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

May 23, 2016
State Capitol, Room 322
Santa Fe

The first meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on May 23, 2016 by Senator Gerald Ortiz y Pino, chair, at 8:37 a.m. in Room 322 of the State Capitol in Santa Fe.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Nora Espinoza, Vice Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Sen. Benny Shendo, Jr.

Absent
Rep. Tim D. Lewis
Sen. Mark Moores

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

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Staff, LCS

Guests
The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, May 23

Welcome and Introductions

Senator Ortiz y Pino welcomed those assembled and asked committee members and staff to introduce themselves.

Medicaid Update — Human Services Department (HSD) Panel

Brent Earnest, secretary, HSD, Nancy Smith-Leslie, director, Medical Assistance Division (MAD), HSD, and Wayne Lindstrom, Ph.D., director, Behavioral Health Services Division, HSD, provided an update on Medicaid enrollment, cost-containment efforts, initiatives and strategies (see handouts).

Secretary Earnest began by announcing that Medicaid enrollment had "exceeded all expectations". As of May 2016, 877,436 New Mexicans are enrolled in Medicaid, with enrollment projected to reach approximately 925,000 by June 2017. According to Secretary Earnest, this enrollment growth is driving the increase in total Medicaid spending. For fiscal year (FY) 2017, the general fund appropriation for Medicaid is $913.6 million. While this is an increase of nearly $22 million from FY 2016, it is about $63 million below the department's request.

Secretary Earnest reminded members of the committee that House Bill 2 (2016) directed the HSD to take action to reduce projected Medicaid spending through: 1) reduced reimbursement rates paid to Medicaid providers; 2) reduced spending on managed care administrative costs; 3) additional cost-sharing requirements (such as copays and premiums); and 4) changes to Medicaid benefits and enhanced eligibility verification.

To assist in meeting these directives, three subcommittees were formed from existing members of the Medicaid Advisory Committee (MAC).

First, a Provider Payments Cost-Containment Subcommittee was tasked with developing recommendations for reducing provider reimbursement rates as of July 1, 2016. The goal was to realize reductions totaling $30 million. This subcommittee provided recommendations on April 8, 2016, with projected savings ranging from $26 million to $33.5 million. Secretary Earnest announced that public comment on this plan will be accepted through May 31, 2016. He emphasized that the HSD's cuts would not fall as heavily on behavioral health providers and long-term care providers.

The HSD will exercise its option of forwarding some expenditures to the agency's FY 2018 budget, according to Secretary Earnest.

A second subcommittee was charged with developing recommendations for cost savings with respect to benefits, eligibility verification measures and cost sharing by Medicaid recipients. This subcommittee started meeting in mid-April, with recommendations due on June 1. Implementation of any adopted recommendations is targeted for January 1, 2017. Should any recommendations require a change in the state's Medicaid waiver, these would likely be delayed and incorporated into the state's "1115" Medicaid waiver renewal application. The current waiver expires in 2018.

The third subcommittee will address long-term strategies, including ways to better leverage Medicaid funding. Members of this subcommittee are currently being appointed. This subcommittee will be merged with the Provider Payments Cost-Containment Subcommittee.

Secretary Earnest noted that the federal government has agreed to a one-time 2017 waiver of the health insurance fees that it requires states to build into managed care organization (MCO) premiums and that are passed on to the state. He stated that, as neither the Medicaid MCOs nor the state will be required to pay this federal fee, a general fund savings of $18.5 million will result. However, the federal Centers for Medicaid and Medicare Services (CMS) will re-impose these fees in 2018.

According to Secretary Earnest, most cost-containment measures require both time and changes in policy. He noted that it takes time to conduct an internal review, promulgate new regulations, conduct tribal consultation, run actuarial rate revisions, change MCO contracts and seek federal approval of state plan amendments, where necessary. Nevertheless, he reported that the following cost-containment measures have been taken:

- a net reduction of 3.4% in MCO capitation rates as of January 1, 2016;
- changes to MCO contractual care coordination requirements to focus on high-needs and high-cost members starting July 1, 2017; and
- changes to member rewards programs starting July 1, 2017.

Despite these measures, Secretary Earnest reported a general fund shortfall of $24.4 million for FY 2017. He listed continuing Medicaid budget pressures, such as:

- the declining Federal Medicaid Assistance Percentage for the Medicaid expansion population;
- changes in federal requirements with respect to autism coverage, hepatitis C treatment, mental health parity and Medicaid managed care;
- requests for rate increases from nursing facilities, Program of All-Inclusive Care for the Elderly providers and intermediate care facilities for individuals with intellectual disabilities; and
- other programs that are dependent on Medicaid financing, such as the Health Information Exchange, the New Mexico Medical Insurance Pool, the New Mexico Health Insurance Exchange and the University of New Mexico's (UNM's) ECHO Cares program.

Next, Ms. Smith-Leslie reviewed managed care initiatives to improve Medicaid services, such as the increasing the use of community health workers, increasing the number of members served by patient-centered medical homes (PCMHs), reducing non-emergent use of emergency departments and increasing the use of telemedicine. Ms. Smith-Leslie stated that all of the MCOs had met the targets set for use of community health workers. She also explained various ongoing payment-reform pilot programs. With respect to adults with serious mental illness and children with severe emotional disturbance, she reported that, as of April 1, 2016, 150 members are being served in San Juan and Curry counties under a state plan amendment. According to Ms. Smith-Leslie, 40% of Centennial Care members are being served in PCMHs, with 10% of enrollees assigned to higher levels of care coordination.

Medicaid MCOs are working with community agencies to better manage "super utilizers". A current pilot project involving the top 10% of "super utilizers" for each Medicaid MCO has demonstrated reduced non-emergent use of emergency departments through better management of care. For example, Presbyterian Health Plan has partnered with Albuquerque Ambulance Service to conduct home visits for those with a history of high emergency department use. She noted that two of the four MCOs had met targets for reductions in emergency department use. In fact, one MCO saw a 78% drop in emergency department admissions. Molina Healthcare has partnered with the Bernalillo County Metropolitan Detention Center to connect incarcerated persons with care coordinators upon release. There was a 45% increase in the use of telemedicine among the four MCOs overall.

Managed long-term care has been in place in New Mexico since 2008. This has kept 85.6% of those members who received long-term care services in 2015 in the community instead of in a nursing facility, Ms. Smith-Leslie said. This community benefit is available to those who are not on the developmental disabilities (DD) waiver program. The HSD has formed a long-term care committee with Medicaid MCOs to address issues raised at LHHS meetings. The MCOs have developed a supplemental questionnaire to be piloted in June 2016 that will be included as part of the comprehensive needs assessment "to ensure members understand the full array of community benefits". In addition, the HSD and MCOs have developed a community benefit brochure and made changes to the Managed Care Policy Manual "to resolve issues identified by stakeholders".

Dr. Lindstrom spoke next, referring committee members to his April 14, 2016 "Behavioral Health Collaborative CEO Report" (see handout). He indicated that the report is more of a tactical than strategic plan, and he reviewed some of the report's contents for the committee. He stated that New Mexico's behavioral health problems fall into three categories: workforce, finance and regulatory reform. A team is tracking the state's progress in these areas and will issue quarterly reports to the Interagency Behavioral Health Purchasing Collaborative.

Dr. Lindstrom identified an immediate concern with the announcement that Agave Health, one of the Arizona agencies brought in by the HSD to replace 15 New Mexico behavioral health providers in 2013, is leaving the state. According to Dr. Lindstrom, Agave

Health had 12 locations in 10 counties serving 3,170 members. The MCOs and OptumHealth New Mexico are currently reviewing claims data from the last 90 days to transition care for these members. Dr. Lindstrom observed that this transition is "unique" when compared to those for two other Arizona agencies (La Frontera and Turquoise Health and Wellness) that previously left the state, in that several providers have come forward to indicate an interest in filling in for Agave Health. A request for information has been put together for providers who want to take on this work. According to Dr. Lindstrom, "cases in active service" have received notice from Agave Health identifying replacement providers and providing information on how the transition will take place. "Anyone who happens to fall through the cracks" should be able to obtain this information, he said.

Dr. Lindstrom reported that Rio Arriba and McKinley counties have been chosen as behavioral health investment zones to build behavioral health infrastructure and capacity. Each county has received $500,000 for this purpose. He also announced a plan to have 4,585 students in Santa Fe and Espanola receive seven weeks of training in the PAX Good Behavior Game by June 2016. According to Dr. Lindstrom, this evidence-based intervention helps students self-regulate, resulting in: reduced need for special education services; reduced crime, addiction and suicide attempts; delayed initiation of sexual activity; and increased rates of high school graduation and college attendance. He stated that, but for austerity measures due to the state's budget crisis, this intervention would have been expanded elsewhere in the state.

With respect to crisis triage centers, Dr. Lindstrom expects the Department of Health (DOH) to promulgate facility licensing rules this summer. The HSD is working on Medicaid reimbursement for this level of care. He clarified that local communities will be responsible for setting up crisis triage centers and expressed concern that there will not be an adequate workforce to run crisis triage centers 24 hours a day, seven days a week. He alluded to issues arising at the crisis triage center in Dona Ana County. He indicated that Bernalillo County is not planning to create a crisis triage center, as it is using a psychiatric emergency room at UNM.

Dr. Lindstrom concluded his presentation by mentioning that the state has received a grant that will be used to establish certified community behavioral health centers, with a goal of putting these centers "on par" with federally qualified health centers.

Committee Questions — Medicaid Update — HSD Panel

Among issues discussed during questioning by committee members were the following.

<u>The impact of reduced Medicaid reimbursements.</u> Several members of the committee expressed concern that reduced rates would discourage providers from serving the Medicaid population. Constituents have reported that some providers are not taking Medicaid patients. In response to questioning, Secretary Earnest stated that the HSD does not track the number of providers that do not take Medicaid patients or wait times for appointments. He stated that the HSD does not know what impact rate changes will have on access to services.

Leveraging Medicaid. The state receives matching federal funds for Medicaid at varying rates. According to Secretary Earnest, the state's regular Medicaid match rate is approximately 70%. For the Medicaid expansion population, the match rate is currently 100%. For family planning services, the state receives a 90% match. One committee member asked whether, instead of cutting provider reimbursement rates, the HSD had considered imposing fees upon providers to generate revenue to use as the state portion for the Medicaid match. Secretary Earnest replied that the HSD does not have the authority to impose fees and would need legislative authority to do so. The committee requested a presentation relating to federal law, including CMS regulations relating to Medicaid provider fees as a strategy for increasing the state's matching funds and for garnering a greater federal match.

Medicaid enrollment procedures. In response to a member's question, Secretary Earnest informed the committee that the HSD has not implemented any changes in Medicaid rules relating to enrollment procedures.

The multiplier effect of Medicaid dollars on the state's economy. A committee member remarked that health care is the top growth industry in the state and that each Medicaid dollar puts $1.47 into the state's economy. He pointed out that reducing state general fund Medicaid spending by $32 million would mean a loss of $130 million when taking the federal match into consideration. Some members questioned the wisdom of cutting spending in the leading job-creating industry in the state. Other members commended the Secretary Earnest on his cost-containment efforts.

Intergovernmental transfer from the UNM Health Sciences Center (HSC). Secretary Earnest was questioned about the HSD's role in seeking an intergovernmental transfer from UNM HSC. There is an FY 2016 supplemental appropriation of $20 million from UNM HSC to Medicaid that Secretary Earnest does not believe will occur. He indicated that there are ongoing discussions about filling the Medicaid budget gap with a $20 million intergovernmental transfer from UNM HSC to the HSD for FY 2017, and this amount is included in the HSD budget for FY 2017. Following the meeting, Secretary Earnest advised that if the $20 million intergovernmental transfer for FY 2017 does not take place, the Medicaid general fund shortfall will grow by this amount. A member noted that UNM HSC has a long-standing contract to provide health services to members of Indian pueblos in the state, and the member asked whether there was any tribal consultation with respect to the proposed intergovernmental transfer. Secretary Earnest stated that, should tribal consultation be required, he believes that UNM HSC would be responsible for doing so.

Pregnancy and contraceptive services. Responding to questions, Ms. Smith-Leslie stated that approximately 82% of births in New Mexico are to Medicaid recipients. The HSD does not currently track behavioral health services provided to young adults who are also parents, and the HSD does not have any specific estimates of Medicaid savings that could be achieved by reducing teen pregnancy. Obstetric services are not included in the proposed rate cuts, according to Secretary Earnest. Ms. Smith-Leslie responded that there are some reductions for certain codes related to family planning and contraception. Several members expressed support for

programs to reduce teen pregnancy, resulting in significant savings to Medicaid, as demonstrated by such a program in Colorado. A member noted that the federal match for family planning services had increased to 90%. The committee requested that Ms. Smith-Leslie inform the committee of any changes to billing codes relating to family planning and contraception.

MCO contracts and network adequacy. In response to questioning, Secretary Earnest indicated that the HSD is not privy to the contracted rates that MCOs have with their network providers. A committee member questioned whether reducing an MCO's capitated rate would necessarily result in lower contracted rates for that MCO's network providers. Another committee member expressed concern that an MCO could decide to drop "an entire system of care", as demonstrated by UnitedHealthcare's recent decision to drop UNM HSC from its provider network, except for certain specialty services. Ms. Smith-Leslie responded that if a Medicaid recipient needs to change the recipient's MCO to stay with a provider, the MAD will assist. In addition, she indicated that UnitedHealthcare would enter into single-case agreements with UNM HSC.

Secretary Earnest responded to questioning about the relationship of MCO per-member per-month Medicaid capitated payment rates (rates) by stating that any Medicaid provider cuts would have an effect on MCO costs and, thus, on rates. When asked how the HSD determines rates, Secretary Earnest stated that the HSD uses actuaries. "Our fee schedule is a basis for which . . . rates are negotiated", he stated. The HSD only knows what an MCO's overall expenditures are, and whether providers' MCO reimbursement arrangements differ from the Medicaid fee schedule is a matter that the MCOs and providers negotiate, he said.

Behavioral health services parity. There was a discussion of the nine-to-one ratio of physical to behavioral health services spending and how the parity required pursuant to federal law between physical health benefits and services and behavioral health benefits and services could be achieved. When asked why utilization of behavioral health services is lower than other Medicaid benefits and services, Dr. Lindstrom explained that this is a phenomenon that is experienced across the country.

School-based programs. Committee members questioned Dr. Lindstrom about the time available in the school day for the PAX Good Behavior Game training. Dr. Lindstrom replied that he had received only positive feedback about this program from the schools. Committee members also requested a presentation by the HSD and the Public Education Department to clarify the scope of Medicaid reimbursement for ancillary services provided in schools. The committee requested a hearing at which both HSD and Public Education Department staff provide testimony relating to school-based programs.

OptumHealth New Mexico. In response to questions, Secretary Earnest stated that OptumHealth New Mexico currently serves as the administrative organization for non-Medicaid behavioral health services, with one year left on its contract with the state. According to Secretary Earnest, the outsourcing of this function will be phased out, with plans to perform this function in-house by FY 2018. A committee member requested information on when suspended behavioral health provider payments will be released. The secretary explained that release of suspended payments

will occur when current administrative hearings conclude. He confirmed that OptumHealth New Mexico is holding the suspended funds. He stated that he did not know whether the funds are being kept in interest-bearing accounts and that he would let the committee know whether they are.

Mesilla Valley Hospital (MVH). A member inquired about the option of using MVH in Las Cruces to serve as a site for publicly funded behavioral health services in lieu of southern New Mexico residents having to make the trek to the New Mexico Behavioral Health Institute at Las Vegas (BHI). The member stated that the DOH appears to be unwilling to do this. Dr. Lindstrom stated that he would defer to the DOH relating to the application of MVH as contractor to serve as a southern alternative to the BHI. In response to a comment about the need for timely access to hospital-based substance use detoxification (detox) services, Dr. Lindstrom stated that MVH is a specialty acute psychiatric hospital. Federal Medicaid regulations require that detox occur in a general hospital, thereby barring MVH's assumption of this role.

Electronic verification. A member requested an update on the HSD's implementation of electronic verification of services rendered in a member's home. Ms. Smith-Leslie stated that the department has been working with the MCOs on a way for home health caregivers to clock in and out to verify that services are being provided at the member's home. According to her, the department has a pilot project in place that offers three alternative ways for home health caregivers to clock in to work.

HSD policy advocacy. A member asked Secretary Earnest whether the HSD had recommended the FY 2017 Medicaid budget provisions in the 2017 state budget or whether the HSD had recommended changes to UNM HSC's oversight structure. Secretary Earnest stated that the HSD has not made any such recommendations.

Emergency Food Assistance

Following questions, the committee chair offered Secretary Earnest the opportunity to address allegations that have recently come to light in federal court hearings on the Income Support Division of the HSD's handling of applications for emergency food assistance. Secretary Earnest stated that at an April 28, 2016 hearing, HSD employees had testified that they, themselves, had changed, or seen others change, applications for expedited food stamps. He explained that there is a lower income threshold for this emergency assistance and that the purpose of the changes was to make some applicants ineligible. Secretary Earnest stated that he was "extremely alarmed" by this testimony. He stated that he had called for an investigation and that the department's inspector general is investigating and is required to report to the court by June 20, 2016. Secretary Earnest continued by stating that directives have been issued to HSD employees to "never change applications". Secretary Earnest stated that the HSD has learned that this practice has been a "long-standing one", going back to 2003, according to some, and that "there is more to look into here". He pledged to take whatever steps are called for. He indicated that he had issued a directive on May 9, 2016 to all field staff in the Income Support

Division and had advised supervisors of the department's policy prohibiting retaliation against HSD employees who have come forward.

In response to questioning, Secretary Earnest explained that the inspector general "operates independently" but reports directly to him. The committee chair stated that he has heard that HSD staff are reluctant to be forthcoming since the inspector general reports directly to the secretary, and the committee chair suggested that an investigation conducted by someone outside the department would be appropriate. The committee chair also expressed concern about the manner in which HSD employees who had come forward to testify about falsification of documents are being treated by the department's defense counsel in trial proceedings. Secretary Earnest replied that "it is important that our employees know they can speak freely about this", and he added that union representation has been made available to HSD employees.

Follow-Up

Committee members requested the HSD to provide the following information:

1. the cross-walk results for behavioral health providers that have applied to replace Agave Health;

2. the percentage of Medicaid deliveries that are performed by midwives;

3. the contraception and family planning services that have been included in proposed Medicaid provider rate cuts;

4. whether OptumHealth New Mexico is holding suspended payments for behavioral health providers in interest-bearing accounts;

5. a copy of the May 9, 2016 directive from Secretary Earnest to Income Support Division field staff; and

6. a written copy of statements that Secretary Earnest and the HSD issued in response to Senator Ortiz y Pino's request that Secretary Earnest resign pursuant to the matter of Supplemental Nutrition Assistance Program application falsifications.

Medicaid Update — MAC Subcommittee Panel

The committee next heard from Joie Glenn, executive director, New Mexico Association for Home and Hospice Care, who has served on the MAC for a number of years. Ms. Glenn is chair of the Provider Payments Cost-Containment Subcommittee that was formed in early February to advise the HSD on provider rate reductions. According to Ms. Glenn, the HSD provided the subcommittee with data on utilization and services under Centennial Care in a timely manner, and the HSD regularly updated the subcommittee on the Medicaid budget. The subcommittee provided several scenarios to the HSD, and the HSD ran numbers for each one (see handout, letter dated April 8, 2016). According to Ms. Glenn, the subcommittee members worked well together, entertained suggestions and engaged in vigorous debate. In fact, various

groups offered consultant services to help run projections. All members of the subcommittee were "at risk" for their constituent base. Ms. Glenn acknowledged that the subcommittee did not assess the impact of suggested scenarios on health services infrastructure, beneficiaries or access to services. Phase two work for the subcommittee is to find additional cost reductions, with plans to merge this subcommittee with the subcommittee on long-term strategy.

Eugene Varela, chair, MAC benefit package, Eligibility Verification and Recipient Cost Sharing Subcommittee, announced that this subcommittee will be having meetings and allowing for public comment and input.

Linda Sechovec, executive director, New Mexico Health Care Association, is a member of the MAC and of the Long-Term Solutions Subcommittee. She provided a handout that explains the opportunities and barriers associated with intergovernmental transfers and provider fee programs. Ms. Sechovec explained that many of the federal requirements associated with using intergovernmental transfers to fund the state portion of Medicaid are complex, and these requirements present hurdles. Assessing provider taxes appears to be a more workable solution to meet the Medicaid shortfall (see handout). She offered to make Joe Lubarsky, a consultant with extensive experience in Medicaid shortfalls and Medicaid payment systems, available to the MAC. Ms. Sechovec reminded committee members that disability services providers are already running lean.

Medicaid Update — Consumer Advocate Panel

Barbara Webber, executive director, Health Action New Mexico, is also a member of the MAC. She reminded committee members that the legislature directed provider cuts. Her organization has already heard from providers that will no longer be taking Medicaid patients, which will, in turn, affect Medicaid beneficiaries. According to Ms. Webber, before adults were added to Medicaid years ago, many had gone without health care. There are ongoing initiatives in colonias and by churches to encourage those who have health care through Medicaid to take advantage of it. She added that health care "transforms" lives when people have access to medication.

Ms. Webber said that she favors the use of provider assessments to raise revenues (see handout). As of the end of the last recession, every state except Alaska has used these assessments. Her handout set forth two scenarios for using provider assessments to raise revenue. She noted that the first would require legislative action but no amendment to the state's Medicaid waiver. She also clarified that her organization does not advocate limiting provider assessments to only those providers that take Medicaid; she suggested a study of categories of providers and of the ways in which other states have designed assessments on health care providers.

Abuko Estrada, staff attorney, New Mexico Center on Law and Poverty, closed the panel discussion. He reminded legislators that the Medicaid program is very cost-effective. According to Mr. Estrada, New Mexico spends less than $92.00 per member per month. For the Medicaid expansion population, the state spends only $14.00 per member per month. He also

pointed out that health care is the largest sector of the state's economy, with health care jobs increasing at a high rate. Mr. Estrada stated that slashing the funding for the program will hurt jobs and exacerbate existing health care workforce shortages — shrinking this sector instead of growing it.

Mr. Estrada called attention to the recent shutdown of the obstetrics department at a hospital in Las Vegas that now requires pregnant women to drive an hour to receive care. He predicts that Medicaid reductions will increase the use of emergency departments, a costly care venue. He criticized cost-shifting to require patients to pay more as "an old idea" that has been rejected in the past. He argued that copays mean less access, less preventive care and less primary care. Increasing cost-sharing means that beneficiaries will wait until they are really sick to seek care, and then they will go to the emergency department.

Mr. Estrada concluded by stating that it is "astounding to discuss imposing fees on low-income individuals when you look at real reasons for the budget crisis": tax breaks that do not benefit most New Mexicans. He said that, instead, the state needs to view Medicaid as a net gain for the economy and raise revenue to maximize its economic potential (see handout, "New Mexico Losing $417 Million in Healthcare Dollars").

Committee Questions — Medicaid Update — MAC Subcommittee and Consumer Advocate Panel

Among issues discussed during questioning by committee members were the following.

Other options to raise revenue or contain costs. A committee member expressed interest in taxing electronic cigarettes, cannabis and tobacco products that are not currently taxed and increasing the per-pack tax on cigarettes. A representative of the American Cancer Association who was in the audience stated that a $1.00 per-pack cigarette tax increase would raise $33 million in revenue. Another committee member asked whether existing laws are adequate to promote wider use of telehealth medicine. The committee member also asked whether consideration was given to targeting conditions such as diabetes or interventions such as long-acting reversible contraception that could result in substantial savings over the long term. Another committee member suggested that increasing the number of psychiatric beds at MVH would avoid the costs of transportation from the southern part of the state to the BHI.

Cost-sharing to contain costs. A committee member brought up the administrative burden for providers that is associated with collecting copays.

Provider taxes to raise revenue. A committee member asked whether provider taxes would be passed on to patients with private insurance. Ms. Sechovec responded that there would need to be "collaboration" on provider assessments to make it a win-win proposition. Another committee member was concerned about the cumulative effect of New Mexico's low rate of Medicare reimbursement combined with a new provider tax on out-of-state providers (such as those in Lubbock or El Paso, Texas) that treat New Mexicans who do not have ready access to care in Albuquerque.

Intergovernmental transfers to fill the budget gap. A committee member urged caution in private-public arrangements to qualify for using intergovernmental transfers for matching federal dollars.

Impact of provider rate reductions on certain providers. One committee member asked about the distribution of rate reductions among providers and noted that most of the rate cuts were directed at UNM HSC. Ms. Glenn stated that Secretary Earnest focused on "winners and losers" under the Medicaid expansion. The amount of uncompensated care that UNM HSC has had to provide has fallen, as more people are insured by Medicaid. Another member asked whether out-of-state providers (that provide services to New Mexicans who live in areas without such services) were having their rates cut and, if so, how that will affect access to care.

Public Comment #1

Several people spoke and provided written comments in support of Families ASAP — New Mexico Brain Injury Alliance (Families ASAP), a community-based organization that has provided family advocacy and support, particularly to Spanish-speaking families with children with behavioral health problems, since the 1990s (see posted letters). According to those who spoke, the organization has lost its funding from the Children, Youth and Families Department (CYFD).

Monica Miura, the organization's statewide program coordinator, stated that the agency has had no audits indicating problems. The director recently attended a grant meeting where it was disclosed that recent allocations went to in-house (CYFD) infant programming. According to Ms. Miura, Families ASAP's very successful behavioral health respite program has been moved in-house to the CYFD and "is now virtually nonexistent".

Eliseo Lopez, the parent of a mentally ill son who has been in and out of hospitals, testified that his angry and violent son has done well in a day program, instead of ending up in CYFD custody or in the juvenile justice system. According to Mr. Lopez, Families ASAP feels like a family. He expressed distress at the cut to Families ASAP funding.

Maria Zamarrípa, a parent of three special-needs children adopted through the CYFD, addressed the committee in Spanish and used an interpreter. She stated that she has worked with a different advocacy agency in the past. She said that her children have been physically abused at a charter school, and as a result, she has filed police reports. Many schools do not want to deal with behaviorally challenged children. Her children have not received services for two years. They are well-behaved at home. After fighting with her children's school for a couple of years, she was referred to Families ASAP by her Centennial Care manager. With assistance from Families ASAP, the school is now giving her children the appropriate services. Ms. Zamarrípa lives in Moriarty and does not have many options. In response to questions from the committee, Ms. Zamarrípa stated that she has gone back to the CYFD for assistance. She has called for her adoption contact, and she gets no return call. She is told to call the care coordinator, she said. The care coordinator has referred her to Families ASAP.

Sarah Jara, who addressed the committee in Spanish, asked the committee for help for her children with disabilities. She stated that Families ASAP is a very important program that does good work. She said that "schools don't listen to us". Families ASAP is an important voice, and schools listen to it. Families ASAP helps translate for her. Each day, her children are better. If Families ASAP disappears, it will be catastrophic for her family.

Teresa Hernandez, who also addressed the committee in Spanish, is the mother of a disabled child. She is happy with Families ASAP. Now there is an individualized education program at the school. Her child is working better at school. There are therapies, and her child is paying better attention at school. She cannot imagine being without Families ASAP and get services twice a week. When left without services, her child regressed.

The committee chair explained that Families ASAP is an advocacy organization that assists in getting services from the schools. He added that when children are not doing well, parents may have to skip work, and this makes it hard for parents to keep working. A member contacted Secretary of Children, Youth and Families Monique Jacobson during this discussion, and she expressed regret at not having a CYFD representative present and requested an opportunity to address the committee regarding Families ASAP.

Teodora Zobel, parent caretaker of an adult child with disabilities who is on Medicaid, Medicare and Social Security, she told the committee that her son has a heart defect and was diagnosed with autism at age 14. She does not want Medicaid cut, and she urges the state not to jeopardize federal programs. She and her husband, who is elderly, are more fortunate than many other people in New Mexico. She wants therapy supports in school for autistic children. Applied behavior analysis is now available for children with autism to help them to self-regulate and focus. Ms. Zobel's son can do calculus but cannot handle the social demands of a job. Ms. Zobel said that they have had private health insurance and help in school, but there are limits to these resources. Therapy supports need to continue. Individualized Education Program meetings have not always been friendly, she said. She needed therapy experts to explain to school officials what her child needed.

Lisa Rossignol told the committee that she is a member of Parents Reaching Out. The organization provides support to families and tracks how families pay for their children's health care. Ms. Rossignol also works with Project ECHO. She urged legislators to keep an eye on the MAC and its proposals for cost-sharing. Her daughter had half of her brain surgically removed to treat her epilepsy, resulting in over $1 million in medical bills. Her husband was laid off, and she was able to access health care through Medicaid. She told legislators that copays penalize high users. Her child received eight therapies each week. She invited committee members to meet with families of children with special health care needs. She argued that funds spent on approved supplies could be better spent on activities that add richness to a child's life experience. Ms. Rossignol also criticized as excessive the amount of a primary care physician's (PCP's) time required as part of care coordination, stating that it is burdensome for PCPs to write letters as part of that coordination. She urged support for Project ECHO, with all MCOs dialing in from throughout the state.

Lecie McNees and Anthony Ross are with Visions Case Management and Amigo Case Management. They told the committee that these organizations are privately owned service providers for DD waiver services. Ms. McNees remarked that DD waiver freedom of choice is important and that some services are completely unavailable in certain counties. Ms. McNees explained that when people are not moved off the DD waiver wait list to services, many agencies are in danger of downsizing or closing. This results in job loss and the inability to create new jobs. Mr. Ross urged the committee to think about the developmental disability population, their caregivers and the need for services.

Medicaid Managed Care Provider Networks and Access to Care

Jenny Felmley, Ph.D., program evaluator, Legislative Finance Committee (LFC), reviewed her report entitled "Medicaid Managed Care Provider Networks and Access to Care", dated April 13, 2016 (see handout). Dr. Felmley's report provides a comprehensive look at Medicaid MCO provider networks and how well they are serving Medicaid recipients. In brief, the LFC performed a survey of PCPs in the seven New Mexico counties with the highest Medicaid enrollment. Specifically, the LFC surveyed PCPs identified by Medicaid MCOs as participating in their networks to confirm whether these providers are taking Medicaid patients and, if so, to obtain data on average wait times for patient appointments. The LFC survey found "significantly fewer PCPs accepting new Medicaid patients than has been reported by the MCOs". Based on the LFC's review of MCO reports, combined with the results of its survey, there is concern that some Medicaid recipients may face barriers when attempting to access health care, Dr. Felmley said.

Committee Questions — Medicaid Managed Care Provider Networks and Access to Care

Among issues discussed during questioning by committee members were the following:

Contractual obligations of MCOs with respect to network adequacy. In response to questions, Dr. Felmley confirmed that MCOs are contractually responsible to assemble provider networks and that reporting on networks is done quarterly for geographic access. A committee member noted that few MCOs are meeting their contractual obligations and asked about imposing penalties. Dr. Felmley stated that she, too, had discussed this with the HSD. According to her, the HSD considers provider shortages to be circumstances beyond the control of MCOs, so the HSD prefers to work with MCOs rather than fine them. The LFC report notes that the HSD has imposed $5.5 million in sanctions for late or inaccurate reporting. A member asked where the funds that are collected go. Dr. Felmley stated that some of this money goes back to the MCOs in the form of performance improvement incentives. Another member commented that perhaps the contractual provisions regarding network adequacy are unreasonable when considering the state's rural expanses. A member also mentioned that the Office of Superintendent of Insurance has a working group on network adequacy.

Wait times for appointments. A committee member noted that wait times for patients with Medicare and private insurance are also quite long, so long wait times are not unique to Medicaid services. The committee member suggested that to decrease wait times, greater focus needs to be placed on the urgent care clinic model. The committee member also criticized the

inefficient and burdensome process that MCOs require providers to go through to obtain preauthorization for tests and laboratory services. The member requested that the LFC survey how much provider time is spent seeking preauthorization.

Emergency department admissions. A member was interested in the diagnoses for emergency department admissions, particularly for behavioral health. Dr. Felmley indicated that the HSD has a report on the top 10 diagnoses responsible for emergency department admissions. However, she advised the committee that the MCOs are not reporting this information uniformly, so comparisons are problematic. Responding to questions, Ms. Felmley stated that the HSD is working on a model to have some providers work late hours to decrease after-hours use of the emergency department.

Credentialing and licensing of providers. A committee member expressed concern at delays in credentialing of providers by one MCO when the providers are already credentialed by another. Dr. Felmley said she is surprised to find that so few providers were credentialed by all Medicaid MCOs. Another committee member mentioned that reciprocity in professional licensing may need to be revisited.

Data as reported by the HSD. A committee member commented that reporting needs to be accurate to assess health care needs. Data should reflect what services are being delivered and where. MCOs need to have accurate lists of their network providers, and this list should be online. Certain members of the committee stated that they do not have confidence in the HSD's data on the number of behavioral health members receiving services. The committee member noted that there is a maldistribution of providers and that the behavioral health system has not recovered [after the suspension of payments to 15 behavioral health providers in 2013].

Follow-Up

The following information was requested by committee members:

1. the top 10 codes for emergency department admissions, as reported by the Medicaid MCOs; and
2. data on the number of physicians who have left private practice.

Review and Update of 2016 Health and Human Services Budgetary Provisions

A team of fiscal analysts and an economist from the LFC gave a rapid-fire presentation updating the 2016 budget for health and human services (see handouts, "Review and Update of 2016 Appropriations", dated May 2016 and a memorandum to Senator John Arthur Smith, chair, LFC, dated May 12, 2016).

Topics highlighted included:

- falling state revenues as a result of oil prices;
- state reserves far below the 10% considered ideal to cushion against economic volatility and to maintain the state's bond ratings;

- the need for Medicaid cost-containment;
- a flat DOH budget;
- the addition of 40 slots for the DD waiver, with the number of those on the waiting list still hovering around 6,000;
- a $38.9 million projected Medicaid budget shortfall for FY 2017; and
- a flat CYFD budget, with child care assistance for 18,000 children each month counting as the department's biggest expenditure.

Committee Questions — Review and Update of 2016 Health and Human Services Budgetary Provisions

Among issues discussed during questioning by committee members were the following.

CYFD budget and cutbacks. A committee member called attention to the chart showing the various programs that fall under the CYFD. The CYFD budget calls for a 2% increase in FY 2017, to $244 million, with the majority of increases in protective services and early childhood services programs. A committee member announced that family reunification services have been cut. Employees of agencies providing these services have left. The member noted that it is ironic that while the CYFD is launching its new "Pull Together" campaign, it is cutting services to unify families. Another member asked the source of funds for the Pull Together campaign. Kelly Klundt, senior fiscal analyst, LFC, stated that the CYFD used a fund balance for the campaign.

DOH budget and cutbacks. The DOH general fund appropriation for FY 2017 is approximately $11.4 million less than for FY 2016. A committee member was critical of the closing of a primary care clinic in the committee member's district. According to the member, this clinic was very effective at providing teen pregnancy services, and its behavioral health therapist was "a savior" for children at school. Another member noted that the addition of 40 slots for the DD waiver was not closing the gap between those on the waiver and those on the wait list, observing that, at this rate, it would take 150 years to move those on the wait list onto the waiver.

CYFD child care assistance. A committee member questioned the rate of uptake on child care assistance. Ms. Klundt stated that she tracks enrollment every month. While enrollment is up 5% from last year, enrollment has been down in recent years, and this has meant that the state was not pulling down as much federal funding as it could have had enrollment been higher. According to Ms. Klundt, the federal child care block grant has been reauthorized but requires recertification every 12 months. She also stated that while 18,000 children receive services every month, the population served is not the same every month.

The *Jackson* lawsuit. Several committee members asked for an exit strategy for this long-standing litigation brought against the state on behalf of persons with developmental disabilities.

Follow-Up

The list of community health agencies being discontinued, and those under contract with the CYFD, was requested by committee members.

Work Plan and Meeting Schedule

Committee members discussed the proposed work plan approved by the committee chair and presented by legislative staff.

A motion to pass the work plan, as discussed and amended, was passed without opposition.

Public Comment Period #2

Erin Marshall with Compassionate Choices provided a handout requesting the committee to assemble a task force on medical aid in dying (see handout).

Bill Jordan, senior policy advisor, New Mexico Voices for Children, stated that "it is tragic and worth noting" that the amount of the HSD budget cuts is approximately what was paid to Arizona providers. These spending cuts amount to $100 million after the federal match. He indicated that his organization is concerned about the impact of budget cuts on children, the disabled and the elderly. He noted that the Medicaid expansion is more than paying for itself, even according to the LFC. He stated that oil and gas prices are volatile and that taxes for businesses and corporations had been cut 37 times in the last few years. He noted that these tax cuts were protected in the budget, and he said that the budget has been balanced on the backs of the poor. Mr. Jordan characterized the tax cuts as "failed" and said that cutting Medicaid decreases revenue. He asked committee members to prioritize raising revenue in January 2017 instead of protecting failed tax cuts. With respect to early childhood, Mr. Jordan said that while enrollment is up by 5% over last year, enrollment is down 25% over the last three years, with 7,000 fewer children receiving assistance. He added that state spending for all preschool programs is less than it was in 2015.

The committee adjourned at 6:30 p.m.