decision was advanced within a health care climate suffering from a general economic decline. A massive state deficit led to proposed budget cuts for Medicaid, the largest purchaser of behavioral health care in New Mexico. The decision provided opportunities for the state government to terminate its relationship with OHNM and to pursue new strategies to address this deteriorating climate, potentially scaling back on benefits packages for clients or entering into lower-cost contracts with competing managed care companies. Although the financial woes now troubling the state and the nation had an impact on New Mexico's ambitious system transformation, several other concerns also impeded change processes. Many of these same concerns compromised the state government's earlier efforts (1997–2005) to reform Medicaid mental health services through managed care (3). In this column, we describe key issues affecting this latest initiative and argue that future reform may founder if these issues remain inadequately addressed.

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Key issues in the transformation

System complexity and implementation

The IBHPC took the lead in coordinating policy, service definitions and packages, and administrative requirements under the reform. Although the IBHPC was successful in bringing to the table all state agencies with a role in behavioral health care, the partnership was less successful in achieving the goal of reduced complexity through policy unification. In particular, the IBHPC was unable to reconcile the varying federal statutory and funding requirements under which the member agencies had operated before the reform. In lieu of synchronized requirements, direct service providers still had to contend with differing expectations of the member agencies, as well as new expectations for increased documentation placed on them by the IBHPC and the SE. Consequently, the reform did little to reduce the administrative burden and related overhead expense for providers participating in the public sector.

The top-down model of planning and implementation employed by the IBHPC created additional hardships, as decision-making power regarding programmatic changes (for example, new services) rested with the state government. Unpredictable timelines shaped by "unanticipated crises or opportunities" and political circumstance led state officials to proceed with several changes without close consultation with providers and clients (4). Within this context, programmatic changes were often rushed, leaving little time for advance preparation, provider training, and information technology (IT) system adjustments. Such consultation would have made it possible to identify and ameliorate potential adverse impacts on provider agency operations and service delivery capacity. Programmatic changes were further hampered by inadequate financial compensation, confusing service definitions, and underdeveloped implementation plans. Finally, the IBHPC and the SE failed to offer enough technical support to provider agencies or attend to sustainability issues.

Insufficient information technology systems

Neither SE (VONM or OHNM) was fully prepared to meet the considerable IT challenges that emerged under the reform. The unusually multifaceted requirements for this system stemmed from the IBHPC's interest in developing a comprehensive approach to claims processing that would facilitate the consolidation of funds from diverse sources. Such a system, for example, had to process claims paid by Medicaid and the Department of Children, Youth and Families, the Department of Corrections, and the Department of Health. Substantial demographic and clinical data for each client had to be entered into the system (typically by direct service providers) to ensure the individual's eligibility for care under each funding source, and only certain services were reimbursable through specific sources. Although the reform was intended to streamline otherwise disparate administrative requirements for enrollment, billing, and reporting across state agencies, prereform requirements were largely left in place and incorporated into the IT system of the SE.

The issue of IT is not simply a technical matter but represents an important contract evaluation issue for state governments partnering with private-sector companies. From the perspective of state officials, these companies are unlikely to invest resources into thoroughly developing and demonstrating IT capacity during the bidding process. Regardless, the readiness assessments undertaken by the IBHPC did not accurately gauge the capability of either VONM or OHNM to establish and operate an IT system of the magnitude required by the reform. Despite its decades of experience in more than a dozen public-sector programs, it took VONM more than two years to create a fully functioning system. However, because VONM's IT system was considered "proprietary," OHNM had to create a new system when it assumed the responsibilities of the SE. The replacement system was rife with problems, especially in the area of claims processing. A common complaint was that data entered into the system "vanished." The incomplete data impaired the ability of state officials and other interested stakeholders to assess access and quality of care during a crucial transition period.

Lack of evaluation and accountability

New Mexico established a publicly available, but now defunct, early warning system in 2001 to facilitate the rapid identification and rectification of service delivery problems under Medicaid managed care. As of this writing, the IBHPC had yet to institute a similar mechanism to ensure the timely dissemination of data to transparently evaluate the present reform. Data related to this reform were typically provided to the public years after collection had taken place, when the information no longer measured current performance. Further, the actual performance measures that the IBHPC had selected to assess the impact of the transformation were neither closely tied to reform activities nor focused on the service delivery issues in greatest need of improvement.

The lack of a comprehensive, well-targeted, high-quality monitoring system made it difficult for state officials and their managed care contractors to be responsive to complaints from providers, clients, and advocates regarding the reform's negative influence on the public service delivery infrastructure (3). Massachusetts, Florida, Colorado, and other states with ambitious Medicaid reforms have allowed independent evaluators to analyze claims data to systematically assess the impact of programmatic changes on care (5–7). Since 1997, the State of New Mexico has denied researchers access to these data.

Inadequate attention to the rural safety net

A characteristic of reform in New Mexico has been the inclusion of rural and frontier areas without careful consideration of the disadvantages that provider agencies in these settings face in terms of workforce capacity, infrastructure, and travel distance. Given their substantial reliance on public funding, rural agencies also tend to be the most susceptible to the

adverse effects of reform. Excessive paperwork demands, large caseloads of clients with complex needs, and practitioner shortages, particularly of specialty providers, contributed to stressful work environments within rural agencies before the reform. Under the recent reform, frequent and ill-defined changes in administrative processes exacerbated this stress.

In addition, persistent delayed payments and lower reimbursement rates contributed to significant financial problems within these agencies, jeopardizing their already stretched capacity to deliver care to poor and underserved populations. Not all agencies had the necessary administrative apparatus in place to adhere to the new billing and reimbursement requirements instituted first by VONM and then by OHNM. In many instances, they lacked the financial resources necessary to purchase basic technology (computers, software, and consistent access to the Internet) to submit required materials to the SE. A lack of ongoing technical assistance from either VONM or OHNM emerged as a central reason why the agencies were unable to build this apparatus or comply with the new requirements (8).

Finally, direct service planning and implementation efforts led by the IBHPC and its managed care contractors favored agencies in urban areas over those in rural and frontier areas. For example, one recently introduced service, Comprehensive Community Support Services (CCSS), a promising program intended to coordinate and provide resources to promote recovery among persons with serious mental illness, did not account for distance and topographical challenges that contributed to greater travel expense in rural and frontier areas. The IBHPC service requirements and utilization guidelines adopted in 2008 imparted the impression that a minimum of 60% of CCSS had to be provided face-to-face and where the client was located, rather than in an office. However, reimbursement for this new service did not account for transportation costs to support the work of CCSS staff in rural and frontier areas. Despite the additional challenges, rural and urban agencies were paid the same rates for CCSS. While adjusting to CCSS, agencies had to simultaneously grapple with lost revenue resulting from the IBHPC's decision to eliminate case management as a reimbursable service from the Medicaid benefits package.

Conclusions

Since its earlier experiment with Medicaid managed care in 1997, New Mexico has struggled with implementation problems. The latest reform raised the stakes because a single managed care contractor was entrusted to administer all public behavioral health monies. Therefore, any problems were likely to exert a wider impact. This reform was heralded for its potential to consolidate funding streams, reduce service fragmentation, and alleviate administrative burden for providers (1). These aims were undermined by a top-down approach to implementation in which the experiences of those delivering or receiving services were not fully incorporated into the design and timing of reform initiatives.

States considering a large-scale interagency reform can learn from New Mexico's attempt to harmonize behavioral health policy and administrative requirements. The following recommendations may aid New Mexico and other states moving forward with such reform:

♦ Address contextual challenges and infrastructure issues within public-sector provider networks and underserved catchment areas (for example, rural and frontier settings) that may affect the ability of behavioral health agencies to adapt to state-initiated changes in administration and service delivery.

♦ Assess realistically the capabilities of corporate partners to create and implement IT systems that can handle the extreme technical demands of comprehensive reform; if necessary, phase in the components of such systems over time. State governments should select judiciously among the potential administrative requirements to include within these systems, facilitate a piloting process, and retain ownership of the final products.

♦ Establish evaluation protocols that include input from providers, clients, and advocates and produce publicly available information to illuminate intended and unintended effects of reform. A transparent, targeted, and time-sensitive early warning system will make it possible to promptly identify problems and spearhead data-driven midcourse corrections.

Concerted attention to implementation issues will enhance reform efforts and assist states in achieving the goal of efficient, effective, and high-quality services.

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