MINUTES
of the
SEVENTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 16-18, 2015
State Capitol, Room 309
Santa Fe

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on November 16, 2015 by Senator Gerald Ortiz y Pino, chair, at 8:57 a.m. in Room 309 of the State Capitol in Santa Fe.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Nora Espinoza, Vice Chair
Rep. Deborah A. Armstrong (11/16, 11/17)
Rep. Miguel P. Garcia
Sen. Mark Moores
Sen. Benny Shendo, Jr. (11/16, 11/17)

Absent
Sen. Gay G. Kernan
Rep. Tim D. Lewis

Advisory Members
Sen. Sue Wilson Beffort (11/16)
Sen. Craig W. Brandt (11/16, 11/17)
Sen. Jacob R. Candelaria
Rep. Gail Chasey
Rep. Doreen Y. Gallegos (11/16, 11/17)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Howie C. Morales (11/16)
Sen. Bill B. O'Neill
Sen. Nancy Rodriguez
Rep. Patricio Ruiloba
Sen. William P. Soules (11/17, 11/18)
Sen. Mimi Stewart
Rep. Christine Trujillo (11/16, 11/18)
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Don L. Tripp

(Attendance dates are noted for members not present for the entire meeting.)

Minutes Approval

Because the committee will not meet again this year, the minutes for this meeting have not been officially approved by the committee.

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Nancy Ellis, LCS
Diego Jimenez, LCS
Erin Bond, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, November 16

Welcome and Introductions

Senator Ortiz y Pino welcomed those assembled and asked committee members and staff to introduce themselves. He then introduced Richard Larson, M.D., Ph.D., executive vice chancellor and vice chancellor for research at the University of New Mexico Health Sciences Center (UNMHSC).

Health Care Workforce Committee Report; Behavioral Health Services

Dr. Larson provided background on House Bill 19 (2012 regular session) that established the New Mexico health care workforce committee, directed state licensing boards to survey their practitioners and directed the UNMHSC to store and act as steward of the data collected. Dr. Larson provided members with copies of the presentation on workforce shortages and the committee's 2015 annual report (see handouts). After three years of data collection, it has become clear that many licensees do not actually practice in New Mexico, Dr. Larson said, revealing an even greater shortage than would have been anticipated without the survey. New Mexico has the highest percentage of physicians over 60 years of age, and continues to lose psychiatrists despite the state having some of the highest rates in the nation for suicide, drug overdose and alcohol-related deaths. He emphasized that because of the cycle of licensee renewals, data are incomplete and future needs may not be the same as in the present.

A subcommittee, formed to examine specific needs of the behavioral health workforce, found the state's health care system to be in crisis, Dr. Larson said, with limited resources, services that are lacking in quality and few training opportunities. Of particular concern is provider reimbursement, he noted, because of New Mexico's extremely low rates and very complex billing requirements. The subcommittee urged the Interagency Behavioral Health Purchasing Collaborative (IBHPC) to provide a strategic plan to establish a financing system that will promote sustainability and retention of providers. It also recommended additional funding to expand access to behavioral telehealth consultations and an expansion of the rural health care practitioner tax credit program to include pharmacists, social workers and counselors. The subcommittee also urged that the IBHPC contract with a nonprofit for recruitment services.

On questioning, Dr. Larson and committee members discussed the following issues:

- shifting roles for physicians in private practice who become hospital employees;
- new opportunities to decentralize residency training into community health centers, hospitals and federally qualified health centers (FQHCs);
- the possibility of including dental hygienists in Dr. Larson's data collection; and
- changes in loan repayment programs to include additional providers and extended time for repayment.

Motions Passed

Motions were made and approved without objection to:

- send a letter to the Higher Education Department urging reinstatement in 2017 of the federal Department of Health and Human Services matching grant to support New Mexico's loan repayment program;
- request that the Legislative Finance Committee (LFC) study the effectiveness of the rural health care practitioner tax credit and whether it is serving its intended purpose; and
- request that the LFC expand the line item to the Board of Regents of UNM in the General Appropriation Act of 2016 to include an additional $300,000 to establish the Center for Workforce Analysis at the UNMHSC.

House Memorial (HM) 129 (2015 Regular Session): Nonprofit Public Contracts Management

Susan Wilger, Southwest Center for Health Innovation and the National Center for Frontier Communities, described New Mexico's nonprofit sector as a major economic force in the state and detailed economic woes of that sector as both federal and state funding levels for nonprofits have fallen significantly over the past several years. A lack of resources and capacity has forced many nonprofits to cut jobs and services, leading to long wait lists for consumers seeking access to critical programs (see handout). HM 129 asked the New Mexico Legislative Council to establish a work group of representatives from nonprofits, state agencies that contract with nonprofits and other members of the public to explore ways to streamline the contracting process and to maximize benefits to the state and nonprofit organizations (see handout). The slow pace of state contract approval and even slower pace of payment for services are huge cash-flow burdens on a struggling nonprofit, Ms. Wilger said, and delay the delivery of critical services. These issues occur statewide and are not unique to New Mexico; in fact, government/nonprofit task forces in nearly a dozen other states have tackled contracting reform and have crafted remarkably consistent solutions, according to information from the National Council of Nonprofits (see handout).

On questioning, Ms. Wilger and committee members discussed ways to move forward with the creation of a task force; all agreed that a joint memorial would be a more effective effort. One member suggested the possibility of federal grant funds to help spearhead the effort for a nonprofit summit; another thought the National Conference of State Legislatures could be a

good resource. Illinois seems to have an especially good template for addressing these issues, Ms. Wilger said, and she vowed to work on putting one together for New Mexico. The committee will look further into these issues next interim.

Public Comment

Erin Marshall, representing Compassion and Choices, updated committee members on *Morris v. New Mexico*, litigation that was heard by the New Mexico Supreme Court in October. The case involving aid in dying was affirmed by a Second Judicial District Court judge, but was reversed by the New Mexico Court of Appeals. *Morris* now awaits a decision sometime this year by the New Mexico Supreme Court. Depending on the outcome of *Morris*, New Mexico may become the fifth state in the union to grant to its residents what Ms. Marshall characterized as a "fundamental liberty".

Speakers representing the OLÉ Working Parents Association spoke of issues they encountered in applying for child care assistance from the Children, Youth and Families Department (CYFD). Diana Maes noted that Secretary of Children, Youth and Families Monique Jacobson said she had not received any complaints about the administration of the child care assistance program, but there have been complaints. Chris Buckman said that the CYFD is asking women to contact their abusers in order to qualify for child care assistance. Mr. Buckman also urged that the legislature invest more dollars in CYFD child care programs. Raina Acosta said she hopes that the CYFD is ready to meet with parents and regain their trust and that the department will agree to post the Parents Bill of Rights in its offices. Gabriella Hernandez said that CYFD issues are the same in Albuquerque, Portales and Clovis; it is a statewide problem. Ellen Gore, representing Early Educators United, urged the CYFD to be more helpful to its constituents. Child care contracts that come and go are hard on the children, as well as their parents, Ms. Gore said.

Minutes Approved

Upon a motion duly made and passed, the committee approved minutes from the September 21-24 and October 5-7 meetings of the LHHS.

Juvenile Justice and Child Care Assistance: Trauma-Informed Care

Secretary Jacobson referred to her August 24, 2015 presentation to the LHHS about the culture of accountability at the CYFD. Secretary Jacobson described the mission of the department to improve the quality of life for New Mexico's children and prepare them to become contributing members of society (see handouts). Secretary Jacobson said concerns raised by members of the OLÉ Working Parents Association with the CYFD's child care assistance program, detailed in a letter to her from the LHHS, were not accurate (see handout). While it was difficult to research without specific client information, most of these cases appear to have been resolved or the client had not met or kept requirements for the program, Secretary Jacobson said. Regarding short (less than 90 days) contracts for child care, she provided statistics showing that over 85 percent of CYFD contracts are for more than 90 days; shorter ones sometimes may be issued due to missing information or for other eligibility reasons. While the CYFD does not post the Parents Bill of Rights in its offices, it is not opposed to considering this approach,

Secretary Jacobson said, noting that child care assistance applications do include a section labeled "Your Rights and Responsibilities" and all notice of action documents describe the right to a fair hearing. The claims made by OLÉ members do not appear to represent widespread systemic issues, Secretary Jacobson concluded, and she urged any parent with specific issues to contact her directly.

Details of a proposed CYFD Child Wellness Center (CWC) described by Secretary Jacobson are included in a $5 million special request as part of the department's 2016 budget (see handouts). The CWC would provide interdisciplinary trauma-informed care to child victims of abuse or neglect in home-like settings. The CWC's environment would be designed to help lessen the trauma of separation for children and increase opportunities for appropriate family interaction and reunification. The secretary also provided a list of legislative priorities for 2016 that includes stiffer criminal penalties for battery on a CYFD worker, for any abuse of a child and for sexual crimes against children. Other priorities include: provision for additional warrants for runaways from juvenile probation; name-based criminal background checks during emergency placement; and mandatory removal of a child placed in a home where an adult has refused to provide fingerprints (see handout).

Reviewing the CYFD's juvenile justice services, Secretary Jacobson said the department remains committed to the Cambiar model of rehabilitation, has initiated staffing changes and is providing conflict resolution without the use of force or isolation. New transition services help youth with successful reintegration, and policies have been revised for investigating reports of abuse and for filing grievances (see handout). Additional factors affecting New Mexico's juvenile justice system include: a high female population; a higher proportion of older juveniles; and requirements for implementation of the federal Prison Rape Elimination Act of 2003.

Dr. George Davis, director of psychiatry, CYFD, described the department's participation in an ongoing study of adverse childhood experiences, such as psychological abuse and parental addiction and incarceration. Brain imaging studies can actually visualize this trauma, Dr. Davis said, and the number of negative experiences a child has been subjected to is a predictor of future difficulties. Yael Cannon, assistant professor, University of New Mexico School of Law, thanked Secretary Jacobson for supporting this study in an effort to better understand the children in CYFD custody. Professor Cannon urged that special education programs be embraced as an opportunity to identify problems and urged a multidisciplinary, generational effort for earlier intervention that integrates legal, social work and home-based services. Dr. Andrew Hsi, professor of pediatrics and family and community medicine at the UNMHSC, described the FOCUS program that provides supports and services for families of children with, or at risk for, developmental delays. Funded through the Department of Health's (DOH's) Family, Infant, Toddler program, FOCUS provides multidisciplinary tools for children (birth through three years) who have been exposed to prenatal drug use, mental illness or family violence to help them to overcome these adverse experiences. Unless the system can embrace these individuals, society will pay a much greater price in the future, Dr. Hsi said. FOCUS is currently working on a pilot project that will track data and report results.

Secretary Jacobson presented copies of her response to another letter from the LHHS questioning the CYFD's commitment to the agenda of the Three Branch Institute (TBI) and described what she said were significant ongoing trainings and programs inspired by the state's work with the TBI. These include a pilot program of education advocates for foster children in Lea County, complex case consultations and an e-learning curriculum on trauma-informed practice and medication use (see handout). Secretary Jacobson also described the CYFD's psychotropic medications review initiative and continuing training for clinicians to assess and address complex developmental trauma for children in foster care and in the juvenile justice system.

On questioning, committee members, Secretary Jacobson and panel presenters discussed the following issues:

- OLÉ parents' contention they have provided the CYFD with many names of complainants over several years and that more than "just a handful" of parents are involved;
- the potential for revision of the child care assistance application to accommodate parents', grandparents' and others' concerns;
- the availability of special services and training for grandparents/kinship guardians;
- the ability of juveniles to refuse psychotropic medications;
- how to address the high rate (37 percent) of juvenile walkaways;
- why the background of the newly hired director of the CYFD's Juvenile Justice Division does not include work with juveniles or experience with the Cambiar model;
- reasons for increased recividism in juvenile justice facilities;
- lack of performance measures to determine whether the juvenile justice model currently being used is working; and
- concern that the CYFD's budget and priorities are focused more on punishment and increased sentences.

Sequoyah Adolescent Treatment Center (SATC) Task Force Report

Dr. David Graeber, medical director, inpatient services, UNM Children's Psychiatric Center, and a member of the task force for Senate Memorial (SM) 115 (2015 regular session), reported on the task force's recommendations for improvements in clinical care, professional staffing, outreach and aftercare for juvenile residents of SATC (see handout). Recruitment of a board-certified child and adolescent psychiatrist for the facility was a top task force recommendation, as well as development of a clinical relationship for case consultation with the Department of Psychiatry at UNM. The group also recommended that the SATC's advisory board be re-engaged (it has not met for the past six years) and that expanded outreach about SATC's mission and program be delivered to current and prospective stakeholders. Recommendations for aftercare urged care coordinators from managed care organizations (MCOs) to become actively involved before discharge and that client outcomes be tracked, using Building Bridges Initiative (BBI) indicators following discharge. The task force recommended maintaining the average daily census at SATC above 27 clients (current financial "break even"), with a goal of 33 to 35 clients. Reserved for future discussion are both the possibility of

establishing a day treatment program and the potential creation of an SATC-type facility for female youth.

Dr. W. Henry Gardner, a former director of SATC and member of the task force, provided the committee with a minority report, objecting to the fact that nearly one-half of participating members were DOH employees and asserting that some information supplied by the DOH may not be accurate (see handout). Dr. Gardner said that data are lacking, but many adolescents are still being sent out of state instead of to SATC, which has not completed implementation of the principles of the BBI and trauma-informed care. Staff has been cut, there is high employee turnover and agency financials indicate a heavy reliance on contracted professional services. Dr. Gardner criticized a lack of transparency in SATC's finances and questioned the DOH assertion of a $470,000 budget surplus for fiscal year (FY) 2015. Committee members were provided copies of testimony from two SATC consumers who detailed similar concerns and complaints about SATC's program and its negative outcomes for their family members.

Recess

The meeting recessed at 5:12 p.m.

Tuesday, November 17

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:49 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

NurseAdvice New Mexico (NANM)

Connie Fiorenzia, program director, NANM, described the history of her nonprofit organization that became the first fully integrated health advice line in the nation in 2006. NANM is a 24/7, 365-day-a-year phone line staffed by New Mexico nurses that receives more than 120,000 calls a year and has 70 percent of the state's population in its database. NANM services help reduce the number of persons seeking admission to hospital emergency rooms; monitor for flu and other syndromes; and offer after-hours access to tele-triage for primary care providers in rural and frontier areas. After nearly 10 years, NANM is at a crossroads, Ms. Fiorenzia reported; the financial model has changed, and now, with more than 24,000 calls a year that cannot be billed, it is no longer financially sustainable. The state's four Medicaid MCOs have established their own advice lines and no longer pay into the partnership. Many other provider groups and hospitals access NANM services but do not partner in the payment system. Despite financial challenges, the changing health care landscape is providing some potential opportunities, Ms. Fiorenzia said, citing a pilot 911 program that provides nurse tele-triage as an alternative to ambulance dispatch, and the provision of NANM-conducted health risk assessments and post-discharge follow-ups that help to reduce hospital readmissions.

Sandy Potter, director of Medicaid clinical operations for BlueCross BlueShield of New Mexico (BCBS), said access to behavioral health services is included in her company's nurse

advice line, and that it is serviced by a bilingual staff of registered nurses in New Mexico, and has a volume of approximately 600 calls per month.

Anita Leal, chief executive officer of CHRISTUS Health, said her organization, which is new to the state, uses Carenet Healthcare Services in San Antonio, Texas, for its nurse advice line; fewer than 300 calls a month are received from New Mexico, Ms. Leal said.

Dr. Darcie Robran-Marquez, chief medical officer, Molina Healthcare of New Mexico (Molina), described her company's advice line and the value it brings to care coordination. Keeping this service in-house helps Molina to direct members to the right level of care, Dr. Robran-Marquez said, and is especially important in disease management. Molina receives approximately 1,200 calls per month through its advice line, occasionally spiking to 2,000 calls per month.

Dr. William Orr, medical director of long-term and complex care for UnitedHealthcare New Mexico (UnitedHealthcare) Community Plan, described the significant advantages of having an in-house call center that integrates member activity into UnitedHealthcare's own records system. While its call center operates nationwide, special diversity training has been provided for New Mexico employees, and Dr. Orr cited the added value of broad health data collection for the organization.

Mari Spaulding-Bynon, executive director of clinical and long-term care operations for Presbyterian Health Plan (Presbyterian), touted the importance of integrating advice calls into the electronic health care records of her organization. Presbyterian's advice line, operating in New Mexico for about three months, handles between 1,800 and 2,000 calls a month and provides translation services and warm transfers to behavioral health services.

David Roddy, executive director, New Mexico Primary Care Association, told committee members that NANM has been providing excellent service and is extremely important to community health centers and rural providers, especially because of its after-hours service. The biggest barrier to recruitment of physicians in frontier areas is the amount of time required for them to be "on call", Mr. Roddy said.

Committee members discussed the need for emergency funding of between $720,000 and $750,000 for NANM in FY 2016, noting that there would be huge consequences if NANM's 120,000 calls were not being answered. It was agreed that the committee would recommend a direct appropriation relative to the benefits to New Mexico residents regardless of insurance status.

Medicaid Costs and Cost Savings

Brent Earnest, secretary, Human Services Department (HSD), provided updates on the Medicaid budget, the FY 2017 Medicaid appropriation request, Centennial Care (CC), behavioral health initiatives and efforts to leverage more Medicaid funds (see handout). Total Medicaid spending is increasing, primarily due to enrollment growth. The total FY 2017 budget

request of $7.163 billion represents an overall increase of 7.8 percent, with increased support from the general fund of $85.2 million, due primarily to the step-down in federal funding. Total Medicaid enrollment as of August 2015 was 822,428. The HSD is pursuing several cost-reduction and revenue-generating options. Priorities for the HSD's Medical Assistance Division include better management of MCO performance and additional cost-containment initiatives for Medicaid expenditures.

CC, now in its second year of operation, is focused on increasing coordination of services and has completed health risk assessments on 423,842 members. A previously postponed program to establish health homes for members with behavioral health needs will be launched in January 2016. Secretary Earnest touted increased rates for the state's primary care providers, slated to continue in 2016, and a 12.5 percent increase in rates for behavioral health providers. With CC, there has been increasing use of community health workers, including a partnership with UNM to expand their role, and an expansion of telehealth services. Ten payment reform projects were approved by the HSD in July, and a total of 65 percent of CC enrollees are participating in a program that rewards members for healthy behaviors. The Safety Net Care Pool (SNCP) program is showing results, with most hospitals reporting a significant reduction in uncompensated care.

Secretary Earnest reported that more individuals now are being provided with behavioral health services and more treatment is being initiated for members diagnosed with alcohol and/or drug dependence, including youth on probation. An area that still needs improvement is follow-up services for individuals after discharge from treatment. The HSD budget request for behavioral health spending is unchanged at $42.03 million, Secretary Earnest said, but savings from Medicaid expansion will be reallocated to increased sexual assault services and new programs to prevent behavioral disorders in children and for establishing a New Mexico Peer Empowerment Center. The HSD is constantly reviewing its programs and seeks to implement more efficient and effective practices whenever possible.

Brian Hoffmeister, program evaluator, LFC, provided copies of the report "Opportunities to Leverage Federal Medicaid Funds" (see handout). The LFC evaluation identified three main themes to more effectively leverage Medicaid funds:

(1) increase billings for services that are eligible but currently funded by state or local entities;

(2) expand Medicaid-eligible services for certain programs; and

(3) reallocate resources from programs with diminished roles due to the federal Patient Protection and Affordable Care Act (ACA). Savings, estimated by the LFC to be between $82 million and $103 million, could be found in DOH public health programs, offender health care in the Corrections Department (CD) and early childhood home visiting in the CYFD and through adjustments to the level of MCO support by the HSD, among others. Additionally, foregone revenue could be recouped by scaling back the New Mexico Medical Insurance Pool. The report

detailed key findings that explored cutbacks in the use of general funds to support rural primary care; the potential of increased Medicaid billing for school-based health centers; potential new public health programs funded by tobacco settlement revenues; possible expansion of problem-solving court systems; elimination of the non-Medicaid administrator contract; more effective leveraging of Medicaid funds for local DWI and substance abuse treatment programs; possible reallocation to the general fund of county indigent gross receipts tax increment funds; and possible increased use of certified public expenditures for eligible Medicaid services, among others.

Copies of department responses to the LFC evaluation (see handouts) were provided to committee members. The HSD expressed concern about the short time line provided for department response and urged that the magnitude of changes proposed by the LFC requires comprehensive analysis and might result in disruption of essential health care services. The HSD objected to a reduction of the administrative and profit rate of the MCOs and noted that suggested changes to the SNCP would require an amendment to the state Medicaid plan that likely would not be approved by the Centers for Medicare and Medicaid Services (CMS). In its response to the report, the DOH cautioned against a rush into policy of LFC recommendations without sufficient vetting of impact on programs. The DOH also noted that prevention and wellness initiatives are most effective in reducing health care costs and improving outcomes, and that the LFC recommendations appear to be focused on cutting public health investments. The CYFD response noted several instances of incorrect data being used in the LFC report and described a lack of infrastructure to support the home-visiting model recommendations. The response from the Local Government Division of the Department of Finance and Administration also objected to the short time line for response to LFC suggestions for major changes in funding of local DWI programs. The CD response to LFC recommendations objected to several assumptions in the report and urged that empirical data be collected before any changes to Medicaid reimbursement are put into place.

Representatives of all four MCOs agreed that comprehensive and creative ways to leverage Medicaid reimbursement are worth examination. Dr. Robran-Marquez said that Molina is looking at care transition nurses who follow up with home visits and at value-based reimbursement with primary care practices and hospitals. Ms. Spaulding-Bynon said that Presbyterian is addressing community partners and tribal entities in managing and maximizing internal teams to help improve health outcomes. Ms. Potter said that BCBS is focusing on reducing emergency room visits by using bridge providers to engage "superusers" who have not allowed care coordination. UnitedHealthcare is expanding peer support networks to coordinate with wellness centers, according to Dr. Orr, noting that peer support has made the greatest difference in reducing the length of hospital stays and getting the patient to providers after release.

Steven Kopelman, executive director, New Mexico Association of Counties (NMAC), provided a written response to portions of the LFC report on leveraging Medicaid funds that pertain to counties (see handout). Mr. Kopelman detailed practical and legal impediments to increased Medicaid leveraging in local DWI programs, including jail-based treatment that is not

covered by Medicaid. He noted that gross receipts tax revenues are actually decreasing in some counties, and the LFC suggestion to transfer excess revenues from county indigent health care programs to the state is inequitable and would result in significant shortfalls for many counties. Collaboration with counties was urged before moving forward with legislative initiatives or program changes.

Economic Aspects of Medicaid Expansion

Dr. Lee Reynis, professor of economics, UNM Bureau of Business and Economic Research, presented an analysis of the economic and fiscal impacts of Medicaid expansion in New Mexico (see handout). This expansion has changed the landscape, Dr. Reynis said, with much higher enrollment than was anticipated dramatically reducing the percentage of uninsured adults. The expansion has significantly reduced uncompensated care, helping to make New Mexico more attractive to health care providers and creating a bright spot in an otherwise gloomy economy. Shortages in service providers have been mitigated by primary care and specialist programs, including clinics in rural areas, Project ECHO and other telemedicine programs. New Mexico is also seeing considerable expansion in health treatment facilities, ambulatory care and hospital care with federal Medicaid dollars flowing into the state. While the state will pick up an increasing portion of Medicaid costs (10 percent by 2020), Dr. Reynis said preliminary numbers show a program that is paying for itself.

Paul Gessing, president, Rio Grande Foundation, provided a cost/benefit analysis of Medicaid expansion from his independent research and educational nonprofit that is dedicated to promoting prosperity for New Mexico. Mr. Gessing cited published reports of a study of Medicaid recipients in Oregon in 2013 that concluded that Medicaid increased health care utilization but did not produce any statistically significant effects on physical health or labor market outcomes, as well as several other studies indicating an increased risk of poor outcomes for individuals on Medicaid. The financial impact of Medicaid expansion on New Mexico's economy and state budget is of even greater concern, he said, noting that by 2017, fully one-third of the state's population will be on Medicaid. It is wrong to think of federal government spending as "free money", he said, as money from Washington, DC, to New Mexico's Medicaid program must come from either taxes or borrowing. Mr. Gessing debunked the economic "multiplier effect" of Medicaid spending, positing that the health care sector in New Mexico had been growing for years, long before the expansion. Broadening Medicaid imposes a hidden tax on people with private insurance, he said, driving up costs in a vicious cycle that increases the number of uninsured individuals. Medicaid desperately needs a sweeping overhaul, Mr. Gessing said, and New Mexico should work with other states to press the federal government for the flexibility required to fix what he described as a badly broken and irresponsibly unsustainable program.

Public Comment

A coalition of New Mexico nonprofit organizations presented a list of the benefits of Medicaid expansion in New Mexico and asked that legislators continue to support it. The group also urged caution in approaching new cost-containment measures to make certain those efforts do not impact services (see handout). Another list with five reasons why the state should fully

fund Medicaid expansion was prepared by the New Mexico Center on Law and Poverty (see handout).

Ellen Pinnes spoke about Medicaid expansion as a bright spot in the New Mexico economy, and she noted that jobs are being created in all corners of the state and uncompensated care is dropping dramatically. Medicaid expansion is low-cost per person and is money well spent.

Bill Jordan, executive director of New Mexico Voices for Children (NMVC), noted that the Congressional Budget Office has estimated that the ACA will reduce the federal deficit by more than a trillion dollars in 10 years. This Medicaid expansion is a win/win for everyone, he said, noting that New Mexico already has shrunk K-12 spending by nine percent and higher education funding by 35 percent.

Dr. Lance Chilton, an Albuquerque pediatrician, spoke of the benefits of expanded Medicaid for children, many of whom had not been signed up until their parents were enrolled. Dr. Chilton described the case of a 12-year-old girl who would have died without coverage from the state's high-risk insurance pool and who is thriving today. The ultimate denial of care is no insurance, Dr. Chilton said, imploring legislators not to make any cuts in Medicaid for children.

Mr. Roddy commented on the LFC suggestions for leveraging Medicaid. Members of his organization of primary care providers, which serves one out of every six New Mexicans, are certainly into leveraging dollars. Great strides have been made by primary care providers at community health centers and FQHCs to improve quality and reduce costs, Mr. Roddy said; he provided committee members with copies of a presentation titled "Four Reasons to Continue Full Support for Primary Healthcare Clinics in New Mexico".

Mark Clay, M.D., ambulatory pediatric physician, UNM, said that he had heard a lot of statistics today. Eighty percent of his patients rely on Medicaid, and it is hard to put a price tag on a treatment that can give life back to a young person.

Medicaid Fraud

Patricia Tucker, director, Medicaid Fraud and Elder Abuse Division, Office of the Attorney General, described the history of Section 1909 of the federal Social Security Act that creates a financial incentive and establishes liability to states for false or fraudulent claims to their Medicaid programs. In New Mexico, the state keeps 25 percent, with 75 percent going to the federal government for any recovered funds (see handout). State law must mirror federal law as described in the federal False Claims Act, Ms. Tucker said, and New Mexico's Medicaid False Claims Act has not yet passed federal review. The initial draft of the Medicaid False Claims Act is undergoing revisions and should be ready for action soon, she said. On questioning, Ms. Tucker said that the state regularly recovers funds from successful prosecution of false or fraudulent claims. Asked about progress on investigations of the behavioral health providers referred by the HSD for fraud in 2013, Ms. Tucker said that an outside contractor hired to manage that process appears to be on target to meet its six-month deadline for completion.

Coordination of Housing Services for Homeless People

A comprehensive report from the SM 44 (2015 regular session) working group was provided to committee members, along with a proposal by the New Mexico Coalition to End Homelessness (NMCEH) describing a plan to expand supportive housing statewide (see handouts). Monica Abeita, senior policy and program advisor, New Mexico Mortgage Finance Authority, described the broad base of participants who worked on the SM 44 working group, which studied housing as a health intervention and examined funding streams for permanent supported housing solutions and for the social services needed to accompany them. The group recommended exploration of innovative financing models, new implementation/demonstration sites and development of a state housing leadership team. The increasing price of housing is affecting the supply of rental units, Ms. Abeita said. Flexible funding streams and payment mechanisms under Medicaid and expanded coverage for non-Medicaid supportive housing-related services should be explored, as well as more supported employment opportunities.

Hank Hughes, a member of the working group and executive director, NMCEH, proposed a $4.5 million investment in new and recurring state funding (to be combined with Medicaid and other leveraged resources) to expand supportive housing throughout the state based on the New Mexico Linkages program, Albuquerque Heading Home, Housing First and Rapid Re-Housing models by providing 280 new Linkage vouchers to house the most vulnerable homeless people. An additional 280 Rapid Re-Housing vouchers would provide six months of payments per household through the Rental Assistance program. Studies have indicated a significant decrease in cost for these housing vouchers when compared to the costs of repeat incarceration and hospitalization. Rapid Re-Housing also is more cost-effective than emergency shelters, according to several different recent studies.

On questioning, committee members and panel presenters discussed the issue of child homelessness and the possibility of investing in "tiny houses" (some are 210 square feet for $7,000) for the voucher program. The committee chair thanked the HSD for its significant participation in the working group and its willingness to address the state's issues of homelessness.

Osteopathic Medicine Act Legislation

Ralph McClish, executive director, New Mexico Osteopathic Medical Association, presented copies of a house bill that proposes to correct antiquated language in the 1978 Osteopathic Medicine Act. This bill does not seek to expand the scope of practice, but rather would give more "teeth" to the Board of Osteopathic Medical Examiners for supervisory authority for physician assistants; would update testing qualifications; and would amend the Pharmacist Prescriptive Authority Act for osteopathic physicians who supervise pharmacy clinicians (see handout). Mr. McClish said he does not anticipate any controversy with these proposed statutory changes.

Public Comment

Tasia Young, lobbyist for the NMAC, spoke of the counties' need to reinstate a sunset on intergovernmental transfers of a one-twelfth tax increment for the SNCP that was agreed to by

counties and the state for a three-year period. That time frame was stripped out of Senate Bill 268 (2014) by the governor, leaving the payments in perpetuity. The counties now are considering a lawsuit, Ms. Young said.

Minutes Approved

Upon a motion duly made and passed, the committee approved the minutes from the October 19-21 meeting of the LHHS in Santa Fe.

Review of Legislation for the 2016 Regular Session

Mr. Hely offered a compilation of bills and memorials for the 2016 regular session for the committee to review and consider for endorsement by vote (see Appendix A). The committee endorsed each item of legislation.

Recess

The committee recessed at 5:13 p.m.

Wednesday, November 18

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:57 a.m., welcomed those assembled and asked committee members and staff to introduce themselves. Representative Espinoza moved that a letter to the LFC regarding the efficacy of the rural health care practitioner tax credit be postponed, as committee members were informed that an analysis by the LFC has already been completed. The motion was approved without opposition and included a request that a copy of that analysis be provided to the LHHS.

Program Evaluation: New Mexico Health Insurance Exchange (NMHIX)

Michelle Aubel, program evaluator, LFC, described three themes that emerged during the LFC evaluation of the NMHIX performance and operations through two enrollment periods (see handout and full LFC report):

(1) the late start and leadership turnover impacted program implementation;

(2) there was limited return on $85 million in federal funds with below-estimate enrollment and underutilized costly small business marketplace; and

(3) uncertain risks and future costs associated with continuing use of the federal platform indicate the possible need for renewed legislative assessment.

The NMHIX has spent $77.5 million, with 61 percent going to information technology (IT) and 33 percent to marketing. With 44,307 enrollments out of an estimated pool of 133,000 uninsured, representing a 33 percent penetration, the LFC concluded that NMHIX enrollment is likely to remain low. The NMHIX spent $18 million on the SHOP small business portal that enrolled only 877 individuals (the federal General Accounting Office reported lower-than-

expected numbers for SHOP enrollment nationally), and there is concern that unsuccessful IT projects may come under federal scrutiny. There is also LFC concern about future federal data sharing and management and a demonstrated need for improved IT security. Given significantly reduced role/functions for the exchange, the LFC study posed questions about the right size and structure for the NMHIX going forward, and it questioned if the NMHIX should be subject to the Audit Act.

Dr. J.R. Damron, chair, NMHIX Board of Directors, told committee members that the LFC evaluation contained extensive incorrect information and data. Dr. Damron reviewed the legislative decision to establish the exchange as a quasi-governmental entity rather than a state agency and to include insurers on the board of directors with regulation by the Office of Superintendent of Insurance (OSI). The NMHIX is a nationally recognized model that has saved the state $19 million by using the federal platform and it is financially sustainable, Dr. Damron asserted; its board of directors remains deeply committed to transparency and to delivering health literacy to New Mexicans. Amy Dowd, chief executive officer, NMHIX, provided copies of the agency's detailed response to concerns identified in the LFC study (see handout). Ms. Dowd introduced Patsy Romero, board member and treasurer, NMHIX, Teresa Gomez, board member and director of Native American outreach, NMHIX, and Dick Mason, chair of the Stakeholder Advisory Committee. The rate of uninsured in New Mexico has dropped by 4.1 percent compared nationally to a reduction of 2.8 percent, Ms. Dowd said, pointing out that the exchange has captured a majority of the target population in just the first two years of operation. The third open enrollment period began November 1, 2015 and will end January 31, 2016, and the impact of preferred provider organization plan cancellations remains to be seen, she said. Outreach efforts and person-to-person assistance are being promoted, as BeWellNM aims to capture a greater percentage of the remaining uninsured.

On questioning, committee members and panel presenters discussed the financial model of the NMHIX and Ms. Dowd's contention that CMS provides more stringent oversight, both operationally and financially, than the Audit Act could accomplish. She also noted that the current annual budget of the exchange — $11.3 million — is considerably less than the original estimate of $25 million, and none of it comes from the general fund; it is financed through an assessment on all health insurance carriers in the state. Regarding enrollment numbers, Ms. Dowd noted that New Mexico is on par with other states that have expanded Medicaid, but enrollment is more challenging because of the large number of individuals who are not eligible for the subsidies. Dr. Damron noted that for every 10 people who come to the exchange, eight are eligible for Medicaid.

Mr. Mason spoke for his advisory committee to compliment members of the NMHIX Board of Directors, who serve voluntarily. The board has listened to concerns of advocates and stakeholders, and outreach provided by the exchange has been very effective, Mr. Mason said. As much as he values the oversight provided by the LFC, Mr. Mason said he has full confidence in NMHIX data.

LFC Health Notes: Changes in Hospital Uncompensated Care

Dr. Jenny Felmley, program evaluator, LFC, provided a detailed analysis of changes in uncompensated care with passage of the ACA and expansion of Medicaid in New Mexico, as requested by HM 33 (2015 regular session). With the rate of uninsured declining in New Mexico from over 18 percent in 2013 to 13.1 percent in the second quarter of 2015, uncompensated care applications from SNCP hospitals declined by more than 30 percent between 2014 and 2015 (see handout). New Mexico hospitals in the aggregate have seen increased net income, as uncompensated care now accounts for less than seven percent of their expenses. Uncompensated care costs probably will continue to decline, Dr. Felmley said, but will not disappear altogether as some populations remain uninsurable and others who are insured struggle with out-of-pocket costs. Enhanced Medicaid rates for SNCP and UNM hospitals appear to have made a significant impact in holding down shortfalls, she said. Hospital markups for the 44 members of the New Mexico Hospital Association averaged 300 percent over cost, lower than the national average, while the 29 SNCP hospitals averaged 177 percent over cost. The New Mexico Primary Care Association also reported improved financial positions for most nonprofit FQHCs and community health centers.

Looking forward, Dr. Felmley said that reduced uncompensated care costs are not likely to result in lower insurance premiums. While these costs have gone down, there still are many moving parts to be understood in this ongoing development. The role of counties in sharing the burden of uncompensated care has changed as well, she said, and some counties are struggling with the new SNCP structure. The fact that hospital charges are not transparent or comparable blocks policymakers and consumers from gauging the true extent and consequences of uncompensated care costs; one hospital in New Mexico may charge five times more than another for a service or procedure that costs exactly the same. A 2015 amendment to the Health Information System Act directed the DOH to develop an all-claims database website to be available to the public by January 1, 2018.

In discussing the counties' role in addressing indigent care, one committee member pointed out that the $30.5 million county indigent fund balance cited in Dr. Felmley's presentation is misleading, because most of that is already encumbered.

Public Comment

Mr. Mason, in addition to volunteer work with the NMHIX, also serves as chair of New Mexico Health Care for All, an advocacy coalition of 19 organizations, and he noted that Dr. Felmley's report clearly indicates that net income of New Mexico hospitals has increased. He wondered what has happened to this profit and whether any of it has gone to reduce costs for consumers. The lack of transparency in hospital costs really is important, Mr. Mason said, urging committee members to keep an eye on the DOH and its development of the public website. It is required to be up by 2018, Mr. Mason noted, but the DOH should implement it as soon as possible.

Dental Therapy Task Force

The LHHS chair announced that the New Mexico Dental Association (NMDA), the New Mexico Dental Hygienists' Association (NMDHA) and the Health Action New Mexico (HANM)

coalition were in agreement about dental therapists in New Mexico and are ready to draft a comprehensive access to dental care bill. The agreement is the result of work by the Dental Therapy Task Force, which was established in 2015 and includes representatives of the aforementioned organizations as well as legislators from both political parties, with facilitation by Philip Crump and David Gold. After four meetings (see handouts), the task force has assembled a summary of the elements of proposed legislation (see handout). Cathy Sovereign, past president of the NMDHA, said members were able to come together with the goal of increasing access to high-quality dental care for rural, tribal and underserved urban New Mexicans. Elements of the task force's proposed legislation include the establishment of a mid-level dental therapist provider who could perform more procedures than a hygienist but less than a dentist; creation of a legislative committee to investigate and recommend action related to dental access; establishment of simplified Medicaid billing processes, dental loan forgiveness and repayment and other incentives; requirement of a dental exam prior to entering public school; and reinstatement of a state dental director who must be a licensed dental professional. The task force's summary also included specific suggestions to reform or improve Medicaid related to dental services.

Representing the NMDA, Dr. Joe Valles thanked legislators for creating this task force, and he reminded committee members that it is not possible to separate oral health from overall health. Pamela Blackwell, Esq., project director, HANM, said she was proud to support this proposal and asked for the support of the LHHS.

On questioning, committee members and panel presenters discussed the following issues:

- the possibility of including class A counties in the legislation;
- the possibility of limiting the dental therapy program to tribal communities;
- complications for school systems required to take on a new gatekeeper role;
- the collaborative effort involved in defining procedures that can be performed by a dental therapist;
- concerns about providing dental care through school-based health centers when adequate funding for these centers already is lacking; and
- a recommendation that service to rural and underserved communities be a key component of the educational program for dental therapists.

Health Impact Assessment (HIA) of Food Taxation

Mr. Jordan and Amber Wallin, director, NMVC's KIDS COUNT, presented results of an analysis of the taxation of grocery purchases and its impacts on the health of the state's children, families and communities. The HIA, conducted in 2014 and 2015, was made possible by a grant from the Health Impact Project, a collaboration of the Robert Wood Johnson Foundation and The Pew Charitable Trusts. Its purpose is to inform public opinion and government decisions on the potential health impacts of food tax policy, particularly on vulnerable groups, and to demonstrate how tax, economic and budgetary policies can impact health outcomes (see handouts). New Mexico is number one in the rate of child poverty and number two in the rate of low-income working families; 67 percent of jobs in New Mexico are low-paying and job growth is the lowest

in the nation, Mr. Jordan noted. Sales tax (gross receipts tax) on food is regressive; the poor pay double the rate of total taxes than the rich. Taxing food would cost, on average, each New Mexico household around $350 per year, or $29.00 per month. For a poor family that spends 25 percent of its income on food, this could harm family economic security, impacting food security, diet and nutrition and health.

The primary policy recommendation of the HIA is that food should not be taxed due to harmful health impacts, regressivity and increased health disparities that could result. If revenue is needed, the state should consider other taxes with less harmful effects on the health of vulnerable populations. These might include repealing the capital gains deductions; increasing corporate income taxes or fees collected from large or multistate corporations; mandating combined reporting; enacting higher personal income tax rates for very high earners; or raising taxes associated with curbing unhealthy behavior. Other considerations recommended by the HIA targeting improved economic security, diet and nutrition included: an increase in current state tax credits; the possible creation of new credits for low-income families with children; maximizing federal Supplemental Nutrition Assistance program benefits; and utilization of U.S. Department of Agriculture at-risk meal program funds. Finally, the report recommended an increase in the state minimum wage and indexing it to inflation.

On questioning, one committee member asserted that Mr. Jordan's presentation was an exercise in "preaching to the choir". Another member wanted it noted in the official meeting record that not a single Republican committee member was in the room for this presentation.

The full report of the HIA is available on the nonprofit's website: www.nmvoices.org.

Public Comment

Valerie Montoya, president of academic programs, Southwest Indian Polytechnic Institute (SIPI), said the school is interested in providing a dental training program and is supportive of diversity and ties to community. Chris Harrington, a department chair at SIPI, said he also supports the bill on dental therapy.

Pam Roy, director, Farm to Table, thanked the NMVC and the many other groups that participated in the HIA and said that New Mexico may be leaving federal dollars on the table across multiple programs.

Basic Health Program (BHP); Federal Waiver

Mr. Hely described the BHP as an option created under the federal ACA to allow states to provide coverage to individuals who are not eligible for Medicaid but who also cannot afford to purchase coverage on a state health insurance marketplace. An alternative to the BHP provided under the ACA that some states are now using is the state innovation waiver option provided in Section 1332 of the ACA. Section 1332, Mr. Hely explained, allows states, starting in 2017, to take innovative steps to provide health care to state residents, including making changes to their state Medicaid or the Children's Health Insurance program; applying premium assistance or cost-sharing assistance to other coverage programs; or removing the federal

individual or large employer health coverage mandates. The ACA stipulates that, while states are free to do any number of things, they must cover as many people as would have been covered under the standard ACA provisions — such as health insurance marketplaces, the coverage mandates and Medicaid expansion — and the cost must be no greater than the costs of implementing the standard ACA provisions. The application process is complex, including required public hearings and considerable analysis and documentation and legislative approval for the filing of a 10-year "blueprint" that must be approved by CMS. States can receive up to the aggregate amount of federal funds that otherwise would have gone to premium tax credits and cost-sharing reductions currently available to low-income households that purchase NMHIX coverage. Mr. Hely provided several handouts from the National Conference of State Legislatures with information and analyses of other states' uses of the waiver. States such as Minnesota and New York are exploring the option of transforming their BHPs into an ACA Section 1332 waiver-based coverage. Other states, such as Arkansas, are exploring the opportunity that an ACA Section 1332 may present to provide more market-based solutions to getting state residents covered.

The OSI created a task force to study opportunities under a Section 1332 waiver, according to Lisa Reid, director of life and health at the OSI. The pot of money available to New Mexico by implementing the Section 1332 waiver is potentially $1 million to $1.2 million, she said, and while there has not been much encouragement to pursue this, the task force continues to monitor what is happening in other states. Utilizing the federal platform for the exchange limits the state's options, Ms. Reid said, but the OSI wants to keep the LHHS updated on this issue.

Adjournment

There being no more business before the committee, the seventh and final meeting of the LHHS for the 2015 interim was adjourned at 4:25 p.m.

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