MINUTES
of the
FIRST MEETING
of the
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE

August 16, 2012
Rehoboth McKinley Christian Health Care Services
Gallup

The first meeting of the Behavioral Health Services Subcommittee was called to order by Senator Mary Kay Papen, vice chair, on August 16, 2012 at 9:20 a.m. at the Rehoboth McKinley Christian Health Care Services (RMCHCS) hospital facility in Gallup.

Present	**Absent**
Sen. Mary Kay Papen, Vice Chair	Rep. Ray Begaye, Chair
Rep. Dennis J. Kintigh	
Sen. Nancy Rodriguez	

Advisory Members	
Rep. Bill B. O'Neill	Sen. Sue Wilson Beffort
Sen. Gerald Ortiz y Pino	Rep. Mimi Stewart

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Kathleen Dexter, Researcher, LCS
Theresa Rogers, Intern, LCS

Guest Legislators
Sen. Dede Feldman
Sen. George K. Munoz

Additional guests are included on the guest list in the subcommittee file.

Funding for Native American Treatment for Substance Dependence, Misuse and Abuse

John Jay Azua, programs manager and interim executive director for the Na'Nizhoozhi Center, Inc. (NCI), gave a presentation on the center's work in treating and reducing the incidence of substance abuse in northwest New Mexico. The NCI, which is operated and staffed jointly by the City of Gallup, McKinley County, the Navajo Nation and the Pueblo of Zuni, is the state's largest inpatient alcohol abuse detoxification and treatment facility, currently serving approximately 24,000 clients annually. A primary focus for the center is its protective custody admission process in which inebriants are sent by law enforcement officers to the NCI, rather than to jail, and held in protective custody for up to 72 hours for detoxification and intervention pursuant to the Detoxification Reform Act. Mr. Azua cites the success of this 72-hour hold and the center's subsequent referrals to substance abuse treatment as one reason McKinley County is no longer ranked number one for incidents of exposure deaths and driving while intoxicated (DWI). He noted that federal funding is not available for detoxification, and for this reason the

center uses the detoxification funding it raises from other sources to leverage federal funding for treatment services.

Since it opened 20 years ago, the NCI has received its operational funds through a combination of grants, Navajo Nation funding, local funding and federal funding, with the latter primarily via direct contracts with the Indian Health Service (IHS) that were made possible under the federal Indian Health Care Improvement Act. Under federal health care reform efforts, however, the IHS no longer contracts directly for services; as of 2011, funds are sent directly to tribes — in the NCI's case, the Navajo Nation — pursuant to the federal Indian Self-Determination and Education Assistance Act. Mr. Azua stated that this change in the funding structure puts the NCI at great risk of having to close its doors, despite 20 years of success. The Navajo Nation contracted with the NCI in 2011 at only 57 percent of the center's full-funding needs, and the Nation has indicated it will again deny full funding in its 2012 contract, if the contract is awarded at all.

Mr. Azua was briefly joined by Dominique Dosedo, program manager for the Juvenile Substance Abuse Crisis Center (JSACC), which is the only residential substance abuse treatment facility for juveniles in the United States. The JSACC serves an average of 30 juvenile clients per month and, like the NCI, provides 72-hour protective custody for detoxification. Also like the NCI, the JSACC has experienced a recent drop in funding that threatens the level of services it will be able to provide.

On questioning from subcommittee members, the presenters addressed the following concerns and topics.

Seventy-two-hour protective custody hold. Non-DWI inebriants are booked but not charged with a crime prior to being placed in protective custody at the NCI. DWI inebriants are booked and placed in jail.

NCI budget and payments. The NCI's annual budget in 2005 was $2 million and has now been cut to $1.4 million without a decrease in the need for services. With its Navajo Nation contract now in question, the NCI is going directly to chapters to push for continuation of the contract. The NCI is paid by OptumHealth, the federal Substance Abuse and Mental Health Services Administration and community grants for services provided to clients under court order.

NCI clientele and services. While the NCI will take clients of any background, 98 percent are Native Americans. The NCI can do substance abuse assessments but is prohibited from imposing mental health diagnoses. Treatment following detoxification is voluntary unless the client is under court order. Much of the treatment offered through the NCI is based in traditional Native healing practices.

Liquor excise tax. McKinley County, which is the only county authorized by statute to impose a liquor excise tax, receives approximately $1.5 million annually from the tax and shares those funds with Gallup. The NCI receives a small portion of the tax for its First Step Program, but the bulk of the tax revenue goes to other programs in the area. Liquor excise tax revenue is disbursed by recommendation of a local liquor excise tax committee, as required by law.

Suggestions. Increase the liquor excise tax. Identify other funds to be appropriated or earmarked for substance abuse detoxification and treatment. Designate the NCI as an institution rather than a program under federal law. Designate in federal statute which institutions will receive funding.

- ★ Senator Ortiz y Pino suggested that the subcommittee recommend to the Legislative Health and Human Services Committee (LHHS) legislation to allow more counties to impose the liquor excise tax.
- ★ Senator Munoz recommended that the subcommittee request that the LHHS send a letter to the New Mexico congressional delegation to identify facilities such as the NCI in the federal budget bill.

Rural Hospital's Perspective on Behavioral Health Services

Gretchen Woods, nurse manager for RMCHCS behavioral health services, gave an overview of behavioral health services provided by the hospital as well as some challenges it faces in getting timely reimbursement. With both inpatient and outpatient services available, the hospital is the most comprehensive behavioral health facility in the area, even after funding shortfalls forced the recent closure of its secure psychiatric unit. The client population is split fairly evenly among three groups — Native Americans, Hispanics and others — with 40 percent of them Medicaid-eligible. Reimbursement for services does not cover all that are provided, e.g., medical detoxification, the costs of which are absorbed by the hospital. Past funding from the Navajo Nation has dried up in recent years, and some private insurance reimbursement is not available because New Mexico does not have the acute care facility-licensing structure required by certain insurers. Nearly all reimbursements to the hospital now come from OptumHealth; however, that company is $750,000 in arrears for behavioral health services invoices dating back to 2009. Some of the delay in reimbursement centers on the facility's child psychiatrist: OptumHealth has intermittently rejected invoices for this doctor's services based on the question of whether he is or is not properly credentialed.

On questioning from subcommittee members, Ms. Woods addressed the following concerns and topics.

Mental health diagnoses and treatment. The most prevalent mental health issues in the area are posttraumatic stress disorder (PTSD) and trauma. Mental health should be treated in the long term, similar to diabetes. A major obstacle to treatment compliance is denial, which leads patients to stop taking medication prematurely. The RMCHCS residential treatment facility receives patients from all over the state.

Funding and coverage gaps. RMCHCS does not receive any funding from the liquor excise tax even though it does treat DWI patients. Indigent care covers some, but not all, of the uninsured who receive services through RMCHCS and women get Medicaid coverage if they have children, but Hispanic males tend to fall into a coverage gap.

Case management. Case management services were reimbursed by the state in the past but no longer qualify for reimbursement. Visiting community health nurses in the area provide case management, even though they are neither trained in nor reimbursed for the service.

Suggestion. Replicate in New Mexico a Seattle community outreach program that puts master's level counselors in the field to work with the mentally ill and reduces law enforcement involvement with this population. A modified version of the program is in place in Gallup through Western New Mexico Counseling, though only with patients who have already gotten initial behavioral health services through RMCHCS.

- ★ Senator Ortiz y Pino requested that subcommittee staff research the issue of acute care facility licensure through the Insurance Division of the Public Regulation Commission and the Department of Health.
- ★ Senator Papen directed Troy Fernandez, senior director of the Behavioral Health Services Division of OptumHealth, to investigate the delays in reimbursements to RMCHCS and the issues concerning the child psychiatrist's credentialing and to report back to RMCHCS.

Centennial Care and the Impact of State Behavioral Health Reform on Native Americans

Cathleen E. Willging, Ph.D., senior scientist and mental health services researcher at the Behavioral Health Research Center of the Southwest (BHRCS), spoke to the subcommittee about concerns regarding behavioral health services under the state's proposed Centennial Care waiver. Unlike the state's current Medicaid system, which "carved out" behavioral health services funding beginning in 2005, the Centennial Care waiver would "carve in" such services, thus blending the funding with all other Medicaid services. Dr. Willging raised concerns about the waiver on several points and made some suggestions as to how the state should proceed.

1. The carve-in model was eliminated in 2005 because of known problems that led to behavioral health programs closing down, providers turning away Medicaid clients and, according to a Legislative Finance Committee (LFC) audit, only 55 percent of Medicaid funding for behavioral health being spent on direct client services.
2. Although the carve-out system has had some difficulties under both single-entity contractors to date — ValueOptions and OptumHealth — it can function well if adequate state oversight and monitoring are in place.
3. The state should prevent problems that arose in past Medicaid transitions by appointing an external monitor to assess the readiness review process and implementation period and by requiring a hold-harmless period to protect providers dealing with changes in codes, processes and rates.
4. Performance data collected across the Medicaid managed care organizations (MCOs) should be made available to the public, as they were prior to 2005. These data are now reported to the Interagency Behavioral Health Purchasing Collaborative (IBHPC) and are not available to the public in a user-friendly format.
5. The waiver should include more billing and service flexibility to allow better access to comprehensive community-based care rather than limit these services to behavioral health homes. In addition, while the waiver calls for nurse care managers in behavioral health homes, a recent BHRCS work force study suggests there are very few psychiatric nurses in the state available to perform care management and coordination.
6. The waiver application includes reduction of administrative burdens only in principle. In fact, by replacing the current single-entity structure for behavioral health services with a multiple-MCO structure and adding regional core service agencies (CSAs) for review at the local level, the administrative burden for providers is increased.

7. Funding for Native Americans' behavioral health care under the waiver should be closely monitored so that MCOs either do not receive per capita payments for care that is actually delivered through the IHS system or are required to use these payments for programs that benefit Native Americans. Services and outreach to Native Americans should be culturally sensitive and linguistically appropriate.

8. A solid evaluation plan for the waiver should be in place from the beginning.

On invitation of the vice chair, Diana McWilliams, acting chief executive officer (CEO) of the IBHPC and acting director of the Behavioral Health Services Division of the Human Services Department (HSD), spoke from the audience about the waiver. The IBHPC is one of the contract signatories and will be involved in the final provider selections. An evaluation committee will score the proposals and submit final recommendations by the end of 2012, with the contracts awarded early in 2013. The administrative burden for providers will be capped at a certain percentage and MCOs will be prohibited from recouping administrative expenses by cutting services. Triggers will be in place under the waiver, and there have been discussions on possibly adding an independent monitor to evaluate the new system.

On questioning from subcommittee members, Dr. Willging addressed the following concerns and topics.

Transition and administration. Providers face problems with any major transition in the Medicaid structure or increase in administrative burden. The hold-harmless period during the 2005 transition helped providers adapt gradually to structural changes.

Subcommittee members expressed concerns over the increased administrative burden for providers under the waiver, the fact that the executive is proceeding with the waiver application without legislative input and that a carve-in structure adds potential for a lack of transparency. One member voiced support for a carve-in structure on the point that it gives clients choices that they do not have under the single-entity management of a carve-out structure.

★ Ms. McWilliams will provide information on access and payment for Native American behavioral health services under the waiver.

★ Senator Feldman requested that: (1) the Behavioral Health Services Division review Dr. Willging's report regarding increased administrative complexity under the waiver and submit recommendations to remedy the situation; and (2) the MCO contracts include specific provisions for credentialing of Native American providers, navigators and home health workers, with an emphasis on case management.

Medicaid Behavioral Health Services Through 2013 and Under Centennial Care

Ms. McWilliams gave the subcommittee an overview of and status report on the Centennial Care waiver application. The application was submitted to the Centers for Medicare and Medicaid Services (CMS) on April 25, 2012; the CMS responded with a request for additional stakeholder input, and the HSD will submit application updates after holding more public meetings and tribal consultations. The waiver's core principles are comprehensive service delivery (within a three-level care coordination structure); personal responsibility; payment reform; and administrative simplicity. Protections in the waiver for behavioral health services include required reporting to the IBHPC; joint decision-making authority between the director of

the HSD's Medical Assistance Division and the CEO of the IBHPC; "fenced funding" for behavioral health services via a separate subcapitation rate; CSAs, with allowances for subcontracts to those agencies; behavioral health homes, to be ready by January 1, 2014; required behavioral health expertise for psychiatrists and leadership staff in MCOs; required coordination between the juvenile justice system and the Children, Youth and Families Department; and a requirement that MCO subcontracts for behavioral health services stay within the contract's overall cap on administrative costs.

On questioning from subcommittee members, Ms. McWilliams addressed the following concerns and topics.

Carve-in structure. While a carve-in favors large, out-of-state MCO corporations that already offer behavioral health services, the contract is not written to favor such entities but, rather, whoever will bring the best outcomes. All contracting MCOs are required to offer behavioral health services and assume the risk that comes with per-member-per-month payments; they are also required to report on their expenditure of these payments. While the waiver's carve-in meets the CMS requirement and the HSD's goal of budget neutrality, it was not designed for savings on behavioral health services, and the HSD has not projected any at this time.

Developmentally disabled (DD) and multiple impairments. DD waiver participants are exempted from the Centennial Care waiver. MCOs are required to address all impairments, including language barriers, in their three-level care coordination and to reach out to consumers rather than waiting for consumers to find the MCOs.

Need for behavioral health services. Eighty-five thousand people get behavioral health services each year through the state Medicaid program. For those leaving prison and leaving behind the behavioral health services they received under the Corrections Department budget, Medicaid expansion in the federal Patient Protection and Affordable Care Act will determine how many qualify for a continuation of those services under Medicaid. Projections for new enrollments have not been made because they depend on the Medicaid expansion but could be as high as 20 percent. In the past, the behavioral health services purchasing plan based services on funding, rather than on need.

CSAs and providers. If medically necessary, CSAs will be allowed to evaluate recommendations from competing providers. CSAs should include in their proposals that they will be contracting out to their existing provider network rather than narrowing the network by providing services in-house.

Electronic records. At this time, providers are not required to convert to an electronic records system; MCOs, however, are required to convert provider records to an electronic format.

Time line for contract awards. The request for proposals goes out with the contract by the end of August. Data will go to bidders on September 17. Bidders have 30 days to prepare bids, then reviewers have 30 days to review bids. Contracts will be awarded in early 2013.

Greg Geisler, senior fiscal analyst for the LFC, joined Ms. McWilliams to present excerpts from compilations of behavioral health actual and projected spending for fiscal years

(FYs) 2008 through 2013 across all state agencies and from all sources, including federal block grants and funding for non-Medicaid programs. Spending is projected to be approximately $392 million by FY 2013, down from nearly $430 million in FY 2008. On questioning from the subcommittee, the presenters clarified that the IBHPC includes prisons but not counties; IBHPC money for the Corrections Department is for outpatient treatment only; and, while funding for non-Medicaid programs is not included in the Centennial Care waiver, the contract includes reference to these programs because MCOs have to interact with them.

★ Ms. McWilliams will provide information to the subcommittee and staff:

(1) to clarify her handout's chart showing the state general fund Medicaid cost increases projected through 2020;

(2) on the trend seen by the HSD executive team supporting a move to a carve-in for behavioral health services, including a list of all states that have adopted this structure;

(3) on the metrics currently under development for evaluating proposals;

(4) on the location of the 44 CSAs in the state, maximum distances that clients will need to travel to a CSA and free transportation to the CSAs available through the MCOs;

(5) on telehealth service requirements, such as Native language speakers;

(6) from the HSD general counsel regarding the contract's compliance with all statutory requirements; and

(7) on penalties to MCOs for avoidable delays in treatment or assessments.

★ Representative Kintigh requested that Ms. Mathis get information on how much the Corrections Department spends on inpatient behavioral health treatment services.

Autism Issues/Senate Memorial 20 and House Memorial 44 Report

Gay Finlayson, autism programs education and outreach manager for the Center for Development and Disability at the University of New Mexico Health Sciences Center, presented the subcommittee with a report and recommendations in response to Senate Memorial 20 and House Memorial 44 from the 2012 legislative session, both of which called for development of a state autism spectrum disorder (ASD) service plan. Though the legislature has funded ASD services and studies since 2007, the incidence of ASD has since risen significantly in the general population to nearly one in 88 today, and the report recommends a $9 million appropriation to adequately meet the increased demand for services. The appropriation would also cover the cost of creating an office of ASDs; adaptive skill building services through the HSD; ASD services through Centennial Care; diagnosis services and parent training programs through the Department of Health; HSD programs for non-disabled ASD adults; professional development through the Public Education Department; and a flex-fund program through the proposed office of ASDs.

On questioning from subcommittee members, Ms. Finlayson addressed the following concerns and topics.

DD waiver. ASD services are not provided under the DD waiver except as a related diagnosis in tandem with a developmental disability. Services are also not available for pervasive developmental disorder not otherwise specified and Asperger syndrome. While some people with ASD do meet the DD definition of intellectual disability — an IQ at or below 70 — many do not.

Other states. Pennsylvania is a leader in ASD services, with a state Office of ASDs as well as waiver services and insurance initiatives for ASD.

★ Senator Ortiz y Pino suggested that the subcommittee recommend legislation to the LHHS to create an office of ASDs.

★ Representative O'Neill suggested that the subcommittee recommend legislation to the LHHS on: (1) getting waiver services for those with ASD who are not intellectually disabled; and (2) providing ASD coverage through public employee health insurance plans.

Public Comment

Dr. Matt Jones, a psychologist with the Gallup Indian Medical Center, presented his concern that although state agencies say they work with Native Americans, he does not see real coordination or collaboration taking place, and said that PTSD in the Native American community must be put in the context of intergenerational historical trauma. Subcommittee members noted that they heard a presentation on intergenerational trauma during the 2011 interim.

Ms. Finlayson spoke of "abysmal" case management available in New Mexico under Medicaid, Medicare and the Coordination of Long-Term Services, or CoLTS, program. She urged the subcommittee to make the MCOs accountable for all contracted services, including case management.

In general discussion, subcommittee members discussed the pros and cons of strengthening the oversight role of the legislature versus creating a health and human services oversight body similar to the Legislative Education Study Committee.

There being no further business, the subcommittee adjourned at 3:40 p.m.