Senate Memorial 30 Task Force Meeting

Tuesday July 11, 2023

Meeting Notes

Attendees:

In Person:

Lisa

Margo

Dr. Davin Quinn

Dr. Bill Shuttleworth

Remote

Dr. Austin Davis (UNMH)

Morgan Chavez (BCBS)

Brooke Parrish (BCBS)

Dr. Baindu Akinrotiba

Dr. Mark Pedrotty

Arya Lamb (DOH)

Crystal Cantu (DHHS)

Cass Brulotte (Insurance Commissioner)

Martha Quintana (APS)

Victoria Herrerra (DHHS)

Cyndi Archuleta (NM Schools Insurance)

Discussion:

1. Requiring Health Insurance Coverage

People are falling out of the system, not seeing scripts for inpatient or outpatient rehab.

The Brain Injury Alliance of New Mexico gets people who come to support groups after 10 years of no help or treatment

Sometimes patients may have received rehab, and then plateaued and they think there will be no further help available for them.

Primary care physicians often don’t understand rehab – the patient has to be prepared to advocate for themselves.

For example, PCPs may have an incorrect assumption about what Speech and Language Pathology can do for brain injured patient, or they patient may not be able to return to work so there is a false assumption that OT wouldn’t be needed.

The Brain Injury Alliance of NM spends an enormous amount of time trying to help the brain injured advocate for themselves because there is an absence of assistance a dvocating for them individually.

Health Insurance Coverage for what?

There’s an incomplete and fragmented continuum of care in NM.

Acute care is strong, but downstream is fragmented or missing entirely.

This means NM is often sending patients to other states (AZ and TX) for care. They then come back to NM when they are discharged from inpatient care and there’s very little outpatient care available.

Need to be able to train a larger brain injury care network

Then it will be important for patients to be able to go back and access care when they need it. This can happen even 10 years or more after they last received behavioral therapy for example. Day programs/half-day programs for these patients is important.

Support for navigators, community navigators, is also important as it is hard for the brain injured patient to find and utilize the options that are available.

So, having required health insurance coverage for Brain Injury is necessary, but many pieces do not exist here in NM, so we need to also make sure those are provided.

Current Insurance Coverage

Three levels of insurance coverage

1. Medicaid
2. Commercial / Private Insurance
3. Federally Regulated Insurance (Medicare, VA, Arisa)

The state can mandate coverage for Medicaid (#1) and has some authority over the private insurance (32). But for #2 it has to be careful, because if they expand the requirements into mandating coverage, the state may be required to reimburse the insurance companies for that mandated coverage. The state has no authority over coverage provided under #3.

\*\*But the essential health benefits wording in the Affordable Care Act has been interpreted to include rehab – could this be expanded into rehab for brain injury treatment.

DOH and the Developmental Disability Waiver through Medicaid

The DD Waiver doesn’t adequately serve (nor describe) the Brain Injured population.

It has been used to help some of the brain injured population, but it isn’t a good solution

There is also an epidemiological need for identifying the prevalence of TBI in NM.

And the preponderance of TBI in the criminal justice system warrants more attention be focused on brain injury by the state.

Comparable State Review

NM is not the first state to try and deal with Brain Injury. Other states have created systems of care that we should be reviewing and learning from.

Dr. David Arciniegas has been involved with other state systems that have set up funding for universal coverage.

Looking back at the three types of Insurance Coverage, it is the Medicaid population that usually has the most need for services, navigation, and support.

\*However, they may not be enrolled in Medicaid or have any private insurance prior

\*\*And the level of family support in this population can vary. If they don’t have support, then they stay in the hospitals or rehab centers for months or even years because they can’t be discharged.

There are also potentially comparable treatment structures for Autism and psychiatric disorders that could be reviewed and learned from.

Mental Health Parity Bill – requires commercial insurance to cover mental health services at the same level as physical health \*\*Not implemented yet.

NM is a prior approval state – so private insurers have to submit their policies for review and only the plans that are approved can be sold in the state. So, the insurers’ plans will have to be pre-approved for covering behavioral health.

Lisa knows an attorney with CYFD who may have some familiarity, and she will reach out to them.

Medicaid – will be in HSD hands. Crystal can get us additional information.

Barriers from HSD/ Medicaid perspective: patients have retirement plans or work history so they end up applying for SSD and they get that benefit and then get kicked out of Medicaid.

The size of need is so big – in one year alone Crystal served 1,000 New Mexicans trying to access the system.

Capturing the whole of the community, and especially those with late onset disability, is tough. Navigating the system alone is even harder for them.

Case Managers

Not really covered, but Medicaid can cover community support workers.

Need Case Managers who can work with and direct among a large team of people/providers.

PCPs are not doing this work.

Jason will pull CO and KS info. Margot is speaking with Gavin from the national Brain Injury Alliance soon as well.

Certified Brain Injury Specialist (CBIS) training should be promoted. There is also a fundamentals training.

Could provide a training with outreach via the Project ECHO model.

\*\*Drs. Pedrotty and Davis do a training with ARCA already to better equip providers in rural offices.

Lovelace is trying to do more CBIS trainings – one every other month. The trainings are free, but the cost for the test is $300.

Dr. Pedrotty has made 3 video trainings as well.

1 – Front line staff training

2 – Health providers training

3 – First responders training

They are also making a podcast and holding 60-90 min ECHO training sessions

Veronica with HSD -

A need for working with therapists, housing services, and setting up a certification for peer support workers.

Supportive housing – in Gallup there is a transitional housing example that may be a good guide.

\*One barrier with some housing options and unhoused shelters is they require the patient to be independent so brain injured populations often require some ADL support.

If the patient doesn’t have family support, the may not get into inpatient rehab because they won’t be dischargeable.

* + - The ABQ Opportunity Center is a discharge destination, but the brain injured population doesn’t do well there.

Step Down Services are Needed

ARCA’s rehab model is based on a medical model.

Applied in the DD population regularly

Rehab is different so finding the sweet spot for continuity of care is crucial

Report Needs:

From the Study Discussions List, the report should include the following:

1. Comprehensive Neuro-rehab Center – if there is a physical injury rehab is available. But if they have emotional or mood based cases, then they don’t get admitted. Cognitive/emotional problems are harder to justify care. What are the conditions for setting up a Neuro-rehab Center here?

\*is the feasability of setting that up in NM harder?

\*Dr. Davis, Lovelace is interested in trying to set this up. Inviting Lovelace Rehab CEO to next task force meeting.

\*Dr. Pedrotty, Mentis and Brookehaven have tried coming into the state prior.

NM also needs a psychiatric/behavioral neuro unit. Have needed it for 15 years? And need to create a psychiatric unit for crises.

(currently if you have a brain injury and it creates a behavior crisis, the psych ED is the only option and it is not tailored for the brain injured patient.

1. Cognitive Psychosocial Rehabilitation – this is covered so it may be part of another discussion
2. A Brain Injury Trained Workforce
3. Supportive Housing/Tranistional Housing
4. Case Managers/Navigation - Jason’s recommendation to add to report.

\*Important to notice NM’s diverse culture with unique family care systems. We will need to include families in the management/navigation of care.

Could family members get CBIS and Dr. Pedrotty’s training, plus care navigation?

BRAIN INJURY REGISTRY

* NM Special Populations Registry Example provided.
* Would allow for the brain injured population to be counted and progress tracked.
* Could connect it to research
* Important because
	+ Let’s us understand the scope of the problem here (how many people, level of disability, what if any treatments they receive, ways they were injured)
	+ The registry could give the patients access to centers of care – connect to services
	+ Provides an opportunity for training on the standardization of brain injury recordation.

\*\*Must be voluntary and HIPAA protected.

OSI can also get some data through an anonymous data call to the private insurers.

A lot of professionals are not trained to properly code a brain injury.

\*Could support a VA model of coding for brain injury.

\*\*Also need a retrospective coding training – people with mild TBI often are not coded at all initially because they have other more urgent medical concerns.

Patient-centered approach for registry

- Patient opt-in

- Connect to research

- Registry and portal to better systems of care

- Registry is patient-focused but coupled with advertising campaign

\*Dr. Shuttleworth’s center would be interested in seeing such a program.

Note: Many people with Brain Injury will need help opting into the system. A family-centered educational campaign.

Also, the Gov. Commission on Disability is interested in a portal for all disabled persons.

Dr. Arciniegas may already be part of or leading a national group creating a Brain Injury Registration.

Next Steps:

* Invite a Behavioral Health representative to the join the task force
* Invite ARCA Neuro to join
* ID anyone else we may want to include, including a rehab facility rep.

Meeting Schedule

Final Draft due by the end of October.

Aim to have a lead author assigned to each subsection

Dr. Quinn volunteered to be the lead author.

Next meeting in early August