MINUTES
of the
SECOND MEETING
of the
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE

September 7, 2012
University of New Mexico Science and Technology Building Rotunda
Albuquerque

The second meeting of the Behavioral Health Services Subcommittee was called to order by Representative Ray Begaye, chair, on September 7, 2012 at 8:10 a.m. in the rotunda of the University of New Mexico (UNM) Science and Technology Building in Albuquerque.

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

Advisory Members

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

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

Guest Legislators
Rep. James Roger Madalena
Sen. Howie C. Morales

Guests
Additional guests are included on the guest list in the meeting file.

Handouts
Handouts and other written testimony are in the meeting file.

<u>Friday, September 7</u>

Welcome
UNM President Robert G. Frank, Ph.D., welcomed the subcommittee to the university and to the Science and Technology Center Campus, which he described as both a research center and technology incubator that is overseen by its own board of directors. He mentioned his past

experience establishing colleges of public health in Ohio and Florida, and he urged the subcommittee to work toward creating a New Mexico college of public health as a collaborative entity across the higher education institutions in the state. Dr. Frank introduced Lydia Ashanin, who handles his executive communications; staff members of the UNM Office of Government Relations, including Marc Saavedra, Tanya Giddings, Renee Santillanes and Matt Munoz; and UNM contract lobbyist Joe Thompson.

Four Quadrant Clinical Intervention Model for Integrated Behavioral Health and Primary Care

Steven Adelsheim, M.D., director of the UNM Center for Rural and Community Behavioral Health (CRCBH), gave a presentation on the work of the Behavioral Health Expert Panel convened by the Consortium for Behavioral Health Training and Research. The panel met during 2011 and 2012 to consider a model of integrated care for New Mexico and centered its discussions on a four-quadrant model of clinical integration that rates patient needs in both physical and behavioral health.

Panel members voiced the strongest support for a hybrid carve-in structure over both the total carve-in model used in the 1990s — in which there was no clear way to track behavioral health dollars — and the total carve-out model used today — in which health information cannot easily be shared across the physical health/behavioral health divide. The panel concluded that a greater percentage of behavioral health dollars should be spent on direct services than is currently the case and that the funding should be tracked and administered separately. There was support on the panel for local or regional governance as well as for a nonprofit, in conjunction with a state agency, to manage the state's behavioral health care system. In addition, the panel felt that the roles of all entities involved, including the Interagency Behavioral Health Purchasing Collaborative (IBHPC), the Behavioral Health Planning Council and local entities, must be clearly delineated. The panel concluded that there should be an increased focus on behavioral health services for children, with expanded early intervention programs; flexibility within the system to address the state's geography and its racial and ethnic diversity; strong efforts to reduce the stigma of behavioral health issues; and greater integration with the education system, tribes and tribal systems, the criminal and juvenile justice systems and jail diversion programs. The panel submitted its final recommendations to the Human Services Department (HSD), but Dr. Adelsheim could not say how the recommendations are addressed in the request for proposals for Centennial Care.

On questioning, Dr. Adelsheim, subcommittee members and Diana McWilliams, IBHPC acting chief executive officer and acting director of the Behavioral Health Services Division of the HSD, addressed the following concerns and topics.

Panel meetings. All of the panel's meetings were held in Albuquerque, with travel costs paid by the state. Members were not allowed to appoint designees.

Treatment compliance. The panel did not focus on treatment compliance but did note the need for better cooperation and referral systems within the juvenile and criminal justice systems.

Substance abuse. Research shows a high rate of psychological disturbance in long-term marijuana users, such as those who begin in adolescence. There is now an inpatient substance abuse treatment unit at Turquoise Lodge, the Department of Health detoxification and rehabilitation facility in Albuquerque. Co-occurring disorders are mentioned in the Centennial Care waiver, with substance abuse screening integrated into primary care.

Centennial Care waiver. The HSD intends to track and monitor behavioral health spending under the waiver. Non-Medicaid dollars, such as block grants, will continue to go to services for their targeted populations and will not be managed by the managed care organizations (MCOs). Psychotropic drugs are exempt from the formulary; generics will not be used if care would be compromised. The HSD held public meetings on the proposed waiver for more than a year, and, according to the HSD, the input was incorporated into the waiver. The waiver was drafted with the proposed expansion of Medicaid in mind.

IBHPC. The IBHPC meets quarterly and is focused on coordinating, rather than duplicating, efforts across agencies. It is also working to establish a statewide standard of care, common screening tools and protocols.

Medical homes and behavioral health homes. The IBHPC created core service agencies (CSAs) that meet the Centers for Medicare and Medicaid (CMS) definition for medical homes, with the limitation that the CSAs cannot turn someone away due to severity. The HSD application for behavioral health homes is on hold at the CMS pending further provider input.

Tribal involvement. Tribes need to have input into the waiver design and also be considered providers under the waiver. Some tribes, such as the Pueblo of Jemez, have their own health care systems.

★ Ms. McWilliams will provide the subcommittee with:

(1) a map that shows where substance abuse facilities and services are available in the state;

(2) the fiscal year 2014 budget for behavioral health services across agencies; and

(3) the budget for the Centennial Care waiver.

★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the Legislative Health and Human Services Committee (LHHS) to eliminate the IBHPC.

Behavioral Health Care for the Chronically Mentally Ill, Now and Under Centennial Care

Patsy Romero, state president of the National Alliance for the Mentally Ill (NAMI), opened her presentation by noting that Senator Papen had received the 2012 State Legislator of the Year Award from the American Psychological Association Practice Organization for her work supporting behavioral health and public awareness. Ms. Romero then gave an overview of the state's three Medicaid transitions in the past 13 years and noted the impacts these have had on behavioral health services patients and providers. Ms. Romero noted that each of the previous models had problems that were addressed, with varying degrees of success in each subsequent

model. She stressed her concern that the Centennial Care waiver application only mentions behavioral health twice and that it is critical to include stakeholders in the system design to avoid problems seen in the past. She urged the subcommittee to push for a system that provides access to the same services across all health plans; includes detailed, enforceable contracts; links physical health providers with behavioral health providers; gives Medicaid recipients real information on services and costs; expands available services in rural areas; and includes a statewide system of crisis response teams.

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

Credentialing. If there are five MCOs under Centennial Care, providers will have to be credentialed by five entities. It would be better to establish a single, statewide credentialing entity, with all MCOs required to accept providers credentialed by that entity.

Stakeholder input. Input from families and patients, not just providers, is important for the Centennial Care waiver.

Payments and administrative costs. When provider payments are delayed or overpaid, providers are unable to get the unqualified audits required when pursuing grant funding. Administrative costs for behavioral health services providers will be higher under Centennial Care because there will be multiple MCOs, and this will leave less money for direct care.

Serious emotional disturbance (SED). Each provider conducts its own test for SED. Patients who are disturbed but do not meet a provider's criteria for SED must get services through a CSA, though that would not include short-term stand-alone case management services.

Work force and provider issues. There are not enough psychiatrists and psychiatric nurses to meet the demand for services under Centennial Care. Ninety-five percent of the state's psychiatrists are in the Albuquerque area, and patients in rural areas must either travel or go without services. Comprehensive care coordination can be done by paraprofessionals rather than registered nurses or physicians. The Legislative Finance Committee could consider expansion of health care professions programs at the state's universities.

Integrated care. Patient-centered health care systems that integrate physical and behavioral health, such as Project Hope and an accountable care collaborative in northern New Mexico, make it possible to easily share information among providers.

★ Senator Morales suggested that the subcommittee advocate for the inclusion of crisis response teams in Centennial Care.

★ Ms. Romero will provide a list of NAMI's concerns about Centennial Care prior to the next legislative session.

Monitoring the Delivery of Behavioral Health Services

Howard Dichter, M.D., gave a presentation on the Early Warning Rapid Management Program (EWP), a tool for highlighting problems in Medicaid managed care systems that has been implemented in Pennsylvania, Oklahoma, Wisconsin and the District of Columbia. By collecting data sorted by subgroups such as MCOs, providers and regions, and by reporting data within three months following collection, the EWP allows states to quickly respond to problems, such as delays in provider payments or complaints about a provider's services. It also gives trend and effectiveness portraits, such as whether substance abuse patients in community living, outpatient, residential or detoxification settings continue their treatment over time. In addition to helping states evaluate and improve their managed care systems, the EWP helps providers improve as well by allowing them to compare themselves to other providers within the system.

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

Substance abuse detoxification and treatment. Based on EWP data, the most effective substance abuse treatment setting is community living with multiple levels of care provided by a single agency, beginning with detoxification. In Oklahoma, the value of medical detoxification is now in question; it strains emergency rooms and takes up beds, and very few patients go on into treatment. Data indicate that a more effective approach would be to provide detoxification services in a medical facility that also houses personnel from a community mental health agency offering continued treatment after release.

Complaints and surveys. Pennsylvania's Medicaid system includes a review committee that meets quarterly to address complaints, and the committee includes a subcommittee on behavioral health. The committee includes results from consumer and provider surveys in its quarterly reports, which are available to the public.

Data collection and accessibility. New Mexico needs to collect data about its Medicaid managed care system and make data accessible to the public and the advocacy community. Data should not be collected by the MCOs but, rather, by an independent entity.

State hospital admissions. The EWP can look at data on how many patients who are transported by county sheriffs to the state hospital for a three-day stay subsequently receive services within seven days of release.

★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the LHHS to require that Medicaid data be collected and made available to the public and to require that the data be reported to the legislature.

Minutes

On a motion by Senator Papen, seconded by Senator Ortiz y Pino, the minutes for the August 16, 2012 meeting of the subcommittee were adopted without objection.

Native American Suicide Prevention and Report on Statewide Clearinghouse for Native

American Suicide Prevention (Senate Bill 417)

Doreen Bird, community-based participatory research specialist, and Utahna Belone, Americorp Vista leader, both with the CRCBH, gave a presentation on Native American suicide prevention efforts and the statewide clearinghouse created pursuant to Senate Bill 417 of the 2011 regular legislative session. The clearinghouse is located in the CRCBH and received its initial operational funding in fiscal year 2013. To date, the clearinghouse staff has held collaboration meetings with several tribal entities and is planning initiatives around the state to provide culturally appropriate behavioral health training; data management assistance for tribes; grant-writing assistance; and outreach that addresses cultural stigma about suicide and promotes an awareness of warning signs. Data reported by the Department of Health show the 2011 rate of Native American youth suicides at 35 per 100,000 population of youth ages 15-24, and, for this reason, clearinghouse efforts will include a strong focus on youth.

On questioning from subcommittee members, the presenters, along with Dr. Adelsheim and Chris Fore, Ph.D., director of the Indian Health Service (IHS) Tele-Behavioral Health Center of Excellence, addressed concerns about funding for local suicide prevention programs. Tribal communities can get suicide prevention grants through the IHS Methamphetamine and Suicide Prevention Initiative. There are also Garrett Lee Smith grants available to all communities through the federal Substance Abuse and Mental Health Services Administration.

★ Senator Ortiz y Pino suggested that the subcommittee recommend legislation to the LHHS setting aside suicide prevention program funding that is not braided into physical health care funding in Centennial Care.

IHS Perspective on Behavioral Health Services Under Centennial Care and Telehealth for Behavioral Health

Dr. Fore and Avron Kriechman, M.D., assistant professor of psychiatry in the UNM School of Medicine and professor in the New Mexico Highlands University School of Social Work, gave a combined presentation on IHS concerns about Centennial Care and about providing behavioral health services via a telehealth network.

Given the shortage of behavioral health providers in the IHS system, the majority of behavioral health services are provided by those trained in physical health. In a recent survey, all IHS physical health providers reported treating behavioral health cases. In the Albuquerque area, IHS behavioral health services are funded at only 48 percent of need, and because it is a line item in the overall IHS budget, it is often left out of funding increases that go to other parts of the budget.

Tribes did not have real input into the Centennial Care waiver application. The HSD did not consult with tribes, and even after tribes submitted written and verbal concerns regarding behavioral health services under Centennial Care, their concerns were not included in the "Concerns" section of the final waiver application. One major issue is that Native Americans in the state will be automatically enrolled in MCOs under Centennial Care, even though 80 percent are currently opted out of Medicaid because they receive care through the IHS. There is also no

retroactive or presumptive eligibility to cover times when eligibility may lapse. Even though the IHS can apply for reimbursement for services provided, getting paid is another matter: OptumHealth did not reimburse the IHS until directed to do so by the state, and OptumHealth is still $900,000 in arrears for invoices dating back to 2010. Tribes are concerned that a requirement for timely and accurate payments does not appear as a criterion in the Centennial Care MCO selection process. They are also concerned that there is no acknowledgment of language or cultural barriers and that unrealistic requirements are included; for example, MCOs are required to make quarterly visits or monthly phone calls to the mentally ill, but many Native Americans live in extremely remote areas or have no telephones.

The UNM Telepsychiatry Program was created to help provide services in remote areas, with health care providers, educators and family members in more than 80 rural communities participating to date. The video- and phone-conferencing program, which works in partnership with Project ECHO, aims to develop local capacity for behavioral health services through a combination of direct psychiatric services, consultation, training and supervision. Trainers include not only psychiatrists but also psychologists, nurses, social workers, counselors, anthropologists, epidemiologists, sociologists and clinical researchers.

The IHS Tele-Behavioral Health Center of Excellence, which is based in Albuquerque, provides services to tribal communities nationwide and helps tribes to get their own telehealth programs in place. Recent research has shown a better client response for tele-behavioral health services than for services provided in person: the no-show rate for tele-behavioral health appointments was 10 percent while the no-show rate for in-person appointments was 35 percent. Of the clients who received tele-behavioral health services, 94 percent reported they would have gone without services entirely had the tele-behavioral health system not been in place. The system saved the IHS $75,000 in 2011 in provider driving costs, and 2012 data show contact with patients has increased 171 percent over the previous year. The presenters urged the subcommittee to consider appropriating funds to upgrade telephone and internet capabilities in tribal communities that still lack the infrastructure to participate in the tele-behavioral health system.

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

Treatment foster care (TFC). Some in the TFC community are concerned that children need in-person contact rather than tele-behavioral health services. Many Native American TFC children are sent to non-tribal families and communities because the state requires a TFC child to have his or her own bedroom; in addition, the lack of internet connectivity in many Native American homes precludes provision of TFC services via the tele-behavioral health system. The center for excellence does not emphasize tele-behavioral health services as a replacement for in-person services but only to supplement care and to facilitate information-sharing among professionals working with a patient.

Telehealth systems. Five Sandoval Indian Pueblos, Incorporated, has a telehealth system

in place; the Pueblo of Jemez has telehealth equipment but is not using it. Alaska has a strong telehealth system that reaches communities throughout the state and is culturally appropriate, and telehealth services are reimbursed under the state's Medicaid program at the same rate as in-person services. Legislators need training on telehealth systems prior to passing telehealth-related legislation.

Opt in, opt out. Under the federal Patient Protection and Affordable Care Act, Native Americans who choose to opt out of managed care will not be penalized because the IHS is considered their provider. Under Centennial Care, all Native Americans will be automatically assigned to an MCO and must actively opt out.

On invitation of the chair, Ms. McWilliams clarified that OptumHealth does pay interest to providers on avoidable late payments effective to the date when full information to process the claims is received. Fines on those late payments, however, are paid to the state, not the provider.

On invitation of the chair, Maria Clarke, health and human services director at the Pueblo of Jemez, elaborated on potential problems in Centennial Care's automatic MCO enrollment for Native Americans, saying that tribal clinics such as the one at the Pueblo of Jemez will not know where patients have been assigned, and the reimbursement process will be seriously hampered. In addition, different members in one family may be assigned to different MCOs. The Pueblo of Jemez has requested a consultation with the CMS and has been told that the agency is looking closely at New Mexico's waiver application in part because of concerns raised by tribes.

Michael Hely, LCS staff attorney, advised the subcommittee that the HSD is seeking to exclude three-month retroactive eligibility for Native Americans in the Centennial Care waiver.

★ Dr. Fore will provide a copy of the IHS concerns regarding Centennial Care that were submitted to the HSD.

★ Senator Ortiz y Pino proposed that the subcommittee suggest to the LHHS that it send a letter to the CMS urging it to disapprove the Centennial Care waiver application.

Early Intervention and Resources

Dr. Adelsheim gave a presentation on early intervention programs for identifying mental illness in children, informing the public about mental illness and changing how communities address the issue. Three-fourths of lifetime mental illnesses manifest themselves prior to age 24, and half of them show up by age 14. Mental illness currently costs U.S. families $247 million annually, and it is projected to be the leading cause of disability in the world by 2020. Implementing an early intervention program in New Mexico that reaches every child in the state would cost only $800,000 a year.

The Massachusetts Child Psychiatry Access Project (MCPAP), which is funded through the state's Medicaid program, works to help primary care providers identify and address childhood psychiatric problems in the no-stigma setting of a primary care clinic. The program supports primary care providers with telephone consultations, patient visits within a week of

referral and assessment results within 24 hours of a visit. Dr. Adelsheim recommended the MCPAP as a model for New Mexico to adopt, in addition to its current Early Intervention and Resources Linking Youth (EARLY) Program. The EARLY Program focuses on identifying childhood psychosis, which is treatable and of a much shorter duration if caught early. New Mexico also participates in the Recovery After an Initial Schizophrenia Episode, or RAISE, Program created by the National Institute of Mental Health.

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

Diagnoses and triggers. Schizophrenia can be diagnosed prior to age 18, though some psychiatrists will only label the patient as having "traits". Some mental illnesses are genetic and some are prenatal, as suggested by recent research finding an increased incidence of autism and schizophrenia in children with older fathers. Childhood schizophrenia is extremely rare.

Drug use. Because the brain continues to develop into the early twenties, the use of any drugs, illegal or prescribed, can affect its development.

Screening. The MCPAP was developed because Massachusetts was sued over a lack of mental illness screening in its Medicaid Early Periodic Screening, Diagnosis and Treatment Program. Such screening should be part of school-based health programs and the juvenile justice system as well. Prior to an initial visit, school-based health clinics are required to give teens a health survey that includes substance abuse screening questions. Medical students do coursework and a rotation in psychiatry, but primary care providers need more training than that, especially training in how to ask about mental health issues.

Residential treatment. Some feel that residential treatment outside the home should be reinstated because leaving a child in the home leaves the child in the problem; others point to a lack of evidence that residential treatment is effective because the child's support system disappears when the child is released.

Medication. Psychiatrists are under pressure to find short, quick solutions, and overmedication can be a problem. Sometimes children are put on medication because a teacher is overwhelmed in the classroom.

Early Detection and Intervention for the Prevention of Psychosis (EDIPP) Program. New Mexico's EARLY Program falls within the EDIPP Program funded by the Robert Wood Johnson Foundation. New Mexico now has a psychosis clinic for early assessments but no funding stream to keep it going. Other states use a combination of state and federal funding for their programs, and New Mexico's Medicaid system could be structured to provide the necessary funding. There is no way to know definitively whether early intervention prevents mental illness or whether the person would have recovered anyway.

★ Ms. McWilliams will provide the subcommittee with:

(1) mental health assessments required under Centennial Care; and
(2) information on behavioral health per capita spending in all states.

★ Dr. Adelsheim will provide the subcommittee with information on California Proposition 63, which imposes a tax on high-income residents and earmarks the funds for early intervention programs.

★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the LHHS to create and fund a program in New Mexico similar to the MCPAP.

Public Comment

Ms. Clarke and Dave Panana, nurse manager at the Pueblo of Jemez health clinic, urged the subcommittee to advocate for directing the per-member-per-month funding for their clinic's clients to the clinic rather than sending it to the MCOs under Centennial Care. They felt that the clinic provides better case management and better, more culturally appropriate services to its clients than the MCOs will provide.

On invitation of the chair, Ms. McWilliams stated that tribes can be designated as CSAs under Centennial Care.

★ Ms. McWilliams will provide the subcommittee with information on whether tribes qualify as CSAs under Public Law 638, the Indian Self-Determination and Education Assistance Act.

★ Senator Rodriguez will advocate for tribes to be designated as CSAs.

There being no further business, the subcommittee adjourned at 4:20 p.m.