

**MINUTES
of the
FIRST MEETING
of the
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE OF THE
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**August 19, 2011
Mesilla Valley Hospital, Las Cruces**

The first meeting of the Behavioral Health Services Subcommittee (BHSS) of the Legislative Health and Human Services Committee was called to order on August 19, 2011 at 10:07 a.m. at the Mesilla Valley Hospital in Las Cruces.

Present

Sen. Mary Kay Papen, Chair
Rep. Ray Begaye, Vice Chair
Rep. Dennis J. Kintigh
Sen. Bernadette M. Sanchez

Absent

Advisory Members

Sen. Sue Wilson Beffort
Sen. Dede Feldman
Rep. Miguel P. Garcia
Rep. Antonio Lujan

Guest Legislators

Rep. Zachary J. Cook
Sen. Howie C. Morales

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Lisa Sullivan, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Abenicio Baldonado, Intern, LCS
Greg Geisler, Legislative Finance Committee

Minutes Approval

These minutes have not been approved by the Behavioral Health Services Subcommittee as subcommittee members were not available for approval before the subcommittee finished its work for the interim.

Friday, August 19

Welcome

Brian Hemmart, chief executive officer, Mesilla Valley Hospital, welcomed the subcommittee and led a tour of the hospital.

Interagency Behavioral Health Purchasing Collaborative (IBHPC) Update: OptumHealth Contract Report

IBHPC director Linda Roebuck Homer introduced the IBHPC's new deputy director, Diana McWilliams, and informed the subcommittee that Ms. McWilliams has also taken on the role of monitor with respect to the ongoing corrective action plan (CAP) under which OptumHealth of New Mexico (OptumHealth) is operating. Alicia Smith and Associates, a contracting agency, used to be the state's monitor, but when it was hired for the Medicaid redesign project, it resigned as CAP monitor.

Ms. McWilliams greeted subcommittee members and informed them that she was a former legislator from the State of Delaware. She distributed a handout entitled "Presentation to the LHHS, Behavioral Health Services Subcommittee Behavioral Health Purchasing Collaborative Update" (Human Services Department (HSD) handout). Ms. McWilliams covered pages 1-18 of the handout. Ms. McWilliams agreed to provide to the subcommittee the tables of data in the handout in larger print.

Subcommittee members inquired about the data on page 10 of the HSD handout regarding turnaround time for claims payment and including information about claim denials. Since the HSD issued the CAP, OptumHealth has been playing 99% of its claims within 30 days to 60 days, according to Michael Evans, chief executive officer of OptumHealth. Mr. Evans stated that he did not know the rate and number of denial of claims, but he agreed to provide that information to the subcommittee later in the day. Subcommittee members also asked for the criteria for the denial of claims. Mr. Evans said the criteria include those "basic to the industry", "national standards" and "local standards". Mr. Evans further explained that there are clinical practice guidelines and medical necessity guidelines that cover OptumHealth's claims processing. The subcommittee requested information regarding the populations — gender, race, class, age — on which guidelines are based.

Subcommittee members asked the total dollar amount that OptumHealth receives in its role as the statewide behavioral health entity. The annual contract is for \$370 million to \$380 million, depending on Medicaid rolls. OptumHealth paid for the monitoring when Alicia Smith and Associates performed the monitor role, and it continues to do so now that Ms. McWilliams, a classified state employee, has assumed that role. A subcommittee member raised a concern regarding the independence of the monitor when OptumHealth was actually paying for her services.

Ms. Homer stated that OptumHealth spent \$330 million in fiscal year 2010 on direct services.

Harrison Kinney, director of the HSD's Behavioral Health Services Division, told the subcommittee that the HSD funds the Turquoise Lodge, a substance abuse treatment facility.

Subcommittee members asked why the state cannot get Medicaid funding for residential inpatient treatment at such places as Turquoise Lodge, Yucca Lodge and Mesilla Valley Hospital. Ms. Homer explained that states have been fighting the Centers for Medicare and Medicaid Services' institutional mental disease (IMD) exclusion rule since its inception 20 years ago. The IMD rule states that adults cannot be covered by Medicaid in an institution unless the majority of the care they receive is not behavioral health-related. Ms. Homer promised the subcommittee a brief describing the IMD issue.

Subcommittee members reviewed the HSD handout, which describes the number of claim denials over time. Upon request, Ms. McWilliams told the subcommittee members that she would send staff for the subcommittee a spreadsheet in color showing the dip in accurate claims for July 2011.

Mr. Evans said that the statewide entity contract requires OptumHealth to maintain a 3% or lower inaccurate or inappropriate denial rate under an audit. Marilyn Van Horn, chief operations officer of OptumHealth, stated that OptumHealth is contractually limited to no higher than 10% denials overall. Inappropriate denials must make up 3% or lower of these denials, she explained. "Inappropriate denial" means a provider submitted a claim accurately and OptumHealth inappropriately denied it. The percentage is not 10% of contract dollars; it means 10% of the total number of claims. Subcommittee members wondered what dollar amount was being denied. Subcommittee members wanted to know dollar amounts on services already provided but that the payer is denying, voicing concerns that behavioral health providers are losing money due to these denials.

Mr. Evans did not know how much it would cost a provider to appeal an OptumHealth denial. An appeal entails a peer-review process to get more information to see whether medical necessity criteria are met. OptumHealth has to issue its determination within two days of its receipt, Mr. Evans believes. The costs likely vary according to whether the provider is small or large. Subcommittee members asked Mr. Evans to provide data on the cost of appeals for providers. Subcommittee members stated that too many denials for small providers could put those providers out of business. Mr. Evans said OptumHealth wants to keep providers in business.

Subcommittee members wanted data on the claims appeals process as well as on administrative denials — how many per year, what kind of denials, dollar amount and actual denials, how many, what kind and whether providers whose claims are denied are small providers or large providers. A subcommittee member stated that OptumHealth should have that data or it would be neglecting its job. Ms. Van Horn stated that OptumHealth's estimate of the cost of processing a claim is \$25.00. Ms. Homer informed the subcommittee that the IBHPC has a lot of this information but has not yet compiled it. Ms. Homer said that the HSD and OptumHealth would provide all of that information that same day.

Ms. Homer provided an overview of the claims appeals process: a claim is made, and, if denied, OptumHealth requests more information. After receiving that information, OptumHealth has three days in which to issue a determination. A request for reconsideration may thereafter be filed with OptumHealth. Upon an unfavorable redetermination, the matter may then go before Ms. Homer at the IBHPC. Thereafter, it may go to the New Mexico Medical Review Association (NMMRA).

When asked about CAP sanctions against OptumHealth for its violations of the contract, Ms. Homer stated that no monetary fine had been assessed upon OptumHealth but that OptumHealth was required to pay 60% of denied claims. Forty percent of the claims were classified as "egregious" denials, requiring the NMMRA to do independent reviews of these. The authorization rate of reconsiderations is 20%. Subcommittee members asked whether interest was being paid on denials, and Mr. Evans said there was no interest paid.

Ms. Homer informed the subcommittee that in its first year as the statewide entity, OptumHealth was sanctioned \$1 million. When the IBHPC amended its contract with OptumHealth, OptumHealth volunteered to fund \$2 million in substance abuse treatment and suicide prevention in Native American and rural communities. Hence, OptumHealth paid out \$3 million at that time, plus the cost of the monitor and its information technology system reconfiguration.

Subcommittee members inquired whether smaller providers and rural providers with fewer administrative staff tend to experience a higher rate of denials, and they requested that the IBHPC provide that data.

Ms. Homer brought to the subcommittee's attention the information on pages 19 through 26 of the HSD handout about: (1) quality improvement goals; (2) performance measures; and (3) health homes.

Mr. Evans next gave his presentation. He distributed a handout entitled "An Overview Presentation" and presented information about OptumHealth's: (1) investment in Native American communities as well as telehealth; (2) value-added services; (3) community reinvestment; and (4) core service agencies.

A subcommittee member asked whether value-added services came out of OptumHealth's administrative losses or medical losses. Mr. Evans replied that value-added services are counted as administrative losses. In response to a question regarding the need for value-added services when core service agencies are supposed to provide comprehensive services, Mr. Evans stated that he thinks that the need for additional services may be attributed to geography.

Jim Ogle of the National Alliance for the Mentally Ill-New Mexico (NAMI) distributed two handouts as follows: (1) a list of concerns from the NAMI to the BHSS about OptumHealth's management of the statewide entity contract; and (2) a copy of a February 21, 2011 letter from the NAMI to Secretary of Human Services Sidonie Squier. Mr. Ogle addressed

the subcommittee about the information in the NAMI handouts. The subcommittee asked OptumHealth to provide within 10 days a written response to the NAMI's concerns as listed in the first NAMI handout.

Subcommittee members expressed the concern that OptumHealth should pay providers interest on reversals of denials of claims. They referred to paragraph 3 of the NAMI's February 2011 letter to Secretary Squier saying that denial of claims results in an extensive loss of revenue to providers, causing many to begin the process of laying off employees and reducing services. The subcommittee discussed writing a letter to request from the HSD's counsel an opinion on whether OptumHealth could be forced to pay interest on denied claims and through adjudication found to have been wrongly denied. Ms. Homer stated that she would request from the HSD's general counsel an opinion in this regard.

Subcommittee members also brought up the statement in the NAMI's list of concerns that OptumHealth had failed to execute its promise in the request for proposals (RFP) to implement crisis response teams throughout the state. These teams are instrumental in protecting individuals living with mental illness from inappropriately entering the criminal justice system. Mr. Evans said he would respond to each of the NAMI's points.

The subcommittee considered the question as to how widespread it is that people living with mental illness get taken to jail inappropriately. Ron Gurley, executive director of the Doña Ana County Forensic Intervention Consortium, a jail diversion program for mentally ill individuals, addressed the subcommittee and stated that the lack of inpatient beds for mental health patients means that mentally ill people often go to jail as an alternative when behavioral health facilities have reached their very limited capacities. Mr. Gurley articulated a need for more mental health courts, pretrial services and diversion to mental health facilities. He stated that Doña Ana County has about 300 beds. Bernalillo County Jail has more than 700 inmates on anti-psychotic drugs. The average stay for individuals living with mental illness in jail is more than 300 days. Mr. Gurley stated that there should be crisis response teams in emergency rooms to divert the people who are there because of mental illness episodes to mental illness treatment facilities.

A motion was made, which was seconded and which the subcommittee then approved. As first stated, the motion was to request that Mr. Evans respond regarding his opinion on OptumHealth's contractual obligations to fund a crisis response team and a request that the IBHPC meet as soon as possible with Mr. Evans to resolve issues from the past and establish what future actions can occur. Mr. Hely requested clarification as to the motion's content. The subcommittee members clarified that the motion was for Mr. Hely to write to the IBHPC and the HSD's general counsel on behalf of the subcommittee and request issue of a legal opinion as to whether:

- interest is due to the providers whose claims were the subject of a recent settlement between OptumHealth and the IBHPC;

- monetary sanctions should be imposed upon OptumHealth for its improperly denied claims; and
- the IBHPC may be required to fund a crisis response team to assist law enforcement in properly working with individuals living with mental illness who are having symptomatic episodes.

Another motion was made, seconded and approved by the subcommittee to direct Mr. Hely to draft a letter on behalf of the subcommittee to Secretary Squier requesting that she respond to each point in the February 21, 2011 NAMI letter.

Becky Beckett, advocate and family member of a behavioral health services recipient, stated that there is more to mental health services than giving medications, and services cannot be cut. Upon request, Ms. Beckett provided the subcommittee with copies of 15 letters from behavioral health services consumers addressing their concerns with OptumHealth and cuts to behavioral health services. In some ways, Ms. Beckett explained, OptumHealth was helpful in that it was quick to help get her daughter's new prescription filled. On the other hand, the paperwork burdens imposed by OptumHealth have not been helpful. Her daughter's providers insisted that she use the time set aside for her therapy session to fill out paperwork for OptumHealth reimbursement, and Ms. Beckett's daughter had to leave without receiving therapy services.

A subcommittee member asked how widespread it is for mentally ill people to be jailed for behavioral health-related incidents. Mr. Ogle responded that 5% to 6% of incarcerated individuals have a mental illness; in Albuquerque, it is closer to 30% of prisoners. Roswell has a new mentally ill prisoner incarcerated each day.

Mr. Gurley stated that the problem of inadequate behavioral health service availability in the state is "compounding itself". There is a drastic shortage of beds for residential or inpatient treatment. He suggested that the federal government may end up running the state's behavioral health system if things do not improve.

Ms. Beckett informed the subcommittee of her opinion that there are not enough core service agencies to serve the state's population of people living with serious mental illness. She explained that, when it is not convenient — *i.e.*, patients are geographically dispersed — individuals will not seek out the core service agencies; they will just go without the services they need.

Ms. Beckett produced a packet of letters to Governor Martinez. The subcommittee passed a motion to make the letters part of the minutes. (See attached.)

RFP for Statewide Behavioral Health Entity; IBHPC Pilot Project

Roque Garcia distributed a handout that included HB 432 (2011 regular session), an article abstract entitled "U.S. Physician Practices Versus Canadians: Spending Nearly Four

Times as Much Money Interacting With Payer", a flow chart of funding for behavioral health and a flow chart of regionalization.

David Hedgcock, executive director of Providence of Arizona, Inc., stated that his entity is based on prevention and its fiscal setup provides incentives to keep people out of the "system". Subcommittee members questioned the value of returning some children to harmful home environments where they will not get the same quality of care as in a residential treatment facility. Mr. Hedgcock stated that the pilot project model promotes regional community solutions. Ms. Beckett stated that she agrees with the regional community approach.

Ms. Homer distributed a handout entitled "RFP for the Statewide Entity", which lists time lines for the statewide behavioral health entity contract. She also distributed a handout from the New Mexico Behavioral Health Expert Panel, dated August 15, 2011, entitled "White Paper Draft". Ms. Homer told the subcommittee that in a few weeks, she would be able to provide an update to the subcommittee about the RFP for a behavioral health statewide entity and Medicaid modernization.

A subcommittee member inquired whether the RFP would include the sharing of risk between providers and a managed care entity. Ms. Homer stated that it could.

A question was asked of Mr. Hedgcock as to whether Providence of Arizona's operations were certified by the National Committee on Quality Assurance as an accountable care organization. He informed the subcommittee that they were not.

A subcommittee member asked whether the behavioral health pilot project would use quality measures to assess the project. Mr. Garcia responded that it would. He went on to explain that administration and profit should be capped at 10%. Providence of Arizona's operations in Tuscon have a ratio of administration and profit to medical loss of 10.5% to 89.5%.

Mr. Garcia stated that the pilot project could be operated statewide, but he believes that the state should have regionalized care.

When asked whether small providers would be part of the pilot project, Mr. Hedgcock responded that Providence of Arizona subcontracts with small providers in the amount of \$180 million per year.

Opioid Addiction Treatment and Payment

Eugene Marciniak, M.D., Region 5 health officer of the Department of Health (DOH), distributed the following handouts: (1) "Medication Assisted Therapy (MAT) for Opiate Addicted Persons at Public Health in New Mexico"; and (2) "Behavioral Health Services Subcommittee 08.19.11: Opioid Addiction Treatment in Public Health". At the DOH, the attitude is to treat opioid addiction as a chronic physical health condition.

Opioid Addiction and Drug Policy

William Wiese, M.D., M.P.H., director of the Institute of Public Health at the University of New Mexico Health Sciences Center, distributed two handouts as follows: (1) "SM 18 New Mexico Drug Policy Task Force Report to Behavioral Health Services Subcommittee"; and (2) the "Fall, 2010 Interim Report on Senate Memorial 33 by the Drug Policy Task Force".

Dr. Wiese presented on the drug policy task force that was continued under SM 18 (2011 regular session), which was an extension of SM 33 (2010 regular session). He introduced Harrison Silver, M.D., with whom he has been working.

Dr. Wiese informed the subcommittee that Jennifer Weiss, a member of the task force, lost her son last weekend from a heroin addiction. She had access to early intervention measures, but there were impediments to insurance coverage. In addition, private insurance does not cover residential substance abuse treatment facilities.

According to Dr. Wiese, approximately 3.2% of New Mexican high schoolers use heroin, which Dr. Wiese characterized as an "epidemic". Eighty-five percent of prisoners in the state have a substance abuse problem, yet the ratio is one substance abuse treatment professional to every 113 prisoners. It is estimated that 5% of the high school students in Bernalillo County alone have used heroin in the last 30 days.

Dr. Wiese said that the risk of relapse continues after recovery. Most people with an addiction do not get treated as though they have a disease, they get treated as though they exhibit bad behavior. Current treatment approach is misdirected, according to Dr. Wiese. A large proportion has a concurrent medical condition that underlies the addiction and probably contributes to the addiction. People with addictions are punished and stigmatized, which exacerbates their avoidance of measures to treat the addiction. In addition, society has an enabling culture that glamorizes substance abuse.

Last year in the state, more people died of unintentional prescription drug overdoses than heroin overdoses. Dr. Wiese suggested that legislation may be in order to address this problem. All harm reduction programs need to be funded. It is critical that primary care be a critical part of providing substance abuse treatment needs, since the state has a dearth of behavioral health care providers and an uneven distribution of them across the state.

Dr. Wiese stated that incarceration exacerbates addiction problems. The cost-benefit ratio for prevention or treatment is huge with school-based and community-based prevention programs: for every dollar, the "payback" is \$25.00 to \$30.00. According to data from the federal Substance Abuse and Mental Health Services Administration, the payback for substance abuse treatment is \$7.00 to \$8.00.

In general, private insurance will not pay for residential substance abuse treatment, also known as "rehab", which takes about 20 to 30 days. Inpatient coverage for a three- or four-day stay in the hospital or outpatient treatment is usually all that is covered.

A subcommittee member stated that she would like to see the DOH educate the public on heroin addiction.

Dr. Wiese emphasized to the subcommittee that early school-based interventions are helpful and cost-effective.

The need for Project ECHO to be used in substance abuse treatment was emphasized by a subcommittee member, who pointed out that it was "short-sighted" to cut Project ECHO funds and try to handle its needs solely through grants.

A subcommittee member reminded the subcommittee and audience that Medicaid is an entitlement program, and prisoners should get fee-for-service substance abuse treatment services.

Other subcommittee members pointed out:

- the need for a comprehensive database to track substance abuse statistics;
- the need for post-prison, reintegration substance abuse treatment supports;
- the role that individual choice plays in substance abuse; and
- that people do not go to prison for simple possession of illegal substances; that parole violations, multiple offenses and psychological evaluations are usually co-occurring.

Public Comment

Rachel Madewell identified herself as a "small provider" and thanked the subcommittee for asking "hard questions". She stated that it is difficult to survive in the current climate and that small providers such as she are being "pushed out".

Maggie McGowan spoke about IMD hospitals, which cannot get reimbursement for adult Medicaid recipients. She hopes that the state can show the impact of this, considering how few adults are on Medicaid.

Mr. Gurley stated that a "tremendous number" of people end up in jail because of substance addiction, and this is costly for communities. The new RFP for the statewide behavioral health entity should consider "all options" for addressing this issue.

Mila Mansaram, the vocational program director for the Community Outreach Program for the Deaf, wants OptumHealth to be reappointed as the statewide entity after the reissuance of the RFP. OptumHealth, she explained, has been good at providing services to deaf, hard-of-hearing and deaf and blind individuals who had been long awaiting appropriate services. These populations are "seriously at risk" because of inadequate services.

Linda Mondy stated that she is afraid there will no longer be behavioral health services available in many places because of inadequate reimbursement to providers. Due to time constraints, Ms. Mondy stated that she would follow up with written comments that she will direct to the subcommittee.

The meeting adjourned at 6:00 p.m.

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