F I S C A L I M P A C T R E P O R T

SPONSOR SFC **ORIGINAL DATE** 2/9/18 **LAST UPDATED** 2/14/18 **HB**

SHORT TITLE Insurance Tax for Substance Use Disorder **SB** 227/SCORCS/SFCS

ANALYST Esquibel/Clark

APPROPRIATION (dollars in thousands)

Appropriation					Recurring or Nonrecurring	Fund Affected
FY18	FY19	FY20	FY21	FY22		
	$67.5 - $1,000.0	$67.5 - $1,000.0	$67.5 - $1,000.0	$67.5 - $1,000.0	Recurring	Human Services Department

Parenthesis ( ) indicate expenditure decreases

REVENUE (dollars in thousands)

Estimated Revenue					Recurring or Nonrecurring	Fund Affected
FY18	FY19	FY20	FY21	FY22		
		$67.5	$67.5	$67.5	Recurring	Substance Use Disorder Response Fund
		$67.5	$67.5	$67.5	Recurring	County Health Care Assistance Funds

Parenthesis ( ) indicate revenue decreases

SOURCES OF INFORMATION
LFC Files

Responses NOT Received From
Taxation and Revenue Department (TRD)

Responses Received From (NOT on this bill but on prior, similar legislation)
Human Services Department (HSD)
Department of Health (DOH)
Office of Superintendent of Insurance (OSI)

SUMMARY

Synopsis of Bill

The Senate Finance Committee Substitute for the Senate Corporations and Transportation Committee substitute for Senate Bill 227 imposes an annual "substance abuse associate tax" of $300 on every substance abuse associate licensed in the state. The tax shall be paid to the Regulation and Licensing Department on or before July 1 each year. The bill creates the "substance use disorder response fund" and distributes half the revenues evenly among the substance use disorder response fund and the counties' health care assistance fund.

Money distributed to the health care assistance funds is eligible for expenditure for the existing purposes in the Indigent Hospital and County Health Care Act. Money in the substance use disorder response fund is appropriated to the Human Services Department (HSD) to fund the substance use disorder response plan. Revenue in the substance use disorder response fund would not revert to the general fund.

The bill proposes creation of a "substance use disorder plan" to be developed by the Human Services department (HSD). The plan shall identify policies for increasing the supply of behavioral health workforce trained in substance use disorder treatment statewide and for funding a robust response statewide to the demand for timely, evidence-based substance use disorder services for medical assistance recipients statewide. As part of the substance use disorder response plan, HSD shall adopt and promulgate rules to allow a LSAA licensed in accordance with the Counseling and Therapy Practice Act to be reimbursed for certain services provided to medical assistance recipients within the licensed substance abuse associate's scope of practice.

FISCAL IMPLICATIONS

The Human Services Department (HSD) indicates the number of licensed substance abuse associates (LSAAs) in the state is approximately 450. Therefore, the total estimated annual revenue generated under the provisions of the bill would be 450 X $300=$135 thousand.

The continuing appropriations contained in this bill are recurring expenses. Any unexpended or unencumbered balances remaining in the newly created substance use disorder response fund or in the existing health care assistance funds at the end of a fiscal year shall not revert to the general fund.

This bill creates a new fund and provides for continuing appropriations. LFC has concerns with including continuing appropriation language in the statutory provisions for newly created funds, as earmarking reduces the ability of the Legislature to establish spending priorities.

HSD provided the following Medicaid analysis on similar legislation.

The bill would require Medicaid reimbursement for the specified LSAA services. It is difficult to estimate the financial impact for the Medical Assistance Programs because it is not known how many state, county, and community programs there may be which currently receive no Medicaid funding but may be able to qualify for their LSAA to be paid by Medicaid for the services specified in the bill.

- There are approximately 450 LSAAs licensed in New Mexico. Many may already be employed by agencies to which Medicaid makes payment (such as Opioid Treatment Centers – Methadone Clinics), while others are employed by facilities to which Medicaid cannot make payment, such as correctional facilities.

- When the Medicaid program is already making payment to a provider for services at a rate that already includes the services of a Licensed Alcohol and Drug Abuse Counselor (LADAC) or an LSAA, that level of provider is already considered as having been covered in the "bundled" or "comprehensive rate" of another service.

- For estimating the additional cost to the Medicaid program, HSD estimates that approximately 40 LSAAs may enroll as Medicaid providers; approximately 50 percent of their time would be devoted to Medicaid recipients; and, of that time, approximately 50 percent of their services would be covered by the Medicaid program.

- By comparing their service to levels of payment for existing providers and services, it is anticipated that the average Medicaid payment would be approximately $60 per hour, inclusive of the supervisor's time.

Forty FTEs equals 83.2 thousand hours annually. If 50 percent of those hours were spent serving Medicaid eligible recipients (41.6 thousand hours), and 50 percent of the services delivered were services that Medicaid could cover, then 20.8 thousand hours of services rendered by LSAAs would become payable under this bill. At $60 per hour, the calculated impact to HSD is estimated to be $1.2 million annually, federal and state funds combined. The estimated federal match for this service is anticipated to be approximately 83 percent.

SIGNIFICANT ISSUES

According to the Department of Health (DOH) 2017 *New Mexico Substance Abuse Epidemiology Profile*:

Eight of the 10 leading causes of death in New Mexico are, at least partially, caused by the abuse of alcohol, tobacco, or other drugs. In 2015, the 10 leading causes of death in New Mexico were malignant neoplasms, diseases of the heart, unintentional injuries, chronic lower respiratory diseases, cerebrovascular diseases, diabetes, chronic liver disease and cirrhosis, suicide, Alzheimer's disease, and influenza and pneumonia. Of these, chronic liver disease, unintentional injuries, and suicide are associated with alcohol use; chronic lower respiratory diseases and influenza and pneumonia are associated with tobacco use; heart disease, malignant neoplasms, and cerebrovascular diseases are associated with both alcohol and tobacco use; and unintentional injuries and suicide are associated with the use of other drugs.

The report also has extensive tables, graphs, and narrative about each substance abuse issue in the state and proportional implications for each county. The full report can be found at: https://nmhealth.org/data/view/substance/1982/.

DOH supplied the following analysis on similar legislation.

Improving access to treatment is key to reducing the negative outcomes related to SUD. The

types of services outlined in the bill are consistent with the National Institute on Drug Abuse's *Principles of Drug Addiction Treatment: A Research-Based Guide* (https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment).

Over eight percent (8.6 percent) of New Mexicans age 18 or older are estimated to have needed but not received treatment (inpatient or outpatient) for substance use in 2015-2016, according to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health (NSDUH, State Estimates of Substance Use and Mental Disorders, https://www.samhsa.gov/data/reports-by-geography?tid=651&map=1). Population data from previous years (2013-2014) indicates that roughly 38,000 (2.5%) New Mexicans over age 18 needed but did not receive treatment for illicit drug use during the past 12 months and roughly 109,000 (7.0 percent) needed but did not receive treatment for alcohol use (https://www.samhsa.gov/data/sites/default/files/1/1/NSDUHsaeNewMexico2014.pdf).

As this bill is written, it charges HSD to create and implement the SUD Response Plan in cooperation with medical assistance contractors. However, the implementation of the SUD Response Plan as outlined in the bill could reasonably be expected to impact DOH drug overdose prevention activities with state licensing boards, healthcare organizations, health insurance entities, and community partners. Having a SUD Response Plan could have some positive impact on the DOH health status indicators of the drug overdose death rate and the alcohol-related mortality rate by improving access to treatment for New Mexicans with SUD.

HSD provided the following analysis on similar legislation.

The most recent edition of the annual New Mexico Healthcare Workforce Report documents the limitations in our state's SUD workforce (*2017 Annual Report*, October 2017). HSD, in concert with its partners on the Behavioral Health Collaborative, currently has response plans that address substance use disorder and behavioral health workforce issues and that promote timely, evidence-based services: the Behavioral Health Collaborative Strategic Plan, the Prescription Drug Overdose Strategic Plan, the Opioid STR Strategic Plan, and the Strategic Plan for Adolescent Substance Use Reduction Efforts (operated out of CYFD). In addition, there are mechanisms in place to encourage and expand the substance abuse prevention workforce, such as requiring contracted providers to identify at least one staff person who must achieve Certified Prevention Specialist status within two years. The proposed inclusion of two services in the SUD Medicaid Waiver, SBIRT and residential services for adult substance abusers, will strengthen New Mexico's continuum of care and encourage workforce development through enhanced reimbursement. The health insurance premium surtax increase would provide additional resources to align and build upon these initiatives in support of a comprehensive response to the SUD crisis and its workforce requirements.

The bill's requirement to include changes in the licensing rules for substance abuse associates has the following implications:

1. Supervision Requirements:

According to NMAC 16.27.13.9, licensure of LSAAs requires 90 hours of education and training in the areas of alcohol, drug, and counseling. The Counseling and Therapy Board considers the LSAA license to be a counseling license, which gives the licensed practitioner the ability to

provide one-on-one services to clients. However, the LSAA license is a restricted license in the sense that the LSAA must practice under supervision at all times and the license and experience requirements for the supervisor are also very specific in the license provisions (*Counseling and Therapy Practice Board Rules and Regulations*, p. 35).

Because the current rule for Licensed Substance Abuse Associates (16.27.13 NMAC) requires that the LSAAs practice under supervision at all times, that requirement must be followed in order for the Medical Assistance Programs to make payment. The Centers for Medicare and Medicaid Services (CMS) require a state to enforce the state's requirements regarding supervision of a provider.

2. BHSD currently ensures that quality clinical supervision is occurring for master's level non-independently licensed clinicians. The revision in reimbursement for LSAAs suggests that they should be included in BHSD's oversight for quality assurance, which would increase administrative work for staff that supports that process.

3. Not all of the services listed in the bill can be covered by Medicaid as coverage of some of the services is not allowed by CMS. Case management is restricted to specific kinds of "targeted" case management which CMS allows. Educational services and mediator services would not be allowed. Some services are not paid for separately from the primary behavioral health service including making referrals, education, reporting, or record keeping. Those are considered covered in the payment for the primary therapy or evaluation services. The same would be true of employing practice theory and research findings.

4. There is a significant payment issue that stems from the wording in the bill. The bill would require the Medicaid program to "reimburse" an LSAA provider even though the LSAA license does not allow the practitioner to practice without supervision.

There is no other instance where Medicaid pays a provider directly who cannot practice independently. Typically, a non-independent provider renders services, then the entity that employs the individual bills Medicaid for the services and then pays the employee and supervisor of the employee through a salary or contract arrangement. For example, Licensed Alcohol and Drug Abuse Counselors (LADACs) working for Behavioral Health Agencies, Community Mental Health Centers, and BH Core Service Agencies are reimbursed by the behavioral health entities as employees or contracted providers and it is the behavioral health organization agency that bills Medicaid for their services.

There are significant treatment advantages to following this current practice.

- The majority of individuals needing drug treatment also have behavioral health issues that can be addressed by a multidisciplinary group of practitioners employed by the behavioral health entities. The scope of services of the behavioral health entity is larger than what is available from the LSAA alone.

- It is typically the behavioral health entity that carries the business license and the malpractice insurance that a provider is required to have.

Of the more than 400 LSAAs listed on the licensing board's website, many of these likely practice in correctional facilities, half-way houses, county and local treatment centers and other facilities that may or may not qualify for Medicaid participation, depending on the facility's licensure.

However, because the bill's wording specifically says that reimbursement would be made to the LSAA, the bill seems to require that all LSAAs be reimbursed by Medicaid even if they were working for a facility that does not qualify for Medicaid enrollment, such as a county, city, and other private and public programs. This would increase costs for the Medicaid program. The increased costs would primarily come from making payments to state, county, and community programs that employ LSAAs who are supervised, as required, by the licensing board.

To comply with the wording in the bill, HSD would need to file a state plan amendment with CMS, which may or may not be approved, because of the direct payment to a non-independently licensed provider. If the bill allowed HSD to keep its current practice of reimbursing the Medicaid behavioral health agency that employs the LSAA, a state plan amendment would not be required.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is not met since HSD and the counties are not required in the bill to report annually to an interim legislative committee regarding the data compiled from expenditure of the funds and the resulting performance impacts to determine whether the tax increase and distributions are meeting their purpose.

Does the bill meet the Legislative Finance Committee tax policy principles?

1. **Adequacy**: Revenue should be adequate to fund needed government services.
2. **Efficiency**: Tax base should be as broad as possible and avoid excess reliance on one tax.
3. **Equity**: Different taxpayers should be treated fairly.
4. **Simplicity**: Collection should be simple and easily understood.
5. **Accountability**: Preferences should be easy to monitor and evaluate

RAE:JC/al/jle