



NEW MEXICO LEGISLATURE

**LEGISLATIVE HEALTH
AND HUMAN SERVICES
COMMITTEE**

2016 INTERIM FINAL REPORT

LEGISLATIVE COUNCIL SERVICE
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INTERIM SUMMARY

Legislative Health and Human Services Committee 2016 Interim Summary

The Legislative Health and Human Services Committee conducted 21 days of meetings, with 267 speakers giving 88 presentations at locations in Santa Fe, Las Vegas, the Pueblo of Isleta, Albuquerque, Taos and Farmington.

Health Care and Coverage

At each of the locations outside of Santa Fe, the committee sought updates from local providers of behavioral health and substance use disorder services on access to services. The committee heard from representatives of Bernalillo and Dona Ana counties regarding their plans for assisted outpatient treatment programs. The state's opioid and heroin overdose epidemic was the topic of several presentations over the course of the interim. In addition, the committee heard from behavioral health providers whose payments were suspended in mid-2013 regarding the status of administrative proceedings. Also related to behavioral health, the committee reviewed laws and procedures related to civil commitment.

The committee heard extensive testimony relating to "boarding homes", also known as "board and care" homes, which have been the subject of controversy, as at least four individuals have died in recent years due to substandard living conditions in some boarding homes. Representatives of the Department of Health and other state agencies and community organizations testified about the role of state agencies, community organizations and individuals in protecting vulnerable individuals from substandard housing and abusive practices.

The state's Medicaid program and the performance of managed care organizations (MCOs) providing services through the Centennial Care waiver program were the subject of many hearings throughout the interim. At issue were matters such as the Medicaid budget and cost reductions made in response to the state's budget situation, MCO services and access to behavioral health services.

The committee received reporting and heard testimony related to access to health care services generally, including the supply of health care professionals statewide and the status of health facilities in rural communities. The presentations included a report from the New Mexico Health Care Workforce Committee, testimony regarding the effect of Medicaid provider reimbursement cuts and testimony from representatives of several health care facilities. There was extensive testimony relating to the lack of obstetrical and gynecological services in areas such as Las Vegas. The discussions regarding access also included reporting about the need for linguistically appropriate services at health care facilities and in provider practices.

Pharmaceuticals and pharmacy benefits purchasing and costs were the subject of testimony by Legislative Finance Committee staff, state agencies, pharmaceutical industry representatives, pharmacy benefits managers, health insurers and consumers.

Public health and health status programs and services were the subject of testimony, including reporting from the Department of Health, testimony on the state's medical cannabis program, public health services and concerns and an overview of the state's trauma system. There was testimony relating to calcium cardiac scans and a quality study regarding bundled hip and knee replacement services. The committee also heard testimony regarding the potential and applications for establishing an all-payer claims database.

The committee toured health care and senior service facilities owned and operated by the Pueblo of Isleta during its visit there in July 2016. The committee was greeted by Pueblo of Isleta Governor E. Paul Torres and senior officials of the Pueblo of Isleta government.

The committee heard testimony relating to a number of licensing and scope-of-practice matters, including those related to chiropractic physicians, naturopathic physicians, occupational therapists and community paramedicine professionals.

A team of committee members, legislative staff and state agency staff participated in the Winnable Battles initiative of the National Conference of State Legislatures and Association of State and Territorial Health Officials and identified tobacco use cessation and prevention and teen pregnancy interventions as two areas of concern for the state. The committee heard testimony from the Winnable Battles team as well as testimony from the Department of Health, the Human Services Department, the Office of the Attorney General and the Tobacco Settlement Revenue Oversight Committee on these initiatives and the legislative and executive responses to them.

The Corrections Health Care Task Force, with representatives from the Corrections Department, provided testimony relating to the health care in facilities operated by the department, counties, municipalities and private contractors.

The committee heard testimony related to recommended changes to local enforcement of driving while intoxicated laws and local liquor excise taxation laws.

In response to the recent issuance of federal regulations on independent contractors and overtime, the committee heard testimony regarding the potential effects of these regulations for home care workers.

The committee heard testimony related to family caregiving, including a Family Caregiver Task Force report.

Children and Families

The committee heard testimony relating to the services and supports that exist for children and families in the state. This included testimony regarding the Annie E. Casey Foundation KIDS COUNT report, reporting from the Children, Youth and Families Department, testimony from the Children's Court Improvement Commission, a review of the status of girls in the state's juvenile justice system and reporting regarding kinship caregivers and child welfare from the J. Paul Taylor Early Childhood Task Force. The committee also heard testimony and

recommendations regarding maternal mortality and morbidity, family planning services and paid family leave.

Human Services

The committee heard testimony about the Human Services Department's administration of the Supplemental Nutrition Assistance Program, formerly known as "food stamps".

The committee reviewed the services and policies related to sexual assault, sexual harassment, gender discrimination and the processing of sexual assault forensic evidence kits (often known as "rape kits").

The committee heard testimony regarding domestic violence services and their availability statewide.

The Aging and Long-Term Services Department provided testimony about the programs and services it administers and about changes at the department and the state's Long-Term Care Ombudsman Program.

Disabilities Concerns Subcommittee

The subcommittee met a total of four days in Santa Fe and Albuquerque, covering 18 topics and hearing from 56 presenters and numerous members of the public. Topics considered included: updates on the number of persons served by the state's developmental disabilities (DD) waiver and of those on the wait list; DD supports and services; public notice and activities related to the coming renewal of the DD waiver; reports from the state's DD community providers and DD case managers; delays associated with outside review of DD waiver budgets; the impact of the state's budget crisis on services and programs for persons with disabilities; the federal Workforce Innovation and Opportunity Act; vocational rehabilitation; independent living; autism; special- needs planning; problems with issuance and renewal of registry identification cards for the state's medical cannabis program; and reports on the cost of the state's DD waiver and on waiver programs used by other states for persons with disabilities.

WORK PLAN AND MEETING SCHEDULE

2016 APPROVED
WORK PLAN AND MEETING SCHEDULE
for the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
and the
DISABILITIES CONCERNS SUBCOMMITTEE

Members

Sen. Gerald Ortiz y Pino, Chair
Rep. Nora Espinoza, Vice Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia

Sen. Gay G. Kernan
Rep. Tim D. Lewis
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Advisory Members

Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Rep. James Roger Madalena
Rep. Terry H. McMillan
Sen. Cisco McSorley

Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. William P. Soules
Sen. Mimi Stewart
Rep. Don L. Tripp
Rep. Christine Trujillo

Disabilities Concerns Subcommittee

Members

Rep. Tim D. Lewis, Chair
Sen. Nancy Rodriguez, Vice Chair
Sen. Craig W. Brandt

Rep. Miguel P. Garcia
Sen. Linda M. Lopez

Advisory Members

Rep. Deborah A. Armstrong
Sen. Ted Barela

Rep. Nora Espinoza
Sen. Gerald Ortiz y Pino

Work Plan

The topics that the Legislative Health and Human Services Committee (LHHS) will cover during the 2016 interim are as follows.

Aging

The LHHS will examine matters relating to the state's long-term care facilities and home- and community-based long-term services, including issues pertaining to oversight, conditions,

litigation, long-term care workers and recent federal regulatory changes. The LHHS will also review matters relating to health benefits and other services and supports for elders aging in place.

Behavioral Health

The LHHS will continue to review the effects of a changing landscape on behavioral health providers and New Mexicans living with behavioral health conditions. The LHHS will review matters relating to specific behavioral health conditions, including opioid dependence and substance use disorders. It will review behavioral health services provided through Medicaid and other state government funding sources and innovations in the private sector.

Children and Families

The LHHS will review a wide variety of issues relating to children and families, including policies and programs of the Children, Youth and Families Department; the state's approach to addressing and preventing child abuse and neglect; evidence-based care to children and families who experience adverse events; juvenile justice; foster care; and services and accommodations for pregnant women and working families. In addition, the LHHS will review reports and recommendations from the Children's Court Improvement Commission and the J. Paul Taylor Early Childhood Task Force.

Corrections Health Care

The LHHS will hold a joint meeting with the Courts, Corrections and Justice Committee to hear a report from the Corrections Health Care Task Force, established pursuant to Senate Memorial 132 (2015). At the joint meeting, the LHHS will also examine the implementation of Senate Bill 42 (2015), providing for Medicaid enrollment assistance for individuals leaving incarceration. Additionally, the LHHS will review reports of lawsuits and other events relating to health care in the state corrections system.

The LHHS will hear testimony relating to solitary confinement and its effect on the mental and physical well-being of incarcerated adults, as well as children held separately from general populations in the state's juvenile justice system.

General Public Health

The LHHS will review a wide variety of matters relating to public health, including matters pertaining to immunization; access to care; the health care workforce; health risks; health disparities; and the impacts of cost on health care, indigent care and the institutions that serve public health in the state. The LHHS will also review matters relating to the state's medical cannabis program.

In a joint meeting with the Tobacco Settlement Revenue Oversight Committee, the LHHS will examine proposals to reduce minors' access to all tobacco products, including e-cigarettes; increase the price of tobacco products, including e-cigarettes; ban the sale of flavored tobacco

products to minors; increase cooperation with tribes, nations and pueblos in the state regarding tobacco sales and use; and promote messaging on tobacco use prevention and cessation.

Hunger and Nutrition

The LHHS will hear reports on matters relating to food and nutrition service availability and the possibility of consolidating food and nutrition programming; the state's Supplemental Nutrition Assistance Program; and methods to address hunger and poor nutrition statewide.

Human Services

The LHHS will review programs and services relating to housing, financial services and assistance, employment programs and the administration of human services programs in the state. Additionally, the LHHS will review programs that address human trafficking, domestic violence and sexual assault.

Insurance

The LHHS will look extensively at the availability and cost of health insurance benefits, network adequacy, carrier practices and consumer rights. The LHHS will also examine topics relating to enrollment, the health insurance exchange and the health insurance market in the state.

Medicaid

The LHHS will review the Medicaid budget shortfall and actions proposed by the Human Services Department to address that shortfall. The LHHS will make this a priority for its review this interim. The LHHS will also look extensively at different aspects of the state's Medicaid program, including access to care; long-term care waiting lists and ongoing care; provider networks and reimbursement; managed care contract oversight; program administration; provider fraud allegations and due process; and the provision of individual Medicaid benefits. The LHHS will obtain reports from the Medicaid for Chiropractors Work Group and the Federal Medicaid Dollars Working Group.

Native American Health

The LHHS will review changes to federal law increasing Native Americans' access to health care at non-Indian Health Service facilities, as well as matters involving access to care on and off reservation; health conditions of concern; and health disparities.

Pharmaceuticals

The LHHS will hear testimony relating to the cost-effectiveness and efficiency of state government purchases of pharmaceuticals, as well as breakthroughs in pharmaceuticals. The LHHS will also hear testimony on the Office of Superintendent of Insurance's oversight of pharmacy benefits management.

Scope of Practice/Licensure

The LHHS will hear the perspectives of the boards, commissions, affected professionals and the community with regard to any changes proposed in the scope of practice for licensed professionals in the health and human services sector.

Women's Health

The LHHS will hear testimony from agencies, experts and the public on many issues relating to women's health and well-being, including reproductive health, public health matters, human services and supports and health coverage.

Disabilities Concerns Subcommittee

The Disabilities Concerns Subcommittee will review issues relating to public and private disability education, employment, financial and independent living services and support, the status of services and support for persons living with developmental disabilities and matters relating to individual disabilities.

**Legislative Health and Human Services Committee
2016 Approved Meeting Schedule**

<u>Date</u>	<u>Location</u>
May 23	Santa Fe
July 6-7	Las Vegas
July 25 July 26-29	Pueblo of Isleta Albuquerque
August 22-24	Taos
September 20-23	Farmington
October 25	Santa Fe
October 26	Santa Fe — joint meeting with Tobacco Settlement Revenue Oversight Committee
October 27-28	Santa Fe — joint meeting with Courts, Corrections and Justice Committee
November 14-15	Santa Fe

**Disabilities Concerns Subcommittee
2016 Approved Meeting Schedule**

<u>Date</u>	<u>Location</u>
August 4	Santa Fe
August 25	Santa Fe
September 19	Albuquerque
October 7	Albuquerque

AGENDAS AND MINUTES

Revised: May 20, 2016

**TENTATIVE AGENDA
for the
ORGANIZATIONAL MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**May 23, 2016
Room 322, State Capitol
Santa Fe**

Monday, May 23

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (1) **Medicaid Update**
—Brent Earnest, Secretary, Human Services Department (HSD)
—Nancy Smith-Leslie, Director, Medical Assistance Division, HSD
—Wayne Lindstrom, Ph.D., Director, Behavioral Health Services Division, HSD
—Joie Glenn, Chair, Provider Payments Cost-Containment Subcommittee, Medicaid Advisory Committee (MAC)
—Eugene Varela, Chair, Benefit Package, Eligibility Verification and Recipient Cost-Sharing, MAC
—Barbara Webber, Executive Director, Health Action New Mexico
—Linda Sechovec, Executive Director, New Mexico Health Care Association
—Abuko Estrada, Staff Attorney, New Mexico Center on Law and Poverty
- 11:30 a.m. (2) **Public Comment**
- 12:00 noon **Lunch**
- 1:30 p.m. (3) **Medicaid Managed Care Provider Networks and Access to Care**
—Jenny Felmley, Ph.D., Program Evaluator, Legislative Finance Committee (LFC)
- 2:30 p.m. (4) **Review and Update of 2016 Health and Human Services Budgetary Provisions**
—David Lucero, Deputy Secretary, LFC
—Christine Boerner, Senior Fiscal Analyst, LFC
—Eric Chenier, Senior Fiscal Analyst, LFC
—Kelly Klundt, Senior Fiscal Analyst, LFC

- 3:30 p.m. (5) [Work Plan; Meeting Schedule; Review of 2016 Health and Human Services Legislation](#)
—Michael Hely, Staff Attorney, Legislative Council Service
- 4:30 p.m. (6) [Public Comment](#)
- 5:00 p.m. **Adjourn**

**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.

The impact of reduced Medicaid reimbursements. 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.

Revised: July 5, 2016

**TENTATIVE AGENDA
for the
SECOND MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**July 6-7, 2016
New Mexico Highlands University
Student Union Building Ballroom
800 National Avenue
Las Vegas, New Mexico**

Wednesday, July 6

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (1) **Boarding Homes**
—Shawn Mathis, Staff Attorney, Legislative Council Service
—John Barnum, President, National Alliance on Mental Illness (NAMI) Albuquerque
—Felicia Barnum, Treasurer, NAMI Albuquerque
—Jim Jackson, Chief Executive Officer (CEO), Disability Rights New Mexico (DRNM)
—Miguel Chavez, Senior Advocate, DRNM
- 10:00 a.m. (2) **Independent Living**
—Jody Jepson, Housing Director, Heading Home
—Breanna Anderson, Communications Director, Heading Home
—Anita Cordova, Director of Development, Planning and Evaluation, Albuquerque Health Care for the Homeless
- 11:00 a.m. (3) **Texas Boarding Home Model**
—Eliot Shapleigh, Former Texas State Senator
—Shawn Mathis, Staff Attorney, Legislative Council Service
- 12:00 noon (4) **Public Comment**
- 12:30 p.m. **Lunch**

1:30 p.m. (5) [Department of Health \(DOH\) Programs Update](#)
—Lynn Gallagher, Secretary, DOH
—Michael Landen, M.D., State Epidemiologist, DOH

3:30 p.m. (6) [Public Comment](#)

4:00 p.m. **Recess**

Thursday, July 7

8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS

8:40 a.m. (7) [Access to Obstetric and Gynecological Services in Rural Areas](#)
—Jeff Dye, CEO, New Mexico Hospital Association (NMHA)
—Ellen Interlandi, RN, Care Consultant, NMHA
—Connie J. Trujillo, Clinical Nurse Midwife, RN, MSN, MBA, Alumbra
Women's Health and Maternity Care, LLC
—Sonda Boulware, DNP, Acute Care Nurse Practitioner, Southwest Heart,
PC
—Margarita Montano, Former Patient, Alta Vista Regional Hospital

10:00 a.m. (8) [Alta Vista Regional Hospital](#)
—Chris Wolf, CEO, Alta Vista Regional Hospital

11:30 a.m. **Lunch**

1:00 p.m. (9) [Cimarron Health Clinic and Ambulance Facility](#)
—Bill Norris, District Administrator, South Central Colfax County Special
Hospital District

2:30 p.m. (10) [Local Behavioral Health Provider Update](#)
—Kevin Norris, CEO, Pecos Valley Medical Center

3:30 p.m. (11) [Public Comment](#)

4:00 p.m. **Adjourn**

**MINUTES
of the
SECOND MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**July 6-7, 2016
New Mexico Highlands University, Student Union Building Ballroom
800 National Avenue
Las Vegas**

The second meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on July 6, 2016 by Senator Gerald Ortiz y Pino, chair, at 8:46 a.m. in the Student Union Building Ballroom at New Mexico Highlands University in Las Vegas.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia

Absent

Rep. Nora Espinoza, Vice Chair
Sen. Gay G. Kernan
Rep. Tim D. Lewis
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Advisory Members

Sen. Craig W. Brandt
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Howie C. Morales (7/7)
Sen. Bill B. O'Neill
Sen. Nancy Rodriguez
Sen. William P. Soules
Rep. Christine Trujillo

Sen. Sue Wilson Beffort
Sen. Jacob R. Candelaria
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Mimi Stewart
Rep. Don L. Tripp

(Attendance dates are noted for members who were not present for both days of the meeting.)

Guest Legislators

Sen. Pete Campos (7/7)
Rep. Tomás E. Salazar (7/7)

Staff

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

Rebecca Griego, Staff, LCS
Alexandria Tapia, Contractor, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Wednesday, July 6

Welcome and Introductions

Senator Ortiz y Pino welcomed members of the committee, staff and those in attendance. Dr. Sam Minner, Jr., president, New Mexico Highlands University (NMHU), welcomed the committee to the university and shared a statement reflecting the importance of health for economic well-being. Dr. Minner highlighted some of NMHU's nursing and social work programs that have created a more accessible and financially affordable option for students to obtain quality training in the field. Dr. Minner outlined some of the features and benefits of the programs offered by NMHU, adding that the university hopes to continue to develop its existing programs and create new health programs in the future.

Tonita Gurule-Giron, mayor of Las Vegas, welcomed the committee to Las Vegas. Mayor Gurule-Giron thanked the members of the committee for their funding support for the community and introduced a few individuals in the audience.

Senator Ortiz y Pino asked members of the committee and staff to introduce themselves. The chair then explained the interim committee process and the 2016 work plan for the LHHS.

Boarding Homes

Ms. Mathis provided the committee with an information memorandum and presentation on the issue of boarding home regulation in the state. Ms. Mathis explained the differences between boarding homes and assisted living facilities. The definition of a boarding home has changed over time, and Ms. Mathis provided a brief history of the regulation of boarding homes in New Mexico since 1970. (Please see handout at www.nmlegis.gov for more information). In 2010, the Department of Health (DOH) promulgated the rules that are currently in effect relating to assisted living facilities. No definition of boarding home was included in those rules. The Public Health Act and rules promulgated pursuant to that act include the term "boarding home" among those entities that the DOH licenses as "health facilities", Ms. Mathis said. During the 2010 legislative session, a house joint memorial was passed requesting the LHHS to study the licensing of housing for persons discharged from the New Mexico Behavioral Health Institute at Las Vegas (BHI) and to consider additional regulations. Due to budget and resource constraints, it was recommended that BHI and the and the Division of Health Improvement of the DOH work with housing operators directly to develop standards.

Ms. Mathis concluded her presentation by noting the importance of creating a clear definition of "boarding home". Additionally, several regulatory considerations were mentioned, including: broad versus specific applicability; intensity or complexity of services; functionality of residents; reimbursable services; cost and capacity of regulatory oversight; and the most appropriate regulatory authority for the service venue. Ms. Mathis informed the committee that the staff plans to continue a presentation on this topic at the upcoming LHHS meeting at the end of July.

John Barnum, president, National Alliance on Mental Illness (NAMI) Albuquerque, provided background on the organization and its ongoing initiatives. NAMI Albuquerque provides advocacy, education, support and public awareness so that individuals and families affected by mental illness can maximize their capabilities and enjoyment of life. NAMI Albuquerque was chartered in 1985 and is an all-volunteer organization. In addition to providing community support for individuals and their families, NAMI Albuquerque also works with police departments, cities, counties and state initiatives concerning mental health. Mr. Barnum noted that housing issues are always a big concern. The organization frequently has difficulty in providing information about group homes and providing substantive reviews of facilities. Individuals with mental health conditions face housing concerns in a variety of scenarios, including when being discharged from hospitals. Mr. Barnum highlighted the issues of group homes from the perspective of NAMI Albuquerque. The organization requests that the committee look into the overall feasibility of requiring some form of registration and inspections for all group homes; consider the development of a statewide directory for group homes, with public access to this information; and allow NAMI Albuquerque to be involved in future housing-related issues that involve those with mental health conditions.

Felicia Barnum, treasurer, NAMI Albuquerque, stressed the tremendous need for group homes in the state. Ms. Barnum noted that boarding homes have a different relationship between owner and resident than a traditional landlord/tenant arrangement. She urged that special considerations be taken when developing regulations specific to boarding homes. According to Ms. Barnum, boarding homes in the state are facing serious overcrowding issues with as many as 12 to 15 individuals in the same residence.

Miguel Chavez, senior advocate, Disability Rights New Mexico (DRNM), provided the committee with some background on the organization and their scope of work. Mr. Chavez recounted the story of boarding home residents Alex Montoya and Cochise Bayhan, who died from carbon monoxide poisoning in 2013. After their deaths, it was determined that the residence was not up to livable standards under state regulations and had not been properly screened or approved. Mr. Chavez added that no steps have been taken since the incident to further regulate or monitor boarding homes.

Jim Jackson, chief executive officer (CEO), DRNM, referred to a few highlights from Ms. Mathis' presentation and to documents she provided to the committee. DRNM supports alternatives for individuals with disabilities. Mr. Jackson echoed that there is a problem

providing housing for people with disabilities in the state and there is a need for more oversight of these facilities to protect these individuals. DRNM recommends amendments to the Public Health Act that would include a clear definition of "boarding home" and a clear delineation of the responsibilities of a boarding home.

After completion of panel presentations, the committee was informed that this topic would be revisited during the July 25-29, 2016 meeting of the LHHS and would involve additional agencies and stakeholders. In response to questions from the committee, the following topics were discussed:

- the limited availability of information regarding housing and lack of resources for families to make informed decisions;
- staffing oversight for boarding homes;
- additional details regarding the deaths of Mr. Montoya and Mr. Bayhan;
- the potential for compiling a more cohesive index of boarding homes in the state;
- investigations of complaints about boarding homes;
- ownership of boarding homes and assisted living facilities;
- financial assistance and costs not covered by programs like Medicaid and Centennial Care;
- tracking done by the Board of Pharmacy on the estimated number of boarding homes, based on custodial drug permits; and
- the need to consolidate information and the potential to look at examples from other states for best practices.

Independent Living

Jody Jepson, housing director, Albuquerque Heading Home (AHH), provided the committee with background on the program's origins. AHH is a community-wide initiative launched in early 2011 designed to house chronically homeless and medically vulnerable people who have physical, mental health or substance use disorders and to create system changes to make homelessness rare, short-lived and nonrecurring. AHH achieves these objectives by collaborating with partners to provide permanent housing, case management and other supportive services so that clients can have an enhanced quality of life and ultimately become self-sufficient. Ms. Jepson explained that AHH employs a "housing first" model — meaning that in the hierarchy of needs, shelter is paramount to survival. After satisfying that basic need, AHH's core vision team next seeks to provide other support to those individuals most vulnerable and most in need.

Among its several programs, Ms. Jepson highlighted AHH's trauma-informed care approach that uses case managers to help understand causes for an individual's mental, emotional and physical status. This approach reduces the blame and shame that some people experience when being labeled. It also builds an understanding of how the past impacts the present, which effectively makes the connections that progress toward healing and recovery. Ms. Jepson described the roles and responsibilities of case managers for AHH clients and the additional

supports the organization provides to the community. She stated that AHH's peer-to-peer program has been a major success. That program uses volunteers to increase the social connectedness of new neighbors (clients) and to provide ancillary services upon request, including help with Medicaid enrollment, literacy classes, flu shots, employment workshops, budget classes and health and wellness education.

AHH has housed a total of 566 individuals, including 87 family members. With the help of the community, AHH has an 85% to 90% retention rate after one year. According to the presentation, the greatest innovation and strength of AHH is the political good will and support it has from city leadership and the business community. AHH has been able to integrate the services of several organizations and thus access resources across service partners to ensure that clients' needs are met. An independent cost-study released in 2013 highlights the cost-saving measures of AHH. A specific finding is that shelter, jail and emergency room costs have been reduced. Data-driven success has helped generate positive project reputation and community support, as well as generating interest among cities in other states.

Dr. Paul Guerin, director, Institute for Social Research, University of New Mexico (UNM), shared the findings of a study on AHH with the committee. Dr. Guerin explained that the study looked at the differences between being housed and not housed and the costs associated with each. The data presented to the members of the LHHS was the result of a phase one study conducted over the course of one year. The following findings from the study were reported as a result of the AHH initiative.

- One year post-AHH study group member costs were \$615,920.49 or 31.6% less than the one year pre-AHH study group member costs. This amounted to an average savings of \$12,831.68 per study group member.
- Study group members reported being homeless an average of 8.59 years in their lifetime.
- Participants were, on average, 44 years of age.
- Study group members' emergency room visits decreased by 36.2% after being housed.
- Emergency room costs declined \$27,167.12.
- The finding of a net cost benefit parallels the findings of the City of Albuquerque Housing First Cost Study and other studies that show that this type of program results in a relative decrease in costs.
- Prior to being housed, jail costs were \$51,540.30. After housing, jail costs decreased 64.2%.
- As expected, social service costs (e.g. case management, outreach and social work) increased by 469.3%.

The study reported that future research includes a longer cost-study time period; more complete service and cost data; a larger study group; and client follow-ups to collect additional self-reported data, including measures of satisfaction and indicators of life improvement. Dr. Guerin added that the next study will also include emergency rescue services. At present, the

data collection for the newest study, which covers a four-year span, is completed but not yet approved for release by the city. The new study is expected to be made available within the next month.

Members of the committee engaged the presenters about the following topics:

- the potential for Medicaid reimbursement for paid staff and the overhead of contract services;
- the success of getting local volunteers involved with the home team program and how those volunteers are recruited and trained;
- salary comparisons for the chief operations officer, which frequently ranges between \$95,000 and \$150,000 a year for nonprofit organizations of comparable size to AHH;
- data collection for the two studies and where the city has achieved cost savings;
- collaboration with other groups, such as boarding homes, and the differences between programs like AHH and boarding homes;
- the social returns on programs like AHH and the unmeasured benefits to society in addition to dollar savings;
- demographics for homeless individuals in the Albuquerque area, including the number of families and veterans;
- the status of various funding sources and grants for AHH, such as the New Mexico Mortgage Finance Authority and the federal Substance Abuse and Mental Health Services Administration. AHH is currently receiving funding from the City of Albuquerque, which has justified the funding through the cost savings study; and
- the importance of case management to the overall success of the program.

Legislative and Regulatory Oversight of Boarding Homes

Eliot Shapleigh, former Texas state senator from El Paso, introduced himself to the committee and provided his professional background. During his time in the Texas State Senate, Senator Shapleigh helped sponsor Texas House Bill 216 (2009) (HB 216), which amended the Health and Safety Code to give local governments the power to license and regulate adult boarding homes for the mentally or physically disabled and the elderly. Under the prior law, these homes were unregulated, and the law only required licensing, inspection and regulation of such facilities when they provided medical services, prescription administration or therapeutic services. HB 216 enacted a model statewide standard for regulation of boarding homes. Local governments in Texas now have the option to regulate the boarding homes, with the regulatory authority to conduct inspections, maintain a registry of boarding homes and certify owners. This approach does not vest authority in any statewide agency. It is instead what Senator Shapleigh characterized as an unfunded mandate to cities and local municipalities to implement these regulations and report back to the state for the consolidation of information.

Senator Shapleigh referred to the information memorandum previously distributed by Ms. Mathis, citing it as helpful in addressing the problems New Mexico is currently facing regarding issues with boarding homes. Ms. Mathis provided the committee with a brief presentation

detailing the Texas model of boarding home regulation and its implementation. Following the presentation, members of the committee discussed with Senator Shapleigh the model used in Texas. At present, the Texas Legislature is looking to amend the law and perhaps change the definition regarding the number of people in a boarding home. In closing, Senator Shapleigh noted that the City of El Paso would be a good comparison to Albuquerque in terms of size and demographics.

Public Comment

Dr. Barbara Perea-Casey, city councilor, City of Las Vegas, spoke to the committee on behalf of the San Miguel County Family and Community Health Council. Dr. Perea-Casey explained the function of the health council and urged committee members to find out about their respective health councils and learn about their health council's involvement in their communities. The health council deals with issues of public concern — offering cooking classes for diabetics, suicide prevention and support, information on health insurance, substance abuse support and much more to their communities. Dr. Perea-Casey said that the San Miguel County Family and Community Health Council is ranked first out of the 33 health councils in the state. Dr. Perea-Casey informed the committee that the council used to receive \$82,000 per year from DOH general appropriations. Currently, it is receiving only \$5,000 from the DOH, \$5,000 from the San Miguel County and \$5,000 from the City of Las Vegas. Due to a lack of funding, the health council has been limited in the services it can provide to the community. Dr. Perea-Casey encouraged committee members to continue to support the work that the health councils do and urged them to continue funding these vital community resources. In response to a question from a committee member, Dr. Perea-Casey explained that the San Miguel County Family and Community Health Council determines priorities based on a resident survey and that teen pregnancy was not one of this year's priorities. The community is still struggling with an urgent need for pediatricians and obstetric services.

Rosalie Martinez, San Miguel County Family and Community Health Council, highlighted some of the successes of the health council. Ms. Martinez noted that the council also does a lot of work with youth and the elderly in the community. They have recently partnered with local high schools to distribute DWI-prevention materials.

Valerie Block Romero shared her personal experience with boarding homes and how she has benefited from available services. Ms. Romero believes that living in a boarding home is still an exclusion from society. She urged the committee to consider the difference between medical support and care and incarceration.

Marina A. Tapia, senior legal counsel, Developmental Disabilities Planning Council, Office of Guardianship, thanked the committee for looking into issues regarding boarding homes. She wished to bring to the committee's attention the changes that the Uniform Law Commission proposes to make to guardianship laws for all states. The Office of Guardianship provides counsel to qualified low-income persons. Most of these individuals need a guardian. Usually, a corporate guardian is appointed. Ms. Tapia is interested in getting this topic on the agenda of an

upcoming LHHS meeting. A member of the committee referred Ms. Tapia to Jack Burton in Santa Fe, and a copy of the memorandum regarding the proposed rule changes was requested to be shared with committee members.

DOH Programs Update

Lynn Gallagher, secretary-designate, DOH, provided the committee with an update on the department. The mission of the DOH is to promote health and wellness in New Mexico. The focus of the mission is changing, and the DOH is seeking a breakthrough of improvements in terms of health outcomes and the health status of the state. This new direction targets four key areas: obesity; diabetes; substance misuse, including tobacco; and teen pregnancy. The department believes that by focusing on these four key issues, the health of New Mexicans will dramatically improve and the state will experience a significant reduction in costs. The DOH is aiming for a 50% reduction in health-related costs within the next four years.

Secretary-Designate Gallagher was appointed to the DOH in April, following the death of former Secretary of Health Retta Ward. Under Secretary-Designate Gallagher, the department has undergone some reorganization and there have been some changes in leadership. In the fall of 2015, the department received accreditation for the Public Health Division and the Scientific Laboratory Division. The department has submitted its strategic plan for fiscal years 2017 through 2019, which focuses on the four key priorities previously mentioned and continues efforts to improve health status in other important areas. Secretary-Designate Gallagher highlighted some of the successes in health improvement in the state: maintaining high immunization rates; increasing family planning usage, including a 27% increase in the use of long-acting reversible contraception (LARC); ongoing decreases in teen birthrates; and a 16.9% decrease in obesity among third-graders. The DOH has implemented the Tobacco Use Prevention and Control Program, as well as an immunization registry with sustainable funding for childhood vaccinations under the Vaccine Purchasing Act. A new focus has been placed on improving oral health. New Mexico is one of only six states to successfully compete for funding from the federal Centers for Disease Control and Prevention (CDC) for asthma, lead, environmental health, public health and private well-being, Secretary-Designate Gallagher said.

The Epidemiology and Response Division of the DOH has been making efforts to tackle the state's issues with drug overdoses. New Mexico has the second-highest drug overdose rate in the nation. During the 2016 regular legislative session, a law was passed that made the opioid-reversal drug, naloxone (NarcanTM), more available, which has already had a significant impact on combating overdose deaths. In June 2016, the National Safety Council rated New Mexico as one of the highest in the nation for overdose-prevention policy implementations. Secretary-Designate Gallagher noted the expansion of several rehabilitation centers and outpatient treatment facilities around the state.

The Medical Cannabis Program is rapidly growing, Secretary-Designate Gallagher said. There has been a 75% increase in the number of actively enrolled patients — the program currently has 26,582 patients. Twelve additional producers have been added, bringing the total

number of producers to 35. The DOH has implemented new administrative rules and a new electronic system, which will better enable the collection of baseline data. In addition, eight new positions have been added to help with new patient enrollment. As of July 5, 2016, a new location for medical cannabis was opened off Rodeo Road in Santa Fe.

Michael Landen, M.D., state epidemiologist, DOH, gave a presentation on the risks that the Zika virus represents to the state and on Zika virus preparedness in New Mexico. Dr. Landen explained that the DOH is currently trying to determine the best approach to dealing with the Zika virus.

The Zika virus was first discovered in Uganda in 1947, Dr. Landen said. From 1947 to 2006, there were only 14 reported cases of the virus. In 2007, there was a large outbreak in the South Pacific, which has since led to the first cases being reported in South and Central America. There have been several reported cases in some areas of Mexico. Dr. Landen provided the committee with an overview of the symptoms associated with the virus. The primary modes of transmission of the virus are a bite from an infected mosquito, maternal-fetal transmission and sexual transmission from infected male partners. While fatalities from infection are rare, the Zika virus in pregnant women can pass to her fetus, causing microcephaly and other severe brain defects. Seizures, developmental delays, intellectual disabilities, hearing loss, vision problems, difficulty feeding or eating, balance and locomotion problems can result, and these can be mild to severe and have lifelong impacts, Dr. Landen said.

Dr. Landen shared a comparison of the virus with viruses carried by the same species of mosquitoes, such as the Dengue and Chikungunya viruses. The mosquito species that carry these viruses, *Aedes aegypti* and *Aedes albopictus*, are present in New Mexico, particularly in the southern counties. New Mexico State University has been doing systematic sampling around the state through its SouthWest Aedes Research and Mapping program.

Since January 2015, there have been 934 travel-associated cases and 287 cases of pregnant women with laboratory evidence of possible Zika virus infection in the United States. In New Mexico, there have been three travel-associated cases and no cases with expectant mothers. Dr. Landen discussed what can be done to prepare for and prevent local transmission of the virus. A lot of effort has been focused on education in cases of local transmission and on eliminating breeding habitats for mosquitoes. Dr. Landen also covered recommendations for traveler Zika virus prevention, detection of cases, testing guidelines and how a community response would be handled for a confirmed case. (Please see handout for more information on this presentation).

Internationally, Zika virus vaccine development is under way. A DNA vaccine and inactivated virus vaccine (similar to the flu vaccine) are both under testing with pending clinical trials. Dr. Landen noted that public health emergencies present opportunities for research and funding for the State of New Mexico. During the outbreaks of influenza and Ebola, the state received funding from the CDC and was able to develop preparedness and control procedures.

With Zika, it is likely that the state can get increased funding for preparedness and birth defects surveillance. To date, New Mexico has received less than \$300,000 in federal funds for Zika virus preparedness.

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

- staffing levels for the DOH and current vacancy rates;
- issues with a backlog of medical cannabis renewals and the need for a regulatory fix to allow purchase of medical cannabis with an expired registry card in emergency situations;
- closures of school-based health centers based on underutilization;
- the impact of those school-based health center closures on the department's programs and goals for lowering teen pregnancy rates;
- state budgetary issues and what the DOH is doing in response to budget cuts;
- promotional campaigns by the DOH to ensure proper vaccinations prior to the school year;
- status on testing, monitoring and tracking of lead in water done through the DOH's lead-prevention program;
- an update on the advisory committee created to implement the Health Information System Act and status of the website set to launch in January 2018;
- updates on ongoing litigation and the current status of the department's compliance with court orders;
- Secretary-Designate Gallagher's professional background and experience in health care;
- the DOH's role in developing a working definition for boarding homes;
- questions related to Zika virus testing — costs, who can be tested and where testing is done;
- transmission of the virus through blood and sexual contact; and
- the actual threat of the Zika virus to the state and the continuous need for funding research in search of a vaccine.

Secretary-Designate Gallagher stated that she did not have the requested information at hand and told the committee she would follow up regarding department vacancy rates, the number of people being affected by the backlog of recertification for medical cannabis registry cards and the number of school-based health centers in the state.

Public Comment

Yolanda Cruz, San Miguel County DWI Planning Council, expressed concern with the proposal to move the local DWI program from the Local Government Division of the Department of Finance Administration to the Behavioral Health Services Division of the Human Services Department (HSD). This issue arose from a house bill during the 2016 regular legislative session. The HSD has plans to move forward with a similar bill during the upcoming legislative session. Ms. Cruz stands in opposition to the move because Medicaid does not cover

all of the programs her organization provides, and she is concerned with the HSD's lack of understanding of their programs. She wants to work with the HSD as partners but wants to use Medicaid funds to better serve community members and avoid potential red tape.

Recess

The committee recessed at 4:23 p.m.

Thursday, July 7

Welcome and Introductions

The second day of the LHHS meeting was called to order at 8:35 a.m. by Senator Ortiz y Pino. He welcomed all those present, and asked members of the committee and staff to introduce themselves.

Access to Obstetric and Gynecological Services in Rural Areas

Margarita Montano, former patient, Alta Vista Regional Hospital, provided the committee with a personal account of her experience with a lack of obstetric and gynecological (OB/GYN) services in the local area. Ms. Montano has had to travel to Santa Fe for appointments and has not had many opportunities to meet her doctor.

Jeff Dye, CEO, New Mexico Hospital Association (NMHA), addressed the committee regarding the lack of OB/GYN services in rural areas of the state. Support and staffing for these services can present challenges in small communities. There are currently 25 hospitals in New Mexico that provide obstetrical services; that number has dropped from 27 in 2010. Specialty hospitals — like behavioral health, rehabilitation and long-term acute care hospitals — do not provide birthing services. Mr. Dye noted that several of the "low volume" — fewer than 233 births per year — rural hospitals have closed their obstetric services. In some cases, these were parts of their systems that they chose to concentrate at another center or they were in close proximity to a center that provided the birthing services.

Ellen Interlandi, R.N., care consultant, NMHA, explained that there are factors and challenges in providing obstetric services. Obstetric services do not stand on their own but are highly intertwined with other services in the hospital. Birthing is a 24/7 service, and lower-volume providers have a disproportionate number of staff on-call. Ms. Interlandi highlighted some of the main functions required for obstetric services, including: the potential for a medical emergency that requires immediate consultation or referral; the potential for surgical intervention; specialized monitoring equipment; and a full-time, board-certified physician with obstetric privileges. In addition to cost and capability, facilities also face issues in reimbursement, recruitment and geographical challenges. Medicaid is by far the largest payer source of obstetric services in the state. In some communities, 90% of births are to Medicaid recipients. To ensure that obstetric services are available in a community, hospitals end up assuming the cost of salary guarantees as well as the cost of malpractice coverage. Ms. Interlandi added that it is difficult to keep the satisfaction and interest of staff. Many members of the staff

do not like having to float to other areas if their love is obstetrics or neonatal care, so they tend to look for other organizations that do not require cross-training to other specialties. Rural and small hospitals face unique challenges in maintaining a full range of services. Nurses are more specialized these days, and it is harder to maintain competency in many areas, Ms. Interlandi said.

Mr. Dye presented various potential solutions to address some of the issues facing obstetric services in New Mexico. (Please see handout for the full list of suggestions.) These issues are being looked at by different groups and at different levels with stakeholders. The DOH is currently looking at what other states are doing to address similar needs. The nationwide trend has been to regionalize obstetric services. Among listed solutions, Mr. Dye discussed the possibility of using staff from urban, high-volume hospitals as a shared system or locum program. He also encouraged the state to address malpractice solutions to lure providers to New Mexico. Ms. Interlandi briefly covered the advance practice professionals matrix included in the handout.

Bill Patten, CEO, Holy Cross Hospital, spoke about the challenges he has faced in Taos and other rural areas. Part of the birthing process is the bonding that families do with hospitals and their doctors. Not having services that support families increases the likelihood of young families moving to larger cities. Holy Cross Hospital now has two doctors providing OB/GYN services, down from three. Because of that decrease, the two doctors are required to be on-call every other night. Mr. Patten noted the toll that takes, not only on their professional lives, but on their personal and family obligations. Holy Cross Hospital is now working to develop a free-standing birth center because the community is in need of these services. The cost of specialized laboratory tests, which have to be sent out, has been a burden. Some patients choose to have a home birth, but when there are complications, an entire team must be assembled in 20 minutes to provide emergency services to mother and child.

Connie J. Trujillo, clinical nurse midwife, R.N., M.S.N., M.B.A., Alumbra Women's Health and Maternity Care, LLC (Alumbra), addressed the committee regarding the experiences of midwives working in Las Vegas and the surrounding rural area. Alumbra is a privately owned clinic serving patients within a 13,470-square-mile area. These midwives have helped with deliveries at Alta Vista Regional Hospital and have recently applied for privileges at Christus St. Vincent Regional Medical Center in Santa Fe. Since the closure of obstetric services at Alta Vista Regional Hospital, Alumbra has helped more than 50 women deliver in other towns, including Santa Fe. Nurse-midwives can attend to and care for women having a normal birth, but if there are any issues with the delivery, nurse-midwives must have an obstetric physician present. Ms. Trujillo mentioned the fatality of a woman and her unborn son who were killed in an accident on Interstate-25 while traveling back from a doctor's appointment in Santa Fe.

Alumbra is a small practice offering maternity and women's health services, but with the closure of the Alta Vista Regional Hospital's obstetric unit, Ms. Trujillo informed the committee, Alumbra is facing the risk of closure. Alumbra has experienced a 10% loss in revenue and

expects a projected 50% loss by the end of the year due to the closure of obstetric services in Las Vegas. Ms. Trujillo suggested several legislative and regulatory changes, including allowing licensed independent practitioners to treat Medicaid patients without physician supervision and requiring hospitals to create contingency plans to deal with the loss of centers and services. Patient abandonment is the real issue, and hospitals should be required to provide more notice of these closures.

Linda Siegle, lobbyist, New Mexico Nurse Practitioner Council and the Nurse Midwife Association, addressed the issue of Santa Fe hospitals not granting nurse-midwives privileges. Federal law allows for nurse-midwives to administer to patients without physician supervision. Legislation passed during the last legislative session providing licensure of birthing centers has been helpful, and the further expansion of these centers may help address some of the issues caused by obstetric services closures. According to Ms. Siegle, home births performed by midwives and nurse practitioners account for 36% of vaginal births in the state.

Following the presentation, members of the committee had many questions and comments regarding the testimony of the panel. A number of topics were discussed, including:

- agreements between some of the native tribes in the state with nearby hospitals and the potential need for a liaison to help some of the tribes and pueblos establish relationships with the UNM hospital and other institutions;
- responses and feedback from the panelists regarding the various suggestions and proposed solutions brought up during the presentation;
- factual questions pertaining to hospital membership in associations, ownership and services;
- issues and circumstances surrounding the closure of OB/GYN services at Alta Vista Regional Hospital;
- the additional effects of not having OB/GYN services on the community;
- other services provided by Alumbra, including the implantation of LARC devices;
- network adequacy requirements for providers;
- the designation of midwives as primary care providers;
- issues related to the recruitment and retention of providers;
- insurance and privacy issues relating to LARCs;
- the role of local community colleges in producing nurses in more rural areas and tuition incentives to retain students after graduation; and
- the impact of OB/GYN center closures on prenatal and follow-up patient care.

A member of the committee requested a written response from Mr. Dye about the suggestions that Ms. Trujillo presented. Another member requested some information on malpractice coverage and what other states are doing to address the issue.

Alta Vista Regional Hospital

Chris Wolf, CEO, Alta Vista Regional Hospital, having participated in the previous panel, presented an update on the Alta Vista Regional Hospital. Mr. Wolf has been managing the hospital since March, 2014. The hospital has 54 licensed inpatient beds (intensive care unit and medical/surgical department), 10 emergency department beds and surgical services. Mr. Wolf gave an overview of the history of the hospital and its current status (see handout for additional information). The hospital has a five-member executive committee, 100 medical staff, 240 employees and 35 volunteers who provide support services. Alta Vista Regional Hospital has recently implemented the use of an electronic medical records system to reduce errors and ease workflow.

Alta Vista Regional Hospital is committed to community involvement and is continuously working on outreach programs. The 2016 strategic goals for the hospital include:

- continued progress toward becoming a highly reliable organization;
- provider recruitment and retention to ensure timely access to care. The hospital needs to hire many medical professionals, including those in the areas of general surgery, OB/GYN services, internal medicine and primary care. The hospital is seeking to fill several nursing positions, some of which are in specialty areas;
- continued improvement of the patient experience; and
- further development of partnerships that enrich the community with needed health care services. This includes expanding working relationships with UNM, Luna Community College and NMHU.

Like some of the other presenters, Mr. Wolf addressed some of the major challenges for rural hospitals. Issues with local school systems, spousal employment and workforce development all affect retention and recruitment of medical professionals. The average income of individuals living in Las Vegas is \$17,000 per year.

Several questions regarding Mr. Wolf's presentation were discussed with committee members, including:

- upgrades to systems to adhere to meaningful use requirements;
- additional costs associated with upgrades, including the addition of three information technology professionals;
- the correlation between local school systems and the recruitment of future professionals;
- cuts in Medicaid reimbursements and their impact on local hospitals;
- issues with the revenue cycle and obtaining timely payments;
- state requirements of services for accreditation;
- staffing inquiries and staffing needs;
- recruitment and retention strategies;

- agreements with UNM regarding telemedicine and the limitation of what can be done through that medium; and
- the need for legislative support for the nursing compact, which is up for renewal.

Public Comment

Joan Krohn, vice president, the National Organization for Women's New Mexico chapter, addressed the committee regarding the ethical questions surrounding patient abandonment in cases of obstetric clinic closures. Ms. Krohn said that there needs to be more effort to communicate with expectant mothers and the community about the closures of these centers. According to Ms. Krohn, more pressure should be put on hospitals to fulfill their responsibilities to the communities. Midwives are being "run out of business" because hospitals have a monopoly on medical care, she stated. Ms. Krohn asked about the purchase of Alta Vista Regional Hospital and the need for more transparency.

Pat Lehan stated that the people in the community feel "ripped off" by Alta Vista Regional Hospital. The company owns several other hospitals around the state and operates out of Tennessee, which Ms. Lehan believes is not in the best interest of the community. She recounted an Alta Vista Regional Hospital press release in which it announced the closure of the OB/GYN services due to market conditions. The closure was done with only six days notice, she said. Staff was provided with substantial notification of the closure, according to Ms. Lehan. She stated that the phone number given on Alta Vista Regional Hospital's press release directed patients to the marketing division, and patients were not connected to the help they needed. There is a petition that has garnered over 1,400 signatures requesting the reinstatement of OB/GYN services. Ms. Lehan also commented on the individuals killed in the car accident, noting that there have been many other victims that have been involved in accidents or experienced other hardships due to the closure. According to Ms. Lehan, the attorney general has called for the reopening of the hospital's OB/GYN services. Ms. Lehan called for the documents and contracts from the purchase of the hospital to be made public.

Margaret Vasquez, cultural anthropologist, said that a big problem in the twenty-first century is fitting one of the oldest human activities, childbirth, into modern health care and meeting the imperatives created outside our kinship systems. With the introduction of technology, childbirth has been corporatized. The focus has shifted from the well-being of mother and child to making a profit and avoiding lawsuits. Dr. Vasquez believes that these imperatives need to be reconciled, and childbirth needs to be shifted to local focus.

Ms. Lehan read a prepared statement that she attributed to Anne Ruggy, CNMWF at El Centro. Ms. Ruggy provides prenatal care to women who cannot pay for care, Ms. Lehan explained. Ms. Ruggy wrote of the socioeconomic impact of having to travel to receive care and services that used to be routine in Las Vegas. Not enough has been done to meet the needs of the women in the community. According to Ms. Ruggy, an OB/GYN from Santa Fe will come once or twice a week to Las Vegas. Alumbra provides safe women's health care, and it is ready, willing and able to provide OB/GYN services in Las Vegas.

Jane Lundsten, Las Vegas resident, shared the story of her last child's birth. Living 45 minutes north of Las Vegas, Ms. Lundsten had unpredictable and unforeseen issues during delivery. She was able to get to the hospital in Las Vegas and was eventually airlifted to the UNM neonatal unit. Ms. Lundsten explained that she and her baby were saved because they had immediate care — the outcome could have been very different without the closer care of the Northeastern Regional Hospital in Las Vegas. She noted that births are not always predictable, and mothers and children deserve the best possible outcomes. A lack of OB/GYN and pediatric services in the area makes it difficult to attract young families to the area.

Micheala Cadena, consultant, Young Women United, informed the committee that licensed midwives offer a lot of care to women. When this group of professionals are not included in policy discussions, she stated, an important part of maternal care options is left out. Midwives have been licensed through DOH regulation since the 1970s. Ms. Cadena added that there are 65 licensed midwives in New Mexico, primarily in Albuquerque but also throughout rural parts of the state. Midwives offer continuity of care, which is so very important to early care.

Cimarron Health Clinic and Ambulance Facility

Bill Norris, district administrator, South Central Colfax County Special Hospital District, provided the committee with the background on the facility and an update on the facility's needs. The South Central Colfax County Special Hospital District was formed in 1986 with the help of Presbyterian Healthcare Services of Albuquerque. There was a critical need to expand health care services in this region of Colfax County. Services in Springer and Angel Fire were limited, and Cimarron did not have a medical provider. Since its inception, the hospital district has been able to expand health care services to all communities within its service area through Colfax General Long Term Care, Colfax General Laboratory Emergency Medicine, Moreno Valley Healthcare Clinic and Cimarron Health Care Clinic. Bill Norris spoke about the different locations individually, the services they provide to communities and their financial and infrastructure needs.

The largest area of need is at the Cimarron Health Care Clinic. The Village of Cimarron has no money and no tax base and is unable to address the main issues at the clinic. In addition to routine primary care, the clinic provides many services, including free blood pressure screenings, flu shots, immunizations and health fairs. The physical building is falling apart, Bill Norris said. He shared photographs detailing the extent of the repairs needed in the clinic.

Bill Norris explained that the hospital district has been looking at related issues to try to combine facilities when seeking funding. One particular concept it is looking at is combining the health care clinic with an ambulance facility. Cimarron has a volunteer ambulance service, which remains very busy. The service is available 24/7 and operates with three ambulances. It has two paramedics, four EMT intermediates, 10 EMT basics and one first responder. The service covers over 1,100 square miles and has gone out on more than 120 calls this year, as of July. Bill Norris concluded his presentation by adding that the district is in real need of funding,

and he does not know where to get help. He wanted to bring this issue to the attention of the committee and potentially get some help in seeking funding sources.

Eric Martinez, lobbyist, explained to the committee that he is considering different approaches to get the funding needed. One option is to have the hospital district added to the Special Hospital District Act so that it can qualify for funding under that act. The district is working on a community development grant application. Mr. Martinez noted that there were some capital outlay appropriations from the districts' legislators; however, the funding was line-item vetoed because it was not enough money to even get started on the project.

Members of the committee discussed with the presenters some of the options for funding and asked various questions regarding the health clinic. Members offered various suggestions for potential funding, such as grants and applications to different foundations. The health clinic has been working with the county, but the county does not have the funds to support it financially. Counties are obligated by statute to help assist in establishing a center for public health; one public health center is already based out of Raton. A member suggested contacting the New Mexico Mortgage Finance Authority to see if it could offer assistance with funding. The presenters noted that all of their audits are up to date and are submitted annually. As a final suggestion, a member offered the possibility of working with local ranchers to raise money from hunting permits.

Local Behavioral Health Provider Update

Kevin Norris, CEO, Pecos Valley Medical Center (PVMC), provided the committee with an overview of the facility and the services it provides to the region. PVMC is a federally qualified health center serving the residents of San Miguel and Santa Fe counties. It is dedicated to providing quality, affordable patient care; promoting preventative medicine and healthy lifestyles; developing education outreach; and ensuring community involvement. Among its many services, PVMC provides comprehensive primary care, family medicine, behavioral health care, opioid replacement therapy and chronic care management. Kevin Norris highlighted the successes that PVMC has seen through Centennial Care.

PVMC has become a vital source of behavioral health service to the community. It offers a variety of treatment options and works with several provider types. In 2015 alone, the center received 1,867 substance use visits and 1,330 mental health visits. PVMC faces several challenges in terms of behavioral health services. The demand for opioid replacement therapy exceeds the supply, causing wait times of four to six months, on average. Socioeconomic factors affect patient care, as does a lack of public transportation. PVMC also faces challenges in the recruitment and retention of mental health and substance abuse counselors.

Kevin Norris outlined some of the strategic priorities for PVMC for the next year. These priorities include: creating a PVMC-sponsored Pecos school-based health clinic; addressing community health disparities; expanding family medicine, pediatric care and OB/GYN services

for the community; construction of a new dental and behavioral health building; and increasing the number of new patients. PVMC is also working to address the literacy issue in the area.

Kevin Norris thanked the legislature and various other departments for their continued support in providing quality health care services to the underserved community. After his presentation, committee members discussed the following issues:

- referrals for psychiatric care;
- the impact of the behavioral health transition on PVMC;
- grants and fundraising done by PVMC to fund various initiatives;
- the creation of a school-based health clinic and efforts to prevent risky behaviors among teens;
- the desire to expand services by adding doctors and providers, including OB/GYN services;
- communities served by PVMC;
- limitations of Medicaid reimbursements for some care; and
- a comparison of Colfax County and its Medicaid eligibility versus that of the Pecos region.

Public Comment

Ms. Romero spoke again to encourage the committee to continue to look for resources to help individuals to contribute to society. Ms. Block explained that individuals with mental illness and other forms of disability need tools to become contributing members of society, adding that New Mexico needs to invest in these tools. Medication management can be helpful when it is used in addition to other support services and is properly monitored.

Adjournment

There being no further business before the committee, the second meeting of the LHHS of the 2016 interim adjourned at 3:20 p.m.

Revised: July 22, 2016

**TENTATIVE AGENDA
for the
THIRD MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

July 25, 2016

8:30 a.m.: Elder Center, 63 Tribal Road 41 at Tribal Road 61

**9:30 a.m.: Pueblo of Isleta Casino, 11000 Broadway Blvd. SE
Pueblo of Isleta**

July 26-27, 2016

**South Valley Family Health Commons
2001 N. Centro Familiar SW
Albuquerque**

July 28-29, 2016

**Science and Technology Center Rotunda
University of New Mexico
801 University Blvd. SE
Albuquerque**

Monday, July 25 — Pueblo of Isleta: Two Locations

- 8:30 a.m. (1) **[Members Meet at First Location: Isleta Elder Center, 63 Tribal Road 41 at Tribal Road 61, Pueblo of Isleta](#)**
—Rita Jojola, Director, Elder Center, Pueblo of Isleta
—Natalie Abeita, Director, Assisted Living Facility, Pueblo of Isleta
- 9:30 a.m. **Members Meet at Second Location: Members and Public Meet at the Pueblo of Isleta Casino, 11000 Broadway Blvd. SE, Pueblo of Isleta**
- Welcome and Introductions; Approval of Minutes**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 9:40 a.m. (2) **[Welcome from Governor of the Pueblo of Isleta](#)**
—E. Paul Torres, Governor, Pueblo of Isleta
- 10:00 a.m. (3) **[Medicaid Update: Cost Reductions](#)**
—Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department (HSD)

- 11:30 a.m. **Lunch (provided)**
- 1:00 p.m. (4) [Native American Aging Title VI Programming](#)
—Rita Jojola, Vice Chair, New Mexico Title VI Indian Coalition
- 2:30 p.m. (5) [Effects of Medicaid Cost Reductions on Native American Recipients; Changes to Federal Matching Funds Policy for Native Americans](#)
—Maria Clark, Health Care Consultant
—Anthony Yepa, Health Advisor, Pueblo of Cochiti
- 3:30 p.m. (6) [Update on Family Caregiver Program](#)
—Lora Church, Director, Indian Area Agency on Aging, Aging and Long-Term Services Department
- 4:30 p.m. (7) [Public Comment](#)
- 5:00 p.m. **Recess**

Tuesday, July 26 — South Valley Family Health Commons, 2001 N. Centro Familiar SW, Albuquerque, NM 87105

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (8) [Welcome and Tour of South Valley Family Health Commons](#)
—Bob DeFelice, Chief Executive Officer, South Valley Family Health Commons
- 10:30 a.m. (9) [Access to Linguistically Appropriate Health Care and Human Services](#)
—Senator Mimi Stewart
—Sovereign Hager, Staff Attorney, New Mexico Center on Law and Poverty (NMCLP)
—Huong Nguyen, Education and Policy Specialist, New Mexico Asian Family Center
—Nkazi Sinandile, Co-Founder and Volunteer Program Coordinator, New Mexico Women's Global Pathways
—Antoinette Sedillo López, Esq., Executive Director, Enlace Comunitario
- 12:00 noon **Lunch**
- 1:00 p.m. (10) [Aid in Dying Decision](#)
—Allen Sanchez, Executive Director, New Mexico Conference of Catholic Bishops

- Barak Wolff, M.P.H., Public Health Advocate
- Emily Bentley, M.P.A., Multi-State Campaign Manager, Compassion and Choices
- Alexandra Smith, Attorney at Law
- Erin Marshall, Aid in Dying Task Force
- Representative Bill McCamley

2:30 p.m. (11) [Workers' Compensation for Agricultural Workers](#)

- Gail Evans, Esq., Legal Director, NMCLP
- TBD, New Mexico Farm and Livestock Bureau

3:30 p.m. (12) [School Supports and Services for Foster Youth](#)

- Grace Spulak, Esq., Director, FosterEd: New Mexico

4:30 p.m. (13) [Public Comment](#)

5:00 p.m. **Recess**

Wednesday, July 27 — South Valley Family Health Commons, 2001 N. Centro Familiar SW, Albuquerque, NM 87105

8:30 a.m. **Welcome and Introductions**

- Senator Gerald Ortiz y Pino, Chair, LHHS
- Representative Nora Espinoza, Vice Chair, LHHS

8:40 a.m. (14) [Housing for and Protection of Vulnerable Persons](#)

- Myles Copeland, Secretary, Aging and Long-Term Services Department
- Juliet Keene, Deputy Director, Medicaid Fraud and Elder Abuse Division, Office of the Attorney General
- Marina A. Tapia, Senior Legal Counsel, Developmental Disabilities Planning Council, Office of Guardianship
- Ben Kesner, Executive Director, Board of Pharmacy, Regulation and Licensing Department
- Sarah Trujillo, Licensing Manager, Board of Pharmacy

10:30 a.m. (15) [Assisted Living](#)

- Linda Sechovec, Executive Director, New Mexico Health Care Association and New Mexico Center for Assisted Living

11:30 a.m. (16) [Public Comment](#)

12:00 noon **Lunch**

- 1:00 p.m. (17) [Update on Assisted Outpatient Treatment](#)
 —Brian Stettin, Policy Director, Treatment Advocacy Center
 —Jamie Michael, Director, HSD, Dona Ana County
 —Douglas H. Chaplin, Director, Department of Family and Community Services, City of Albuquerque
- 2:30 p.m. (18) [Update on Behavioral Health Access](#)
 —Maggie Hart Stebbins, Bernalillo County Commissioner
 —Lisa Simpson, Technical Advisor to the Adult Detention Reform Coordinator, Bernalillo County
 —Lauren Reichelt, Director, Rio Arriba County Health and Human Services Department
 —Barney Trujillo, Commissioner, Rio Arriba County
- 3:30 p.m. (19) [Status of Administrative and Civil Proceedings Involving Referred Behavioral Health Providers](#)
 —Patsy Romero, Chief Operations Officer, Easter Seals El Mirador
 —Shannon Freedle, Chief Executive Officer, Teambuilders
 —Nancy Jo Archer, Executive Director, Hogares

4:30 p.m. (20) [Public Comment](#)

5:00 p.m. **Recess**

Thursday, July 28 — The Rotunda, University of New Mexico Science and Technology Park, 801 University Blvd. SE, Albuquerque, NM 87106

- 8:30 a.m. **Welcome and Introductions**
 —Senator Gerald Ortiz y Pino, Chair, LHHS
 —Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (21) [Welcome and Update on Health Sciences Center; Addressing Campus Sexual Assault](#)
 —Robert G. Frank, President, University of New Mexico (UNM)
 —Elsa Cole, University Council, UNM
 —Nasha Torrez, Dean of Students, UNM
- 10:00 a.m. (22) [Sexual Assault Programming](#)
 —Claire Harwell, Esq., Project Director, Community Justice for Survivors of Sexual Violence Project
 —May Sagbakken, Director, Rape Crisis Center of Central New Mexico
 —Kim Alaburda, Executive Director, The New Mexico Coalition of Sexual Assault Programs (NMCSAP)
 —Karen Herman, Ph.D., Director, Sexual Assault Services, NMCSAP

- 11:30 a.m. (23) [Public Comment](#)
- 12:00 noon **Lunch (provided)**
- 1:00 p.m. (24) [Forensic Evidence for Sexual Assault Survivor Services and Proceedings](#)
—Sarita Nair, Chief Government Accountability Officer and General Counsel, Office of the State Auditor
—Donna Richmond, Director, La Piñon Sexual Assault Recovery Services of Southern New Mexico
- 2:00 p.m. (25) [Health Information Exchanges/Interoperability/Privacy and Security](#)
—Thomas East, Ph.D., Chief Executive Officer and Chief Information Officer, LCF Research
—Dale Alverson, M.D., LCF Research
—Nick Edwardson, Ph.D., M.S., Assistant Professor, School of Public Administration, Senior Fellow, Robert Wood Johnson Foundation Center for Health Policy, UNM
—Jon Law, Executive Director, Paseo del Norte Health Information Exchange
- 4:00 p.m. (26) [Public Comment](#)
- 4:30 p.m. **Recess**

Friday, July 29 — The Rotunda, University of New Mexico Science and Technology Park, 801 University Blvd. SE, Albuquerque, NM 87106

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (27) [SNAP; Human Services Program Efficiencies](#)
—Sovereign Hager, Staff Attorney, NMCLP
—Christopher Collins, General Counsel, HSD
—Jon Courtney, Ph.D., Program Evaluator Manager, Legislative Finance Committee
- 10:30 a.m. (28) [Food and Nutrition Programs](#)
—Tony McCarty, Executive Director, Kitchen Angels
—Cindy Howell, R.N., B.S., L.N.C., Vice President of Healthcare Services, Molina Healthcare of New Mexico (MHNM)
—Catherine Sierra, R.N., Manager, Transitions of Care, MHNM

11:30 a.m. (29) [Public Comment](#)

12:00 noon **Adjourn**

**MINUTES
for the
THIRD MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**July 25, 2016
Elder Center, 63 Tribal Road 41 at Tribal Road 61
Pueblo of Isleta Casino, 11000 Broadway Blvd. SE, Pueblo of Isleta**

**July 26-27, 2016
South Valley Family Health Commons
2001 N. Centro Familiar SW, Albuquerque**

**July 28-29, 2016
Science and Technology Center Rotunda
University of New Mexico
801 University Blvd. SE, Albuquerque**

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on July 25, 2016 by Senator Gerald Ortiz y Pino, chair, at 10:09 a.m. at the Pueblo of Isleta Casino Ballroom in the Pueblo of Isleta.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Rep. Tim D. Lewis (7/28, 7/29)
Sen. Mimi Stewart
Rep. Christine Trujillo*

Absent

Rep. Nora Espinoza, Vice Chair
Rep. Deborah A. Armstrong
Sen. Mark Moores

Advisory Members

Sen. Craig W. Brandt
Sen. Jacob R. Candelaria (7/29)
Sen. Linda M. Lopez (7/25, 7/26, 7/27, 7/28)
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Howie C. Morales (7/25, 7/29)
Sen. Bill B. O'Neill (7/26, 7/27)
Sen. Mary Kay Papen (7/25, 7/26)
Sen. Nancy Rodriguez (7/27, 7/29)
Rep. Patricio Ruiloba
Rep. Don L. Tripp (7/25, 7/26)

Sen. Sue Wilson Beffort
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Sander Rue
Sen. Benny Shendo, Jr.
Sen. William P. Soules

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

*Appointed as a voting member for the duration of this meeting by Speaker Tripp. Prior to the meeting, Senate President Pro Tempore Papen appointed Senator Stewart as voting member of the LHHS in place of Senator Shendo.

Staff

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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file and posted on the New Mexico Legislature website at:
https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Monday, July 25

Pueblo of Isleta Elder Center Tour

Members of the committee met at the Isleta Elder Center to tour the center and the adjacent assisted living facility. The tour of the center was led by Rita Jojola, director, who provided the members with background on the center and the many services it provides. More than 216 services are provided daily to pueblo members, including home services, respite, chore assistance, veteran support, fitness and mobility programs and meal delivery. The center seeks to expand its intergenerational program, which brings in children from the community to participate in traditional arts and crafts with elders.

Natalie Abeita, director, showed members of the committee the Assisted Living Facility located next to the Isleta Elder Center. The facility has a separate area dedicated to memory care. Members of the committee were able to view sample rooms and see the community areas of the center. Ms. Abeita explained that when a resident comes in, the medical staff works with the families to develop individual care plans. The facility is currently in the process of getting a Medicaid provider number to enable billing on behalf of Medicaid-eligible residents.

Welcome and Introductions — Pueblo of Isleta Casino

The official beginning of the meeting occurred after the tour. Senator Ortiz y Pino began the meeting by providing an overview of what the members of the committee had seen at the two centers for the benefit of the audience. He then asked members of the committee and staff to introduce themselves.

Welcome from Governor of the Pueblo of Isleta

E. Paul Torres, governor, Pueblo of Isleta, welcomed committee members and thanked them for choosing the Pueblo of Isleta as the meeting site. Governor Torres is in his fourth year of service as governor. He also serves as the chair of the All Indian Pueblo Council. Governor Torres shared with the committee that he had been invited to give an invocation in the Tiwa language of the Isleta people at the Democratic National Convention being held in Philadelphia. He stated that the Pueblo of Isleta is focused on achieving better health care for the entire community, and the aim of this meeting is to share experiences on what is working. He extended an invitation for the annual Isleta fiestas held in August and September.

Medicaid Update: Cost Reductions

Nancy Smith-Leslie, director, Medical Assistance Division, Human Services Department (HSD), presented to the LHHS on Native American participation in the Medicaid program. From June 2013 to June 2016, Medicaid has experienced a 64% increase in enrollment. Under the General Appropriation Act of 2016, the department was charged with implementing changes in the Medicaid program to reduce projected spending and reduce reimbursement rates paid to Medicaid providers in Medicaid managed care and fee-for-service (FFS) programs. A Provider Payments Cost-Containment Subcommittee of the Medicaid Advisory Committee (cost-containment subcommittee) was formed to make recommendations for reducing provider reimbursement rates, with a goal of saving the General Fund \$30 million. Taking the subcommittee's recommendations into account, the HSD issued a proposal in April with additional reductions to achieve the savings goal. Ms. Smith-Leslie highlighted where rate reductions would occur and the phases in which the professional fee schedule changes will happen (please see handout for more information). The estimated savings for fiscal year (FY) 2017 from all provider rate reductions is between \$105 million and \$122 million total, of which \$21 million to \$26 million is General Fund savings. Following a period of public comment and tribal notification of cost-containment recommendations, two other subcommittees were formed: the Benefit Package, Eligibility Verification and Recipient Cost-Sharing Subcommittee and the Long-Term Leveraging Medicaid Subcommittee. The HSD is expecting recommendations from these two subcommittees in September.

As requested by the LHHS, Ms. Smith-Leslie addressed Native American enrollment in Medicaid. There are currently 126,050 Native Americans enrolled in Medicaid, 35,184 of whom are enrolled in Centennial Care. Ms. Smith-Leslie summarized the outreach initiatives being taken by the different managed care organizations (MCOs) in relation to Native Americans. The Native American Technical Advisory Committee was established at the beginning of Centennial Care and continues to meet quarterly to facilitate collaboration between the HSD and appointed tribal representatives. The HSD is currently participating in a six-state study group composed of states with the highest percentage of Native Americans enrolled in their Medicaid programs. Through coordination with the federal Indian Health Service (IHS), the study has determined that the largest potential for savings in Centennial Care is with long-term care services. The IHS and "Tribal 638s", which are facilities operated by tribes pursuant to federal P.L. 93-638 or 25 USCS §1651, have not traditionally had a significant role in the delivery of long-term care services.

Ms. Smith-Leslie reminded the committee that the HSD receives 100% federal "matching" funding for Native Americans enrolled in either FFS or managed care.

Angela Medrano, deputy director, Medical Assistance Division, HSD, provided the committee with an update on the NurseAdvice New Mexico (NANM) telephonic assistance hotline as requested pursuant to Senate Memorial 105 (2016). The HSD convened a task force on June 30, 2016 consisting of representatives from different health organizations. The HSD granted NANM access to the Medicaid web portal and made improvements to the process under which NANM invoices Medicaid MCOs for nurse advice services it provides to their enrollees. Now in its tenth year, NANM continues to explore revenue diversification options. Moving forward, the HSD is taking steps for researching its options for reimbursing NANM for services to Medicaid FFS recipients and to continue meeting with the New Mexico Hospital Association to explore options for contracting with additional hospitals.

Following the presentation, members of the committee discussed the following topics with the representatives from the HSD:

- participation during the public comment and tribal notification period;
- outreach efforts to hospitals not currently contracted with NANM and additions in membership to the task force to include stakeholders;
- the impact of rate reductions on providers from surrounding states;
- exemption from the Safety Net Care Pool Fund and hospitals with enhanced rates;
- inquiries on cost-containment recommendations, including co-payments for prescription drugs and value-based purchasing;
- the potential impact of rate reductions on practitioners and services;
- plans for monitoring rate reduction impacts, since rate cuts have not yet been implemented;
- the exploration of different ways to leverage Medicaid revenues;
- monitoring turnaround time from MCOs;
- state plan amendments to federal Centers for Medicaid and Medicare Services (CMS);
- IHS facilities around the state and Native American representation on HSD staff; and
- the impending deficit even with the estimated savings from the rate reductions.

After questions from the committee, the HSD and staff agreed to provide the following information:

1. a membership list of the cost-containment subcommittee;
2. the process for obtaining pre-authorization for benefits, to be explained by the MCOs as an agenda item at a future LHHS meeting;
3. a glossary of frequently used terms and acronyms for legislators' use; and

4. an economic assessment of rate reductions required through House Bill 2 on the economy, the effect of these reductions on the state's health care provider community and the recruitment and the retention of medical professionals in New Mexico.

Public Comment

Abuko Estrada, staff attorney, New Mexico Center on Law and Poverty (NMCLP), addressed the committee with a few points regarding the previous presentation. According to Mr. Estrada, there was confusion about the prescription co-payment recommendation at the meeting of the cost-containment subcommittee. He noted that the vote among cost-containment subcommittee members on this issue was not unanimous and that some members had abstained from the vote. In regard to tribal input, Mr. Estrada stated that there has been fairly limited tribal input provided on the issues and there has not been enough notice to tribal members to submit comments and attend meetings. The department has state and federal obligations to consult and collaborate with the tribes, but during this process of proposed rate cuts and discussion of co-payments, very little tribal input was given. Only a handful of tribes participated in the summit described by the HSD representatives from the previous panel. The HSD has obligations to provide adequate access to care, he stated, and the HSD has not properly analyzed what cuts will do to providers of care and the economy. Mr. Estrada concluded his statements by adding that the state cannot cut its way to health and prosperity, and he urged legislators to find other ways to fund health, education and public safety.

Ellen Pinnes of the Disability Coalition stated that she was pleased that the committee expressed concerns on the impact of cost-containment measures during the previous presentation. Ms. Pinnes stated that there is a federal law that requires the HSD to perform an analysis on the impact of cuts prior to making changes, not just to monitor effects after it implements measures. While the MCOs are obligated under their contracts to provide access to care, it is the HSD that is responsible for ensuring access. Ms. Pinnes repeated Mr. Estrada's assertion that there was not a unanimous cost-containment subcommittee vote and that there was a lot of confusion about brand-name prescriptions versus generics at the subcommittee meeting. She believes that if more people had understood the extent of the measure, more people would have stood in opposition to it.

Eric Lujan also addressed the committee regarding the previous presentation. Mr. Lujan has been assisting the All Pueblo Council of Governors with its newly formed health committee. He was present at the cost-containment subcommittee meetings held by the HSD and confirmed what was stated by the two previous speakers relating to voting on that subcommittee. According to Mr. Lujan, there was a lot of confusion about what was being voted on at the meeting. He stated that the document that the HSD distributed and that purported to explain the motion in question on cost containment was not very clear. Only five tribes participated during the consultation process, meaning that input from 15 other tribes was not included, and tribes are not getting the information they need regarding this issue. Mr. Lujan added that the IHS does not provide long-term care services and referrals come from the tribal level, not from the IHS.

Native American Aging Title VI Programming

Regis Pecos, co-founder and co-director, Santa Fe Indian School Leadership Institute, addressed the committee regarding the program for Native Americans offered pursuant to Title VI of the federal Older Americans Act. He began by stating that the Santa Fe Indian School Leadership Institute is one of only a few indigenous think tanks in the country and is celebrating its twentieth anniversary this year. Mr. Pecos provided the committee with an overview of the evolution of response in tribal communities. In the 1980s, there was no policy for state-tribal relations, education, taxes or environment in place for the tribes. Tribes were not eligible to receive state funds as this would violate the Anti-Donation Clause of the Constitution of New Mexico. When the federal government began decentralization and delegating more power to the states, there was no existing foundation or framework for tribes. One of the first major areas of development was the response for the delivery services and care for Native American elders. In 1991, New Mexico established the Indian Area Agency on Aging (IAAA). Over time, this has developed into one of the most comprehensive policies and statutes on education and taxes in the nation. The frameworks represent the best articulation of shared responsibility between the state and its 22 federally recognized tribes and pueblos. Mr. Pecos noted that one change that needs to be considered is the adaption of the federal Older Americans Act and federal appropriations to state programs under Title III. There is ongoing study as Congress considers the reauthorization of Title III appropriations and a reassessment of what was developed more than 25 years ago.

Rita Jojola, vice chair, New Mexico Title VI Indian Coalition, provided the committee with her professional background and how she became a part of this program. Ms. Jojola has worked to develop a strong program for the Pueblo of Isleta, and she explained some of the programs offered at the centers toured by members earlier in the morning. The types of services provided by the centers, including home delivery meals and chore assistance, are done in part with federal and state funding as well as a third party through Medicaid. Ms. Jojola is now working with the Santa Fe Indian School Leadership Institute to support her colleagues in other tribes and pueblos to expand capacity to provide services that are needed. The institute is pursuing a study to identify gaps and create a plan to address needs. Ms. Jojola added that support from the state is appreciated, and she asked for any additional help the legislature could provide in moving forward.

Mr. Pecos stated that the hope is that the coalition can come back before the LHHS with some policy recommendations that will help to fully maximize resources to address the needs of elders as an alternative to institutionalization. He is looking for a comprehensive and intergovernmental approach to better support elders and to keep them in their communities. Mr. Pecos noted that there is a concept of shared responsibilities among the tribes when it comes to caring for elders; the Pueblo of Isleta facilities are a great example of a cost-effective approach for making available assets work for a specific tribe.

Following the presentation, members of the committee and presenters discussed several points, including:

- whether the Medicaid Program of All-Inclusive Care for the Elderly (PACE) of therapeutic adult daycare services could be adopted at the Pueblo of Isleta. Ms. Jojola said that the Pueblo of Isleta had attempted to bring PACE to the pueblo, but it was not yet feasible;
- working to find opportunities to partner and connect with communities;
- recognition of the University of New Mexico Hospital (UNMH) by the HSD as an Indian hospital;
- the need for services for individuals starting at age 50 due to health disparities;
- an explanation of Title VI funding and how it is applied to communities;
- the organizational structure of IAAA and how it fits into the overall Area Agencies on Aging Program;
- reversions of federal funding for elderly services;
- issues with meeting administrative needs and requirements; and
- statistics of life expectancy, individuals living in poverty and the number of Native Americans receiving social security benefits — Ms. Jojola will follow up with this information.

Effects of Medicaid Cost Reductions on Native American Recipients; Changes to Federal Matching Funds Policy for Native Americans

Maria Clark, health care consultant, discussed the impacts of cost reductions on Native American health care with the committee. Medicaid cost reductions are being seen in prior authorizations since most MCOs require pre-authorizations for all imaging services. Ms. Clark explained that this is causing a delay in care to patients. For example, UnitedHealthcare's prior-authorization approvals are taking between four and six weeks. UnitedHealthcare is also no longer contracted with the UNMH, which has been a "huge loss of services", according to Ms. Clark. Molina Healthcare of New Mexico takes seven to 10 days to issue prior authorizations. Ms. Clark highlighted other issues and delays being seen with the different MCOs. According to her, there is no enforcement of the obligations of the MCOs; the state allows them to set their own rates, and the intensive treatment units are not getting paid. Ms. Clark stated that she was unsure why Native Americans are limited to access of care when a 100% federal funds matching percentage (FMAP) exists. The FMAP is an incentive, and the MCOs take no risk with the 100% FMAP. Long-term care on tribal lands is dysfunctional and suffers from a lack of coordination. Ms. Clark concluded by adding that the UNMH has a unique relationship with the IHS and should be considered for designation as an IHS facility.

Anthony Yepa, health advisor, Pueblo of Cochiti, discussed how reimbursement to providers is going to affect Native American care. Mr. Yepa believes that there are misunderstandings between the Medicaid MCOs and the state under Centennial Care. Indian health care is the responsibility of the federal government, and federal and state legislation has made it unclear for the MCOs to know what services they provide. Tribes are obligated to

comply with the federal Indian Health Care Improvement Act. It was believed that Centennial Care was going to save \$470 million because of coordinated care and case management. However, Native Americans used to be limited in what services they could receive from the IHS — only 62% of IHS costs were ever funded, and that was for primary care. Mr. Yepa stressed the importance of examining MCO contracts. He has reviewed the 250-page contract that the state signed with the MCOs, but he does not believe that the HSD has the capacity to monitor compliance with that contract. Mr. Yepa raised concerns that guidelines and deliverables of the contract are not being met by the MCOs, in particular, the required health risk assessment for enrollees and subsequent follow-up with case managers. In the Pueblo of Cochiti, patients are not being properly contacted by case managers, and no tribal training from the MCOs has taken place. MCOs are at only 56% compliance with care coordination, two and one-half years into contract performance under Centennial Care. MCOs have over-assigned individuals to the lowest level of care, "Level 1", with 70% of enrollees in that category. Ten percent are in Level 2, and 5% are in Level 3 — the most acute. Mr. Yepa would like to see more enforcement from the HSD regarding data reporting and state reimbursement if the MCOs are not providing services.

In response to the presentation, members of the committee inquired about the following issues:

- requirements for prior authorization and its current use for primary care;
- the importance of compliance with federal law;
- the impact of UnitedHealthcare's termination of its contract with the UNMH for Native Americans;
- services provided under FFS, such as health risk assessments;
- the per member/per month capitation rate for Native Americans;
- statistics on appeals filed relating to the health risk assessment's recommendation for level of care; and
- the overall impact on patients and providers from the Medicaid cost reductions.

Public Comment

Ms. Pinnes, representing the Disability Coalition, noted that there has not been a huge increase in Medicaid enrollment. Budget cuts are a reflection of the state's decline in revenues. Medicaid costs are not out of control, she explained. The per-person cost in Centennial Care has only increased by 1% from 2014 to 2015. She reiterated that it is important to remember that this is not related to the cost of expansion; rather, it is due to a lack of state revenues. The University of New Mexico (UNM) Bureau of Business and Economic Research showed an increase of \$75 million to the state due to Medicaid expansion.

Eric Lujan commented about the previous presentation and the termination of the UNMH/UnitedHealthcare contract. Members enrolled in UnitedHealthcare's Centennial Care plan were given the option to switch MCOs, and Native American enrollees need to be notified that they have the right to switch insurance providers. Members were supposed to receive letters

informing them of the contract change. The UNMH has stated that it will continue to see those patients at their own cost to ensure continuity of care. Mr. Lujan explained that the 100% FMAP will only apply if the service is provided at an IHS clinic and only if primary care is rendered on tribal land. He noted that the FMAP needs to be extended to non-IHS service providers, and the UNMH is the best place for this to happen.

Update on Family Caregiver Program

Lora Church, director, IAAA, Aging and Long-Term Services Department (ALTSD), addressed the committee regarding the family caregiver program. The IAAA is designated by the state to develop a comprehensive and coordinated service system of senior centers and adult daycare services in partnership with New Mexico's 19 pueblos and two Apache nations. The IAAA's general operational functions include contract management of state general funds for the provision of services (\$2.5 million for FY 2017) as well as providing program monitoring, technical assistance, advocacy and training. Ms. Church was present to provide an update to the committee about the "Savvy Caregiving in Indian Country" initiative that was launched in fall 2015.

Ms. Church provided the committee with some background information on the Native American population in the state. There are approximately 224,000 American Indians residing in New Mexico, about 17,650 of whom are elders over the age of 65. In American Indian families, family members provide an estimated 90% of long-term care, 10% more than other ethnicities. Census data illustrate that the need for long-term care among American Indians will double over the next 25 years. Ms. Church discussed some of the financial, physical and emotional burdens families experience with providing long-term care as caregivers. A four-agency partnership has been created to address caregivers' needs in Indian Country. The partnership includes the Alzheimer's Association New Mexico Chapter, the National Indian Council on Aging, the ALTSD's Office of Alzheimer's Disease and Dementia Care and the IAAA. Together, the partnership has developed the Savvy Caregiver in Indian Country initiative, a lay caregiver education program, which is an expansion of the Alzheimer's Association's evidence-based training program offered to the general public. Ms. Church explained the four-phase process for the community trainer that prepares individuals for implementation of this program in their tribal communities.

Ms. Church gave an overview of the accomplishments, lessons learned and next steps for the four-agency partnership. In the last year, the partnership has created an orientation packet for the tribal community trainers that includes participant and facilitator forms to complete throughout the course of the Savvy Caregiver in Indian Country program. The IAAA and ALTSD have expanded the statewide service delivery database to collect training data. Two tribal senior centers at the Pueblo of Isleta and the Pueblo of Laguna have expressed interest in implementing this model at their facilities. Staff from both locations have completed the first three phases of training, with the last stage being implementation. The four-agency partnership continues to expand and create relationships with other programs and has presented its initiative at various conferences and trainings around the state. Ms. Church stated her belief that the

partnership's efforts will collaboratively help meet the goals of the New Mexico state plan for Alzheimer's disease and dementia and the state plan for family caregiving.

Members of the committee discussed with Ms. Church the role of community health workers in tribal areas and the need for professional credentialing as well as cultural and traditional knowledge. Ms. Church noted that the Savvy Caregiver in Indian Country program can be downloaded at the National Indian Council on Aging website.

Recess

The first day of the meeting recessed at 3:55 p.m.

Tuesday, July 26

Welcome and Introductions

The second day of the meeting was reconvened at 8:44 a.m. by Senator Ortiz y Pino. The chair welcomed everyone to the South Valley Family Health Commons and asked members of the committee and staff to introduce themselves.

Welcome and Tour of South Valley Family Health Commons

Bob DeFelice, chief executive officer (CEO), South Valley Family Health Commons, welcomed the committee to the center and provided an overview of the commons' parent organization, First Choice Community Healthcare (First Choice), and its future plans. First Choice was founded 40 years ago in response to a need for access to care in the South Valley. Started in the rectory of a church, First Choice now has eight community health centers located in three counties and one school-based health center. The South Valley Family Health Commons serves more than 55,000 people for medical, behavioral health, dental and federal Women, Infants and Children Program services and employs more than 400 individuals. Mr. DeFelice noted that the commons is a Medicaid provider that contracts with all of the MCOs and is also a Medicare provider. About 50% of individuals who receive services at its centers are covered by Medicaid; 12% are covered by Medicare; 15% are covered by private health insurance; and the other 23% are not eligible for health coverage. The commons is eligible for community health grants that help offset some of its operational costs so it is able to continue to provide services to the underinsured and uninsured. Mr. DeFelice explained how the commons applies a sliding-fee scale based on family size and income of the individual, essentially providing coverage for the individual.

Over the last few years, the commons has faced many challenges in the rapidly changing health care environment. The increased cost of doing business has been a constant issue, with changes adding over \$2 million to its budget. Mr. DeFelice attributed some of this cost increase to the implementation of electronic health records, which he feels is not the solution to productivity and cost. While it is important for clients, electronic health records have been a burden to providers by adding the need for new equipment, tech support personnel and extra compliance measures.

Mr. DeFelice discussed some common charges at First Choice clinics: basic medical visits cost \$158, for which 95% of patients pay a \$30.00 copay. For people without health coverage, First Choice attempts to get people covered. It has a \$35 million annual operating budget, according to Mr. DeFelice.

First Choice receives significant drug pricing discounts through the federal pharmaceutical discount program authorized by Section 340B(a)(5)(C) of the federal Public Health Service Act, known as "340B".

Mr. DeFelice explained that First Choice is able to recruit and retain some physicians through the National Health Service Corps loan repayment program. Through UNM's Project ECHO telehealth program, First Choice practitioners are able to consult for subspecialty care in areas such as hepatitis C care, rheumatoid arthritis and medically assisted treatment of substance dependence.

The commons has continued to expand its services over the years in response to the needs of the community. This has included increasing its behavioral health, dental and opioid support services. It currently has 18 physician providers who are licensed to prescribe Suboxone, each of whom has more than 100 clients. Mr. DeFelice added that the commons has developed its role as a teaching center through its partnerships with UNM and Central New Mexico Community College (CNM). Several family practice residents and nurses are currently doing their clinical rotations at the commons.

Mr. DeFelice cautioned that even with all of the work to increase the access to health care, communities are still facing many health challenges. The commons is committed to identifying social determinates that affect health and partnering with other community organizations to improve wellness. Mr. DeFelice shared a video with the committee that illustrated the direction that the commons is going with the expansion to a 20-acre facility. The new facility will include a teaching health center, a childhood development center, a workforce training center, a fitness center, a restaurant that serves healthy meals from locally grown produce and a community farm with a learning center. The video highlighted the goal of creating a "wellness ecosystem", with each component being self-sustaining.

Following the presentation, members of the committee engaged Mr. DeFelice about several aspects of his presentation and the facility. Before the committee was taken on a tour of the facility, the following topics were discussed:

- the challenges and benefits of electronic health records and systems interconnectivity for both patients and providers;
- the goal for the additions to the facility to become a model for health centers around the state;
- details on the medical resident program with UNM and CNM;
- retention of medical students post-graduation;

- student loan repayment incentives;
- issues with staffing of medical professionals and competitive salaries;
- an explanation of how the commons provides services to uninsured individuals and how the sliding scale is applied for payment;
- the dental center's expansion, successes and capacity for servicing the community;
- issues with credentialing providers with health insurers; and
- a request to work with the Albuquerque Public School District rather than create a charter school. Mr. DeFelice explained that the partnership was to be with an existing charter school.

Access to Linguistically Appropriate Health Care and Human Services

Senator Stewart introduced the panel to the committee and provided background on the issue of language access in the International District of Albuquerque. During the 2016 regular session, Senate Joint Memorial (SJM) 10 was passed establishing a Language Access Task Force. SJM 10 requests that the Department of Health (DOH) work with other state departments and agencies to develop a model for language access in state health and human services agencies to ensure that individuals with limited English proficiency (LEP) have full and meaningful access to state programs and services, as required under Title VI of the federal Civil Rights Act of 1964. Members of the panel shared their experiences in working with minority populations in this area and the challenges faced by these individuals.

Sovereign Hager, staff attorney, NMCLP, has been working on language access around New Mexico for several years. The directive under Title VI places the burden on state agencies to provide reasonable access to written translation of materials. State agencies have to assess the need for these services, determine the frequency of agency contact with this population and assign a reasonable part of their budgets to meet these needs. According to Ms. Hager, many state agencies are not meeting this need. Instead, state agencies rely on community-based workers to bear the costs and expend resources when this is really a state obligation. SJM 10 is about collaboration between community-based workers and state agencies to accomplish this federal requirement.

The New Mexico Asian Family Center is the only nonprofit organization that serves the Asian community in the state. Huong Nguyen, an education and policy specialist for the center, noted that New Mexico is one of five majority-minority states with many different racial communities. Approximately 180,000 people in New Mexico speak a language other than English. While Spanish remains the most spoken language in the non-English speaking population, many other languages continue to emerge, including Navajo (Diné Bizaad), Chinese and Vietnamese. Members of the community are impacted when services are not readily available. Ms. Nguyen shared stories where language barriers are an issue that impact youth and their parents. The center works with the Children, Youth and Families Department (CYFD) and the DOH to provide language services in child abuse cases and health screenings for infectious diseases. Ms. Nguyen stressed that if these language services are not available, necessary translation would not happen.

Nkazi Sinandile, co-founder and volunteer program coordinator, New Mexico Women's Global Pathways, spoke about some of the challenges her organization faces. Typically, it has served a majority of people from African countries, but recently it has been faced with an increase in refugees from the Middle East and Asia. The refugee population has been increasing by 50 to 100 people per month. The work is done on a volunteer basis or occasionally by donation. Ms. Sinandile stated that frequently children are relied on for interpretations, causing opportunity for inaccuracy and error. She shared with the community a few stories that illustrate the need for language services, particularly in emergency and public safety situations. Immigrants and refugees only know to call 911 in times of trouble, but there is no one available to help interpret the issues or problems to emergency workers. Fortunately, no deaths have resulted from an inability to communicate, but Ms. Sinandile noted that it is a real concern.

Antoinette Sedillo Lopez, executive director, Enlace Comunitario, addressed the obligation that the state has to honor different languages. The federal government already has a language assessment tool for each federal program; the state needs to have a planning tool to assess the needs of the community. It is not enough to have a bilingual person in an agency since there are several other languages that may need interpretation. Ms. Sedillo Lopez said that the agency or department needs to plan if it is going to use community services, and if so, it needs to train and fairly compensate those groups providing the services. By means of a federal grant, the Albuquerque Police Department (APD) was able to develop a curriculum that has established a process for dealing with individuals in emergency situations who do not speak English. APD officers are provided with cards listing potential languages that they might encounter. During a situation, an officer can ask an individual to point to the language the individual speaks, and the officer can then get the appropriate interpreter on the phone through the use of a hotline. This model has increased officer safety and expanded emergency workers' ability to get people the help they need. It has received praise by the U.S. Department of Justice (DOJ) and is known as the APD Model; however, this training has not yet been provided for the whole department. Enlace Comunitario and the other groups present are requesting the LHHS's endorsement to extend SJM 10 another year and to direct agencies that are listed in the memorial to submit their plans to the committee within 60 days.

Kay Bounkeua, executive director, New Mexico Asian Family Center, echoed the statements of the other panelists regarding the challenges that individuals who do not speak English face. Her family came here as refugees from Laos, and she shared her experience of having to act as an interpreter for her parents. This is something, she says, that remains an issue.

Ms. Hager directed the committee to a handout that could be used to determine the status of an agency's LEP services. Any agency receiving federal funding is supposed to have some type of LEP service in place. She noted that the organizations present on the panel are available to aid agencies in developing their LEP services. The handout asked the agencies listed in SJM 10 to provide information on the following:

1. all policies, procedures or other similar documents regarding LEP, including, but not limited to, agency plans, policies or procedures governing usage of translation or interpreter services;
2. all training materials relating to the support of LEP persons; and
3. the agency's most recent analyses of New Mexico language demographics and the populations accessing services.

The following topics were discussed when the chair opened the panel for questions and comments:

- whether entities, such as law enforcement agencies, health clinics and those mentioned in SJM 10, now have language access plans in place;
- whether language access advocates have enlisted medical malpractice insurers in the effort to educate health care providers on the importance of language access;
- an article in the *Albuquerque Journal* by Cecilia Portal relating to language interpreting services in Spanish;
- the creation of a nonprofit organization to certify language interpreters; and
- community health specialists, a profession promoted by Francisco Ronquillo to employ health professionals from other countries as health care workers, that can use their health expertise and multilingual competencies to assist non-English-speaking patients.

Motion 1

A motion was made by Senator Stewart, seconded by Representative Trujillo, for staff to draft a letter to the state agencies listed in SJM 10 inquiring about the status of their LEP services. The letter is to follow the language of SJM 10, asking them to submit their plans and to address the information requested above. The motion passed without objection. The committee determined that it would wait on the agencies' responses before extending the memorial during the upcoming session.

Minutes Approval

Upon review and proper motion by the committee, the minutes from the first meeting of the LHHS were approved unanimously.

Aid in Dying Decisions

Representative Bill McCamley testified before the LHHS on the issue of medical aid in dying. Representative McCamley shared his experience with his father, who suffered from a terminal nerve degeneration disease before his death in 2014. When his father was first diagnosed, his father signed an advance directive to refuse extraordinary measures to be kept alive, allowing him the opportunity to control his own end-of-life choices. In New Mexico, under the current law, his father would have been unable to make that decision. Representative McCamley believes this should not be a government decision — if a person is determined to be mentally competent and has a terminal illness, the person should have a choice over the person's

own body. He underscored that this is not assisted suicide. Representative McCamley will be sponsoring legislation during the 2017 session to make New Mexico the sixth state to extend this right to its residents.

Barak Wolff, public health advocate and former director of the DOH's Public Health Division, explained that aid in dying is the practice of allowing a mentally capable adult to take a self-administered dose of a lethal prescription to end the adult's life in the face of a terminal illness. He believes it is important to normalize the conversation and remove the fear surrounding this issue by encouraging families to have these discussions. There needs to be a shift in social policy and perception, which begins with getting out the facts of the issue. Mr. Wolff stated that today's discussion was not for the purpose of debating the issue but rather to begin the conversation.

Allen Sanchez, executive director, New Mexico Conference of Catholic Bishops, represented some of the concerns of the Catholic community. New Mexico, he stated, took away the power of a judge and jury to take a life when it enacted legislation banning the death penalty. It is unclear why this power should be accorded to a patient and doctor, he said. He believes this to be an ethical issue and stated that compassion is calling people to be with someone during that person's suffering. Mr. Sanchez raised the questions of who determines "competency", experimental drug treatments and doctors knowing the right time to write the prescription. There are too many stories where people live longer than expected, Mr. Sanchez said. He reminded the committee that this issue deals with life itself and that it is the responsibility of the state to protect the vulnerable.

Emily Bentley, multi-state campaign manager, Compassion and Choices, provided the committee with an overview of national trends relating to aid in dying. Colorado is currently in the process of joining Montana, Oregon, Washington and Vermont in passing aid in dying legislation through a ballot initiative. It is expected that 19 states will be proposing legislation this year. According to data she provided, the public supports the belief that government does not have a role in these decisions. Ms. Bentley provided the committee with several handouts, including a Compassion and Choices federal policy agenda, a fact sheet about aid in dying and a peer-reviewed article on Oregon's state law (please see website for more information). Medicare will now reimburse doctors for discussions with patients about end-of-life options. Ms. Bentley noted that Compassion and Choices is available to the committee to answer any questions and provide information. She added that aid in dying is a safe medical practice, and in 20 years of its use, there have not been any reports of abuse or coercion.

Alexandra Smith, an attorney who represented plaintiffs in the recent New Mexico Supreme Court case, *Morris v. Brandenburg*, explained some background on the issue. Ms. Smith explained that three conditions must be met in order for a patient to receive aid in dying medication: 1) the patient has a terminal diagnosis with six months or less to live; 2) the patient must be mentally competent to make decisions; and 3) the patient must self-administer the prescription. This practice is for situations where death is imminent, and it gives individuals the

chance to determine the time, manner and place of their death. Ms. Smith provided some information about the New Mexico Supreme Court case. The decision of the court was not that the practice should not be legal in the state, but rather, if it is to be done, it should be regulated legislatively. She noted that some concern had been raised about protecting vulnerable individuals like the poor and uninsured, when in fact, those that are interested in seeking out the practice tend to be well-educated, financially well-off and younger.

Erin Marshall, health policy consultant, Aid in Dying Task Force, has been working on education of these issues with various groups. Ms. Marshall talked about the first meeting of the voluntary task force and some of the membership that had attended. The goal of the task force is to establish a body of information to provide to the legislature to help in informed decision-making on the issue.

Upon request of the chair, several members of the public stepped forward to provide their input on the issue.

- Babs Mondschein, a resident of Albuquerque, shared her experience about her sister who had a brain tumor. Her sister had many complications and suffered through intensive care and eventually hospice. Ms. Mondschein believes her sister deserved a death with dignity and stands in support of this legislation.
- Nancy Abel is a member of the task force as a private citizen. Ms. Abel stated that everyone has these stories, and hers was about her brother. Her brother lived in Oregon and was diagnosed with leukemia. Ms. Abel said her family was privileged to witness the kind of death she would hope for herself and her loved ones — peaceful and painless, in the comfort of his own surroundings. Ms. Abel, along with millions of Americans around the country, hopes New Mexico joins them.
- Dr. James Zacharias, family therapist, spoke about his sister. Her doctors did not want to talk about the option with her, and she was finally referred to an end-of-life team that made the distinction between suicide and end-of-life choice.
- Laurie O'Doroughty voiced her strong support for adding this as an option for people in New Mexico.
- Jan Wilson believes that everyone should have a choice in this matter. She does not think this is about politics or ethics. Ms. Wilson shared her personal experience of her mother who was put under hospice care. Her mother had already done her advance directive prior to hospice, which made it easier on the family. The family had talked about the option and her mother did not want to take the medication for aid in dying but she agreed that people should have the choice.
- Dr. Lance Chilton, a retired pediatrician, believes people need dignity in death. Dr. Chilton shared a few stories of loved ones who had had terminal illnesses. He was unable to help them to die with dignity, and they should have been given this option. Dying with dignity is not requiring any one person — patient or physician — to do this; rather, it should be an option available to individuals.

Dr. Nancy Guinn, M.D., is a hospice and palliative care expert for Presbyterian Healthcare Services. She has analyzed current protocols on end-of-life decision-making and recommends changes to New Mexico law. In Oregon, she explained, two physicians must certify a terminal diagnosis. Dr. Guinn believes that New Mexico is too rural for such a requirement, and nurse practitioners and physician assistants should be permitted to make this certification.

After hearing from members of the public, the committee discussed the following issues with the panel:

- how the six-month mark is quantified in determining when the prescription is written;
- how determination of competency is made by physicians;
- how other states have legalized this practice — statutory versus ballot initiative;
- information on the task force, including membership, its work plan and the goal for an academic approach;
- inquiries about feedback from various professional medical associations;
- the importance of drawing feedback from the various religious and ethnic communities in the state;
- the distinction between aid in dying and assisted suicide;
- conscientious objection for physicians and pharmacists;
- information on the prescription itself — how Seconal works and how it is self-administered by the patient; and
- the need to hear from health care professional organizations.

In closing, Mr. Wolff recommended the HBO documentary *How to Die in Oregon*. He noted that the film is very informative, and he recommended it for viewing by people on both sides of the issue.

Workers' Compensation for Agricultural Workers

Gail Evans, legal director, NMCLP, gave the committee an update on workers' compensation for agricultural workers as well as background on the recent New Mexico Supreme Court case, *Rodriguez v. Brand West Dairy*. The plaintiff, Mr. Rodriguez, was injured while working at the dairy. Ms. Evans also told the committee about another individual who was injured on a chile farm back in 2012. Both individuals filed workers' compensation claims, and both claims were dismissed. New Mexico state law had an exclusion for farms and ranches that did not require them to carry workers' compensation insurance. When taken before the New Mexico Supreme Court, it was ruled unconstitutional discrimination to exclude farm and ranch laborers from the mandatory coverage of the Workers' Compensation Act. Ms. Evans noted that this ruling only impacts 7.5% of farms and ranches in the state, as the ruling only applies to operations that employ three or more paid workers. According to Ms. Evans, workers' compensation premiums are payroll-based, so coverage is only mandated for paid employees. Therefore, volunteer labor of family members or neighbors does not mandate coverage. The farm and ranch industry has over a billion dollars in profit per year; the cost of providing

workers' compensation to farm and ranch laborers is approximately 1% of the industries' profits. Due to the ruling of the court, there is no need for additional legislative action.

Zach Riley, New Mexico Farm and Livestock Bureau, stated his belief that the profits mentioned by Ms. Evans are not necessarily true and only represent a small percentage of the industry. Coming from a ranching background, Mr. Riley stated that in reality most farmers and ranchers make just enough to survive. This ruling really affects small farmers and ranchers in that, because they are afraid of legal ramifications, they will be unable to get the help necessary to do their work, which could result in a loss of crops and profits. Mr. Riley is unhappy with the court's decision and views it as a circumvention of the legislature. He stated that the decision would affect 90% of New Mexico's farms and ranches.

Members of the committee discussed the following points with the presenters:

- outcomes for the two individuals;
- the court ruling was not retroactive;
- efforts being made to enroll workers in Medicaid and other health insurance;
- the rationale of the court's decision;
- the inherent danger of the industry and the impact on rate costs;
- liability insurance carried by most producers to cover injuries;
- the issue with undocumented and contract workers employed by industry;
- the potential for tax incentives for small operations to help offset workers' compensation costs; and
- the possible need to reevaluate the number of workers requirement.

School Supports and Services for Foster Youth

Grace Spulak, director, FosterEd: New Mexico, presented to the committee about FosterEd's initiative. FosterEd works to ensure that low-income children have the resources, support and opportunities they need for healthy, productive lives. The program operates in four states, including New Mexico. New Mexico is the first state to incorporate youth involved in the juvenile justice system into this project. Ms. Spulak explained the FosterEd program model and highlighted some of its key milestones. FosterEd works with state and county partners to develop an individual plan for the student with a focus on the student's education by creating goals that can be reached within six weeks. An "education champion" — somebody who is going to be involved in the student's life for a long time — is identified to help support the student's long-term success. Part of the process is identifying barriers to the student's success and asking that student what the student's goals are. Ms. Spulak specifically talked about the Lea County project that focuses on students in foster care and those on court-ordered probation. There are currently 42 students in the program in Lea County, ranging between the ages of four and 19; however, there are 69 students in the county who would be eligible to participate in this program.

According to 2014 CYFD data, there are 2,156 children in protective custody and another 557 children on court-ordered probation. Many of these children are school-aged and could be eligible for FosterEd. Ms. Spulak underscored the importance of data sharing among state agencies, particularly among those involved with the foster care system and the juvenile justice system. Several memoranda of understanding between state agencies have been established as part of FosterEd's initiative to improve education outcomes for young people in the two systems.

In response to the presentation about FosterEd, the committee made the following inquiries:

- how the program was established in Lea County;
- qualifications of an education champion;
- current funding sources and efforts to receive federal funds to make the program sustainable in New Mexico;
- outreach to schools to provide training to staff on trauma and the effects of trauma on student behavior;
- helping with the transfer of school credits when students are moved to different schools or from detention facilities;
- the availability of counseling to students; and
- tracking of students who "age out" of the system or return to their homes.

Public Comment

Denicia Cadena of Young Women United addressed the committee regarding the needs of young women in the criminal justice system. The number of women and the duration of time that they stay in the system continue to grow. The closure of the juvenile wing of the detox center at Turquoise Lodge further limits options for help. There are few resources available to women, and the representative urged the committee to keep their needs in mind when addressing criminal justice issues. A member of the LHHS informed those present that a center in Carlsbad that had previously closed has now received the capital outlay funds necessary to reopen.

Recess

The second day of the meeting recessed at 5:01 p.m.

Wednesday, July 27

Welcome and Introductions

The third day of the meeting was reconvened at 8:44 a.m. by Senator Ortiz y Pino. The chair welcomed everyone and asked members of the committee and staff to introduce themselves.

Housing for and Protection of Vulnerable Persons

Myles Copeland, secretary, ALTSD, addressed the committee regarding the department's Adult Protective Services Division (APSD) and the Long-Term Care Ombudsman Program

(LTCOP). The responsibilities of the LTCOP are to identify, investigate and resolve complaints made by or on behalf of residents; provide services to assist the residents in protecting their health, safety, welfare and rights; and represent the interests of residents before governmental agencies and seek administrative, legal and other remedies to protect residents' rights and well-being. The LTCOP offers an independent voice to residents. The LTCOP operates with only nine staff members who oversee approximately 100 volunteers in the LTCOP. In FY 2015, staff and volunteers provided 9,952 consultations to residents, facility staff and other individuals. The program also educated more than 6,200 residents, providers, family and community members on ombudsman services, resident rights and long-term care support. In the last three years, the ombudsman has responded to more than 3,600 complaints. When a complaint is filed, the program works with the facility to find a resolution. Within 60 days, 99% of all complaints are resolved.

As a department, the goal is to prevent individuals from needing the APSD. The APSD responds to situations in which functionally impaired adults are being harmed, are in danger of mistreatment, are unable to protect themselves and have no one else to assist them. The APSD works with individuals 18 years of age and older. Secretary Copeland noted that only 6% of victims ask for help themselves; therefore, anyone who suspects that an adult is being abused, neglected or exploited has the duty to report it to the APSD. Individuals have a right to self-determination and can refuse service from the APSD. Like the LTCOP, the APSD maintains strict confidentiality of the victims and reports. With more than 6,000 investigations conducted per year, the APSD prioritizes cases based on level of urgency ranging from a few hours to a couple of days for response. The ALTSD works on lots of programs to support independent living and believes that home care and adult daycare can help people live at home longer, thus maintaining independence.

Juliet Keene, deputy director, Medicaid Fraud and Elder Abuse Division, Office of the Attorney General (OAG), informed the committee that the division is the federally certified fraud control unit for Medicaid. It has jurisdiction over Medicaid provider fraud and abuse, neglect and exploitation of those who reside in residential facilities. The division is looking at increasing authority over home situations. Ms. Keene talked about how cases the division receives from the APSD, HSD and DOH are handled. The OAG has a good relationship with the Office of Guardianship (OOG) in the Developmental Disabilities Planning Council (DDPC), working with both corporate and family member guardians.

While the division gets a lot of referrals about boarding homes, those are not currently under the purview of the division because these facilities do not provide assistance for activities of daily living (ADL), and boarding homes generally house individuals with behavioral health issues. Under the current law, boarding homes do not fall under the authority of any agency. In a brief discussion with a member of the committee, Ms. Keene agreed that the OAG would need some legislative authority in order to oversee boarding homes since they do not fit into the definition of a "facility". This is something the OAG will be pursuing in the future. For this upcoming legislative session, the OAG wants to reintroduce the Medicaid False Claims Act

legislation. The OAG does experience some difficulty receiving reports about abuse, neglect and exploitation at facilities. Ms. Keene concluded her presentation by informing the committee that the annual report for the OAG would be available soon and briefly highlighted some of the successes from the previous year.

Marina A. Tapia, senior legal counsel, DDPC, OOG, addressed the committee about the roles and limitations of her office's authority. The DDPC OOG provides legal services to income-eligible, allegedly incapacitated adults who may need a guardian appointed by the district court. Once the guardian is appointed, the OOG's role is limited, and the authority of the guardian over the protected person is provided through the court. Ms. Tapia talked about some of the issues affecting protected persons, including limited financial resources and housing. The OOG does not have authority when it comes to boarding homes. The DDPC is extremely concerned about individuals who live in boarding homes. The DDPC OOG recommends a statutory or regulatory definition for "boarding homes" and the examination of the Texas law to see how it could be adopted for New Mexico.

Brendan Gould, national certified guardian (NCG), executive director, Honor Guardianship Services, LLC, explained that there are two types of guardianships: limited and plenary. Mr. Gould spoke about some of the conditions in boarding homes, including poor handling of medications and operator intentions, but noted this is not always the case. He believes that boarding homes help prevent recidivism because once individuals have placement in a home, they stop returning to jail. Boarding home operators receive around \$675 per month per person. According to Mr. Gould, overregulation of these homes could cause well-intentioned operators to close due to limited funding.

Maryhelen Kelley, NCG, Ayudando Guardians, shared her experiences with boarding homes and operators. Ms. Kelley serves 161 clients, 60 of whom are on the developmental disabilities (DD) waiver and 36 of whom are in boarding homes. She currently has 10 individuals on a waiting list for guardianship. Like Mr. Gould, she said that the intentions of boarding home operators vary — some really want to help while others are in it to make as much money as they can. Individuals with mental illness are better off with more structure, and boarding homes can teach them about independent living. Ms. Kelley believes it would be cost-effective for the state to help subsidize boarding homes by making placement more available and allowing for some regulation of the homes.

Ben Kesner, executive director, Board of Pharmacy, Regulation and Licensing Department, noted that the Board of Pharmacy is the only state agency that has some data on the number of boarding homes in the state due to its issuance of custodial drug permits. There are two levels of permits: boarding homes and nursing homes. As far as medications go, both types of homes are required to have a pharmacist who visits every three months. The Board of Pharmacy will license a location that has two or more individuals, and the operator pays for pharmacist inspections. Mr. Kesner added that the majority of the homes licensed are family residents caring for elders.

In response to the presentation, the committee addressed the following topics and concerns with the panel:

- the disparity between the number of active custodial drug permits and the list of facilities classified by the DOH as boarding homes previously provided to the committee;
- the lack of resources for reporting activities of concern and neglect in boarding homes;
- the need for educating the public on its responsibility to report issues and mistreatment;
- staffing issues in nursing homes;
- levels of Medicaid reimbursement to facilities and the statewide formula based on resident needs;
- self-determination of residents in nursing homes and the ombudsman perspective to allow for personal choice;
- quality of care in nursing homes and questions about complaint investigation;
- the handling of medication and controlled substances;
- the impact of facility closures on communities;
- the need for oversight and regulations of boarding homes;
- the potential for adaptation of the Texas model for boarding homes;
- ombudsman program availability for Native Americans and tribal governments;
- monitoring of guardians and lack of reporting from family guardians; and
- restructuring of the process for awarding guardianship contracts for corporate guardians.

Assisted Living

Linda Sechovec, executive director, New Mexico Health Care Association and New Mexico Center for Assisted Living, met with the committee to discuss assisted living facilities in the state. Ms. Sechovec stated that behavioral health is becoming a larger concern, and facilities are struggling to meet the needs of the population and the needs of individuals. While the definition for licensure of assisted living facilities varies from state to state, generally, assisted living facilities offer a multifaceted residential setting that provides personal care services, 24-hour supervision and assistance, activities and health-related services. The goal is to minimize the need to relocate by allowing "aging in place" and hospice services; accommodating individual residents' changing needs and preferences; maximizing resident's dignity, autonomy, privacy, independence, choice and safety; and encouraging family and community involvement. In 2010, some revisions of the regulations occurred, including new rules for administrator and staff training, Alzheimer's care and hospice services. New applicants for licensure are required to submit a description of their program services. This program narrative should identify the geographic services area; primary population served; types of services and care; and professional services. Ms. Sechovec talked about some of the personal care and health services offered by assisted living facilities, noting that they are not the same as boarding homes.

One issue for assisted living facilities is the disclosures required at admission. A facility may provide assistance with ADL and periodic professional nursing care for adults with physical or mental disabilities. National regulations have physical plant standards that are not always in line with the needs of the residents and are further out of line with the needs of the boarding home population. Ms. Sechovec discussed the usage of antipsychotic drugs in assisted living facilities nationwide and how it compares to New Mexico. The state is lower than most in usage, but about 17% of nursing home residents do require this medication; this issue has been trickling into assisted living facilities. Since there is not a federal payment program or regulations for antipsychotic drug usage in assisted living facilities, these settings may not have access to the same resources about alternative approaches to care.

Ms. Sechovec shared some of the other policies and procedures followed by these facilities. Assisted living facilities do have admission and retention policies that will not allow for the admittance of individuals requiring 24-hour continuous nursing care. Exceptions can be made for current residents receiving hospice care. Facilities must meet the state's criminal history screening requirements for administrative and care staff positions. Additionally, assisted living facilities are subject to DOH inspection and monitoring. Ms. Sechovec noted that funding is limited and surveys are not conducted as frequently as they should be. Public financing for these facilities is limited in New Mexico. Typically, only services are covered under Medicaid and Centennial Care — room and board charges are between the facility and the prospective resident. The average cost for an assisted living unit in the state is \$3,600 per month.

On questioning, Ms. Sechovec and the committee members discussed the following topics:

- the need for a centralized location of information on facilities and program narratives;
- Medicaid reimbursements for services in an assisted living facility versus a nursing home facility;
- limited coverage under Centennial Care;
- concern about levels of care between private payers and Medicaid recipients;
- demographics of assisted living residents;
- inspection process and survey compliance;
- instances of potentially unfair sanctions and penalties for facilities;
- the process for ADL assessment and degree of assistance evaluation; and
- specific constituent issues with which Ms. Sechovec is willing to help.

Public Comment

Sandy Skaar noted that some individuals with developmental disabilities end up in boarding homes because they cannot afford the high cost of assisted living.

Jennifer Weiss-Burke, executive director, Serenity Mesa Health Center, expressed her dismay with the closure of the DOH's Turquoise Lodge substance dependence treatment services. Ms. Weiss-Burke noted the extremely limited options for substance detoxification (detox)

facilities for individuals under the age of 18 in the state. Formerly, individuals would receive treatment at Turquoise Lodge and then transfer to Serenity Mesa Health Center. With this closure, there is a loss in the continuum of care. She is very concerned with the dangerous nature of detox and the potential loss of life that will occur now that services have been cut off. The outpatient options proposed by the DOH are limited and not as helpful in the detox process, and emergency rooms are not a viable solution. She suggested a reduction in the number of adolescent beds as opposed to the outright closure.

Adan Carriaga works for Molina and is an individual in long-term heroin recovery. He shared his personal experience with drug addiction and detox. He raised the issue of a suicide plan being a condition of admission into a hospital. Medicaid does not cover the cost of detox. Some of the MCOs have service options for adults but not for adolescents. Mr. Carriaga mentioned that Molina is having the internal discussion about what can be done for adolescents in the wake of the Turquoise Lodge closure. He is concerned with the number of detox centers closing all over the state. Mr. Carriaga added that a person can detox with Suboxone, but that person has to already be in the process of withdrawal.

Jeff Holland, executive director, Endorphin Power Company, mentioned that there are regulations against placing adolescents with adults in detox facilities. According to him, the closure is cutting off the support that helps to prevent issues down the road. Mr. Holland stressed that the first 72 hours is crucial to the success of detox; to remove access to detox services risks failure.

Members of the committee asked for public comment on this issue. The concern with the of lack intensive outpatient treatment (IOP) and the success of IOP was raised. Members questioned claims by Turquoise Lodge of issues with filling the beds and the potential lack of outreach done by the facility. The method by which the closure was conducted was also called into question. Ms. Weiss-Burke noted that just because the beds are not full does not mean they are not needed. According to her, there is a need for more adult beds, but closing the ones available for adolescents is not the answer. Members of the committee requested some information on which IOPs offer detox and what type of detox they support. Concern was also raised about the condition of suicidal status for admittance. The public advocates stressed the importance of early determination and intervention. The chair noted that public comment on this issue would be opened up on the last day of this meeting.

Lorraine Mendiola has a son who is mentally ill and under the guardianship of Ayudando Guardians. Ms. Mendiola submitted a letter to the committee detailing her dissatisfaction and concern with the conditions of boarding homes in which her son has been placed. Her letter contained some examples of her son's experiences. She has attempted to communicate with various agencies and has been told that boarding homes are not regulated because they do not provide ADL. She is requesting legislation to be introduced during the upcoming session that requires all existing and future boarding homes in the state to be licensed, monitored and regulated.

Update on Assisted Outpatient Treatment

Brian Stettin, policy director, Treatment Advocacy Center, presented as part of a panel to provide the committee with an update on assisted outpatient treatment (AOT) and the newly enacted law. Mr. Stettin explained what AOT is, adding that it is a new form of civil commitment outside a hospital. Usually, a petition to the court is done prior to discharge from the hospital and is for individuals who have struggled with adherence to treatment resulting in repeated hospitalizations or incarcerations. There is a hearing where the patient is represented by counsel and an order is issued directing the patient to participate in treatment and directing the local health system to provide resources. A treatment plan must be part of the order issued by the courts. The purpose is to motivate the individual to participate in treatment; other states have this type of program and have demonstrated its efficacy. The newly enacted law does not mean AOT will be a reality, but it does offer an option for a local government to have a memorandum of understanding with the local court. To make this work in any part of the state, there will need to be some upfront investment. Access to AOT is available in both Bernalillo and Dona Ana counties. Last December, Congress appropriated \$15 million for states to seed new AOT programs. Jurisdictions in New Mexico applied for the grant in June, and they believe the state's program has a good chance of receiving funding. Grant award notification will be in September.

Jamie Michael, director, Dona Ana County Human Services Department (DAHSD), represents one of the jurisdictions that applied for the grant program. In establishing the program in Dona Ana County, Ms. Michael worked with a variety of organizations, including Mesilla Valley Hospital, La Clinica de Familia, district courts and attorneys, New Mexico State University and the National Alliance on Mental Illness. In the last two years, the DAHSD has hospitalized 150 individuals two or more times. There have had been more than 300 civil commitment hearings in Dona Ana County, which take place every Friday at Mesilla Valley Hospital. The DAHSD hopes to use the federal grant money to help La Clinica de Familia to hire case managers and providers, Ms. Michael said. The majority of participants are Medicaid-eligible males between the ages of 18 and 38, making La Clinica de Familia a good fit for this program. The district judge oversees the inpatient commitment hearings and is committed to making this program work. Ms. Michael stated that the DAHSD anticipates a decrease in hospitalizations, a reduction in emergency room visits and less law enforcement involvement. If the DAHSD does not receive the grant, Ms. Michael stated, it will continue to try to serve as many people as it can with the resources it has.

Douglas H. Chaplin, director, Department of Family and Community Services, City of Albuquerque, helped submit an application for the grant in the amount of \$1 million per year for the next four years. If awarded, the grant will accelerate the formation of infrastructure to ultimately reduce incidences and duration of psychiatric hospitalization, homelessness, incarcerations and interactions with the criminal justice system. Mr. Chaplin provided an overview of the comprehensive screening that AOT consumers would receive. He projects that with the grant, the City of Albuquerque will be able to serve 345 individuals over the next four years.

The panelists discussed with the committee the following topics:

- criteria required to petition the courts, which include a history of not adhering to treatment and multiple hospitalizations;
- the question of suicidal intentions as a basis for hospital admissions;
- the distinction between voluntary versus involuntary inpatient treatment;
- the "black robe" effect: using the authority and status of judges to encourage patients to do the things they need to do for themselves;
- an explanation of the mobile crisis teams and trainings for the APD;
- information sharing and access to mental health history for judges;
- the potential for reducing the prison population for individuals meeting program requirements;
- the need for state-funded beds in the southern part of the state and the difficulty of transporting patients to Las Vegas;
- commitment on behalf of the courts and district attorneys to the AOT program; and
- other possible avenues for funding in the event that the grant is not awarded.

A member of the committee requested information regarding the criteria for psychiatric hospital admission. This question was raised by the previous presentation about emergency rooms only admitting patients if they admitted to suicidal thoughts. The member wanted to see a written document detailing admission criteria.

Update on Behavioral Health Access

Maggie Hart Stebbins, Bernalillo County commissioner, was returning to testify before the committee on the progress of efforts made by Bernalillo County for the treatment of behavioral health. In recent years, several tragic events in Albuquerque have called attention to the issues facing the city and the need for appropriate training for law enforcement. Commissioner Stebbins shared a presentation that provided data on overdose rates and the history of behavioral health efforts in the county. In 2014, a joint task force between the county and the city was created to address opioid abuse. During the general election that year, 69% of Bernalillo County voters approved the advisory question on a new gross receipts tax dedicated to expanding access to behavioral health services, generating an estimated \$17 million per year. That revenue was first available in December 2015.

The task force identified four key areas of priority: (1) crisis services; (2) community supports; (3) housing; and (4) prevention, intervention and harm reduction. Commissioner Stebbins discussed the recommendations and the business plan set forth by the task force (see handout for full details). Lisa Simpson, technical advisor to the adult detention reform coordinator, Bernalillo County, explained that the county has been using data-driven analysis to identify drivers of the criminal justice system costs by looking at who is in the system and why and how resources can be better used to serve them. By using data-driven strategies, the county has been able to work with criminal justice partners to reduce the jail population by 48%. Identifying the needs and characteristics of the population with frequent use of health care and

criminal justice resources allows access to services to be prioritized and services to be designed to meet the needs of that population. Ms. Simpson expanded on the community connections that are helping to supply supportive housing and wrap-around services to decrease the potential for relapse. She also discussed the efforts to expand crisis services with a hotline and the creation of a regional mobile crisis team. A focus has also been placed on providing services to schools since having mental health resources available at schools increases the likelihood of students seeking care by over 90%.

Barney Trujillo, commissioner, Rio Arriba County, noted that Rio Arriba County has ranked number one in heroin overdoses in the country for the past two decades. The county has been working to create a culture of accountability to restructure the treatment system. Rio Arriba County has created the Opiate Use Reduction (OUR) Enterprise to reduce the number of overdose deaths in the county through a short- and long-term strategy. In the short term, Rio Arriba County seeks to immediately reduce overdose deaths through an intensive outreach, education and Narcan distribution campaign targeting the highest-risk individuals. Next, the county plans to improve long-term accessibility and effectiveness of treatment services by forming the OUR Network, an accountable health network composed of service providers in Rio Arriba County sharing health information technology, case management and finance structure that reimburses providers for production of individual health outcomes.

Lauren Reichelt, director, Rio Arriba County Health and Human Services Department, stated that reducing deaths does not mean treating the drug problem. Overdose prevention does get immediate help to the individual and potentially moves the individual closer to a detox program. Santa Fe Mountain Center, an OUR Enterprise member, distributed 3,352 doses of Narcan to 1,214 individuals. Its efforts resulted in 62.7 reversals per month, or a little over two per day. At the same time, overdose deaths dropped from 39 in 2014 to 23 in 2015. Ms. Reichelt talked about how law enforcement has been trained to administer doses of Narcan and the efforts that have been made to educate the public on recognizing and stopping an overdose. OUR Network seeks to improve access to services and success rates of treatment by integrating Rio Arriba County's hospital, primary care, behavioral health, substance abuse treatment, courts, jails and other providers into a network charged with: (1) care coordination; (2) quality assurance/evaluation; and (3) outcome-based reimbursement. District and magistrate courts are tied into the network and encouraged to refer for services prior to sentencing. Ms. Reichelt highlighted several successes of the program and noted that it has been recognized by the White House for its efforts to develop a data-based care coordination network and jail diversion model.

Several members praised the two counties for their work to address this critical issue. In response to committee members' questions, the following points were discussed with the panel:

- efforts to reward MCOs and providers for working with programs;
- information about the Hoy Recovery Program;
- the voucher process for housing in Bernalillo County;
- the focus on long-term supportive housing;

- work by case managers to establish housing and ensure continuation of medication prior to release from detention centers;
- consequences for program violations and judges' discretion;
- an explanation of the medication Narcan and how it is administered;
- the importance of support during reentry into the community;
- the need for ensuring positive environment changes post-incarceration;
- the critical role for early intervention in the school system;
- prioritization of needs in Bernalillo County for the spending of tax revenues and the target date for funding to be available;
- the usage of existing nonprofits and community organizations to address needs and the potential for them to receive funding from the tax revenues; and
- the need for coding approval for billing of detox services at Hoy.

Status of Administrative and Civil Proceedings Involving Referred Behavioral Health Providers

Patsy Romero, chief operations officer, Easter Seals El Mirador (ESEM), provided an update to the committee on the investigation status. It has been three years since the suspension of Medicaid funding for behavioral health providers, and the behavioral health providers have lost the ability and right to provide services to more than 1,200 children and their families. The investigation by the OAG lasted for nine months, and ESEM was cleared of fraud twice. In the process, ESEM spent over \$1 million to comply with the investigation and administrative costs. ESEM has appealed the fair hearing process to the district court and has filed a civil lawsuit against the HSD and several HSD employees for federal civil rights violations. It is also in the process of suing OptumHealth for breach of contract, as OptumHealth is still withholding ESEM's funds. Ms. Romero described the hearing process, which she deems as unfair. According to her account, the HSD acts as auditor, judge and jury with the right to overturn the hearing officer's decision. The provider is limited by the hearing officer's decision, and the process does not follow an opportunity for the provider to defend itself.

Ms. Romero detailed ESEM's experience with the credible allegations of fraud events. She discussed a Legislative Finance Committee (LFC) report that says that the HSD has error rate of 6.4%, which is deemed acceptable by the HSD. According to Ms. Romero, there was no evidence that ESEM hurt anyone or that it denied any services. This was caused by minor, non-intentional human errors. ESEM claims that OptumHealth owes it \$660,000, while OptumHealth is claiming that the amount owed is only \$370,000. Ms. Romero is cautious of OptumHealth's claims system and noted that there has been no proof that \$11 million is in an interest-bearing account that is owed to New Mexico providers. According to her, ESEM fears retaliation, and the MCOs have been told by the HSD not to allow ESEM to be re-credentialed. Ms. Romero urged the committee to support upcoming legislation by Senator Papen regarding due process and to provide for an even playing field for providers in the state.

Shannon Freedle, CEO, Teambuilders, shared his experience with the HSD and the fraud allegations. Teambuilders was a community-based behavioral health provider for children. Mr.

Freedle claims that Teambuilders was targeted along with 14 other providers by the HSD and subsequently put out of business. Teambuilders was the last to be cleared by the OAG, with no instances of fraud discovered. Agave Health, a company that occupied the building Teambuilders had, gave notice that it was planning to leave the state. Teambuilders contacted the HSD about reopening after having been cleared of fraud allegations, and then received an overpayment demand letter for \$12 million. Since mid-April to the present, Teambuilders had the opportunity to submit additional information that should have been requested originally. Mr. Freedle said that Teambuilders has reduced the number of challenged claims by 75%. He thinks the remaining alleged failed claims are within the national expected margin of error. He thinks Teambuilders will get to 5% or less, the threshold within which extrapolation is prohibited. The amount being extrapolated totals \$3.2 million. Teambuilders' fair hearing is scheduled for the following week.

Mr. Freedle added that he has watched the needs of children and the communities go unserved. He claims that this company and he, himself, have been publicly defamed and have become victims of character assassination. He believes that the HSD did receive some information, but that the HSD acted brashly on it. Going on three years, no instances of fraud have been uncovered, and there is still no end in sight. According to Mr. Freedle, OptumHealth owes Teambuilders \$5.5 million. Teambuilders will also be filing a lawsuit over this issue.

Nancy Jo Archer, executive director, Hogares, used to operate nine facilities in four different counties, employing 266 staff members. Open Skies, an Arizona company, took over the buildings Hogares occupied following the fraud allegations. In November 2014, 18 months after its suspension, Hogares was contacted by the OAG to supply documents for the audit process. Ms. Archer stated that Hogares delivered everything to the OAG, noting the demanding amount of effort to comply. The HSD wanted to negotiate overpayment, asking for \$9 million. Hogares declined to negotiate and applied for a fair hearing. She echoed Ms. Romero's sentiment about a lack of fairness in the process. Hogares had \$2,000 in claims considered faulty; under the HSD's audit, the amount was \$6,000, extrapolated to \$9 million. Ms. Archer claims that OptumHealth owes her company \$2 million. OptumHealth stopped adjudicating claims and wants Hogares to subscribe to networks to allow Hogares to see its own data at \$100 per month. Hogares has filed a lawsuit against the HSD and OptumHealth.

Members of the committee expressed frustration and sympathy for the panelists. In response to the presentation, the committee addressed the following topics with the panel:

- calls for the resignation of the secretary of human services;
- impacts on the community and the children receiving services from these providers;
- the long-lasting effects of dismantling the system and the difficulty of recovering from the loss of services;
- clarifications on the various monetary amounts involved;
- the unacceptable length of time this process has taken;
- the loss of clients during the transition and the lack of outreach;

- the status of other providers with fraud allegations;
- various questions about the extrapolated values;
- personal lawsuits for defamation of character; and
- the personal and professional toll of the allegation.

Public Comment

Mark Johnson, ESEM, thanked the committee for its support throughout this process. He stated that ESEM was forced to turn over its business with no disclosure and no due process to Arizona companies that do not provide the necessary services to the communities. Mr. Johnson provided more background on the incident. He noted that the HSD released funds for the DD programs but never responded to release funds for behavioral health, even though the practices were the same for both services. According to Mr. Johnson, the behavioral health program was shut down for \$300 worth of billing errors — an error rate of less than 3%. He believes that the extrapolation that is being used by the HSD is not viable. In the over \$265 million of billings reviewed, the OAG found \$42,500 in billing errors. Mr. Johnson claims that the extrapolated amount is being used to mislead the public about the issue. In a meeting with the secretary of human services in which Mr. Johnson offered to pay the original amount, he was told that was not possible because it would set a precedent and that the "HSD needed a win".

Former Representative Liz Thomson thanked the committee for not letting what she referred to as "this disaster" go unheard. The impact from this will never be known in terms of the lives of the individuals it affected, she said. Ms. Thomson expressed disappointment in the lack of bipartisan representation, which existed when the issue first surfaced. According to her, the HSD has shown a pattern of disregard for vulnerable persons. The issue with the Supplemental Nutrition Assistance Program (SNAP) is further evidence of this. Ms. Thomson hopes those responsible will be held fully accountable.

Maggie McCowan, New Mexico Behavioral Health Providers Association, stated that she believes that the state is in the middle of a behavioral health workforce crisis. The allegations against providers are partly responsible for that, causing the loss of leadership. As an association, it has requested the HSD to standardize the auditing process. The HSD said it is working on it but cannot talk about any of it until this issue is settled.

Recess

The third day of the meeting recessed at 5:58 p.m.

Thursday, July 28

The fourth day of the meeting was reconvened at 8:37 a.m. by Senator Ortiz y Pino in the UNM Science and Technology Center Rotunda.

Welcome and Update on Health Sciences Center; Addressing Campus Sexual Assault

Dr. Robert G. Frank, president, UNM, told the committee that one of the most important things the university does is work to graduate students and that providing a safe environment is very important to student success. He highlighted some recent record high retention and graduation rates and talked about several buildings that will be getting improvements and renovations. UNM has focused on doing more for the campus with fewer resources and continues to cut costs, according to Dr. Frank. He outlined several ongoing reviews in the interest of increasing communications and reducing redundancy. Former student athlete Jill Pilgrim was hired to evaluate residence halls, revealing that athletes were not being treated differently; however, there were some things that did need improvement. UNM has been focusing on creating a culture of support and advice so students and faculty know where to go for resources and help if something happens to them.

Elsa Cole, University Council, UNM, has been part of the University Council for three years. Ms. Cole provided background on what led to the university's attention and recent efforts to determine the extent of issues of sexual misconduct at the school. Following her hire, Ms. Pilgrim's firm conducted a review and assessment on UNM's climate for sexual violence; the subsequent recommendations are known as the Pilgrim Report. UNM has begun the immediate implementation of those recommendations as well as those from the eventual DOJ review, including clarifying and consolidating policies and procedures and improving and increasing training and outreach.

Ms. Cole provided the committee with background on the DOJ investigation and Title IX of the federal Civil Rights Act of 1964. In April 2011, the United States Department of Education's Office for Civil Rights (OCR) issued a "Dear Colleague" letter clarifying that Title IX of the Education Amendments of 1972 requires schools to address reports by students of sexual assault as they are forms of sex discrimination. Following the release of the Pilgrim Report in December 2014, the DOJ informed UNM that the DOJ would be conducting a Title IX policy and procedures review of the campus regarding reports of student sexual assault and harassment. Although the OCR has opened and conducted numerous investigations on campuses across the country of sexual assault incidents, this is the only investigation that the DOJ has undertaken alone, and it is solely focused on policies and procedures, not any particular incident. Ms. Cole summarized the findings of the DOJ investigation, which was completed in June 2015. UNM continues to send the DOJ updates on UNM's policies, efforts to train staff and faculty about UNM's policies and efforts to educate staff, faculty and students about procedures for reporting and addressing sexual assault in ways that are timely, thorough and fair. Ms. Cole noted that ongoing collaboration with the DOJ has been cordial.

In April 2016, the DOJ issued its report acknowledging the many efforts made by UNM but still finding the university's policies and procedures to be not in compliance with Title IX. According to Ms. Cole, the report stated that UNM must take additional specific steps to bring itself into compliance. UNM's attorneys had an initial meeting with DOJ attorneys on June 22, 2016 to work on an agreement to address UNM's obligations under Title IX to prevent and

address sexual harassment and sexual assault and to provide clear and consistent procedures for reporting, investigating and responding to such conduct. UNM's suggestions regarding the agreement have been taken back to Washington, D.C., by the DOJ for review by the department.

Francie Cordova, director, Office of Equal Opportunity (OEO), UNM, is charged with investigating all issues and claims of violations of protected status and discrimination at UNM. Ms. Cordova discussed the structure and scope of the OEO, which directly reports to the university president on matters such as Title IX and disabilities accommodation. Student employees and staff received extensive, trauma-informed training to deal with issues of abuse. The OEO has been working to establish policy and process improvements while creating reporting templates to ensure case consistency. Ms. Cordova explained several initiatives the office has undertaken, including a climate survey, engagement and training with police, training on various policies and focusing on response and support (please see handout for full details). The OEO realizes that the problems are campus-wide, and it is working to create campus partners.

Nasha Torrez, dean of students, UNM, noted that there are a lot of things UNM has been working on. Ms. Torrez informed the committee about the LoboRESPECT Advocacy Center, which provides confidential and anonymous reporting for sexual assault or misconduct. The program is designed to provide support and relief in the aftermath of an assault. Ms. Torrez explained how LoboRESPECT, a student group, uses peer mentors to encourage student involvement. UNM has implemented mandatory online training and continues to spread the message through campus outreach, student orientations and a designated "safety week". UNM has also organized a Sexual Misconduct and Assault Response Team (SMART) that has completed a handbook with protocols and other written resource material for students, faculty and staff. The UNM Dean of Students Office is working to identify, develop and standardize ways to provide supportive measures to affected parties, according to Ms. Torrez. The "Protect the Pack" strategic campus-wide marketing plan is being used to foster responsibility among students.

Dr. Frank added that the university is a very complex place with moving parts and that it has changed the first year experience for students. UNM is dedicated to making sure the school is a safe and positive experience. According to Dr. Frank, UNM is working to reinforce the idea of peer help and the notion of looking out for each other. He admits that UNM has a long way to go but is doing so much better. He believes that if the Inspection of Public Records Act was amended to protect witnesses, more people would be willing to come forward.

Following the presentation, members of the committee discussed the findings of the DOJ report and the presentation. Some key points addressed were:

- a comparison of UNM's statistics to other universities — Ms. Cordova offered to share these data when they become available;

- plans to handle the potential increase in claims following efforts to increase awareness of issues and existing resources;
- the impact of the budget deficit on UNM's programs;
- the need for greater involvement and feedback from students;
- efforts to create consistency among policies and simplifying the procedures;
- the involvement of student athletes and coaches in the programs;
- the importance of understanding Title IX and its relation to universities and colleges of all size;
- the role of the university in regard to criminal charges;
- the time frame and statute of limitations for report filing;
- training level of campus police and its ability to handle investigations;
- student self-defense;
- neutrality in administrative hearings;
- the current status of DOJ involvement and next steps for implementation of recommended changes to UNM policies and protocols;
- the campus climate survey availability to the LHHS; and
- the issue of backlogged evidence and rape kit processing.

Sexual Assault Programming

Ashlynn Ota, student, began the presentation by sharing a letter she wrote to Dr. Frank regarding her sexual assault (the letter is available on the legislative website). Ms. Ota expressed concern and frustration with the administration's handling of her case and UNM's response to the DOJ report. Ms. Ota detailed the facts of her case and stated that she does not believe UNM has taken this issue seriously nor has it made the reduction of sexual assaults on campus a priority.

Claire Harwell, project director, Community Justice for Survivors of Sexual Violence Project, provided the committee with an overview of Title IX and other related laws protecting student's civil rights. The committee received several handouts supporting her testimony. Ms. Harwell represents students and believes UNM's response to the issue was unacceptable. The problems identified by the DOJ have been ongoing. Title IX requires a prompt, competent institutional response and an investigation of all complaints; the DOJ found the OEO has taken way too long in addressing and handling complaints. Ms. Harwell stated that it is the university's responsibility to mitigate harm following an assault; instead, students have experienced institutional betrayal. Students need to have the information about how to file complaints and know what their protections are. Ms. Harwell noted that the effects of a sexual assault and the handling of the case create real, long-lasting impacts on the victim's life. Trauma affects the chemical makeup of the brain. Scientifically, individuals are affected by apologies for medical errors. Ms. Harwell believes that if the university would do waivers for victims, it would help the students heal. She detailed a few legislative recommendations that would encourage oversight for the departments and increase reporting and training requirements.

May Sagbakken, director, Rape Crisis Center of Central New Mexico, is a member of the UNM SMART. She highlighted some of the steps the university has taken in addressing sexual

assault, acknowledging that UNM has made great strides in this area. Updated policies and campus-wide trainings are great, but there is more that needs to be done. The university needs to be held responsible for what it has not done and for not moving fast enough to address issues. UNM has not involved all stakeholders to ensure successful implementation of these policies. Ms. Sagbakken believes that without DOJ involvement, nothing on this issue would have been done. Sexual assault on campus has long been a persistent problem. She added that only when trauma is brought to light can victims begin to heal.

Aubriana Romero-Knell is a survivor of sexual assault at UNM. She shared her experience with the committee and stated that students are not allowed to carry any form of self-defense devices. She partook in a protest with other students carrying Nerf guns without darts to draw attention to the issue. A resolution was approved through the Associated Students of UNM (ASUNM) to allow students to carry mace; however, the administration took no action on the matter. She added that when UNM turns down allegations, it creates an environment where students feel they should not report assaults.

Karen Herman, director, Sexual Assault Services, New Mexico Coalition of Sexual Assault Programs (NMCSAP), called attention to the broader issue of sexual violence in New Mexico. She shared the following: 66% of incidents annually reported involve children; one in four women will experience attempted or completed rape in their lifetime; and one in 20 men will experience sexual assault. Ms. Herman underscored that early intervention is key in helping survivors cope and heal. She described what the comprehensive services would entail and the need for the expansion of services. There is a need to address violence in Native American communities and to address the evidence backlog in the criminal justice system.

Kim Alaburda, executive director, NMCSAP, thanked the LHHS for its continued support and attention to this issue. The NMCSAP receives \$2.9 million in recurring funding from the DOH to conduct trainings and build support infrastructure. Funding helps pay medical bills for victims, Ms. Alaburda stated, because victims should not have to pay for their own examinations and evidence collection. This year, the NMCSAP received an additional \$25,000 to expand its services to Spanish-speaking communities; the NMCSAP hopes to be able to expand services to other ethnic communities and rural parts of the state. Ms. Alaburda closed by adding that this is an opportunity to move the state forward by helping children, women and the most vulnerable people of the state.

Members of the committee thanked the panel and the survivors who came forward today to share their stories and experiences. Committee members inquired about the following information:

- the importance of teaching people what constitutes "rape";
- the need for directing messages to men and instilling in youth that rape is unacceptable;

- the problem with an offender not being properly punished and the effect that has on condoning the behavior and preventing individuals from coming forward after an assault;
- what is being done at other universities to address this issue;
- the importance of not assigning blame on the victim for the use of alcohol or drugs to excuse the violent criminal action;
- UNM police training and involvement in SMART;
- regulation of fraternities and sororities on campus;
- the need to educate both males and females on sexual assault and violence;
- the unintentional penalization of victims through the loss of benefits and scholarships as a result of dealing with their trauma;
- unclear campus policy about the use of mace; and
- the desire of the LHHS to readdress this issue in the future with an update on UNM's and the DOJ's progress.

Public Comment

Nandi Baldwin, former student, witnessed the daily activities of the women's resource center and would see all of the women coming in for help. Women are very underserved at UNM. She believes there is a need to stop the language of placing blame on the victim and a need to change the message from telling women to learn self-defense to teaching young men "don't rape".

Gail Houston, professor of English, and chair of the ethics committee, UNM, shared a personal story of a student coming forward after a sexual assault by a professor. The OEO was involved with the case. Professor Houston informed the committee that it was rumored that the perpetrator was returning to the department. She said that the students and faculty are very affected by this decision. Professor Houston expressed disappointment that Dr. Frank did not stay to hear the public comment. Men need to be here to show respect and concern and this needs to be a priority. She asked why it is okay to treat women this way, causing them to leave the department in situations like this. Professor Houston believes universities should cherish and protect the whistleblower.

Liz Hutchison, professor of history and director, Feminist Research Institute, UNM, appreciates the attention to the broader issue of gender inequality. She stated that the members of the faculty are part of this community and they are part of the problem and part of the solution. Professor Hutchison believes the training of faculty is crucial. She urged the support of all of the work in response to the DOJ findings. Professor Hutchison added that there are many silent survivors.

Danielle Kabella, Ph.D. student in anthropology, also expressed concern about the professor being allowed to return to the department. She believes she received an unfair grade and that it was due to sexual motivations. Ms. Kabella went to the OEO to complain and an eight-month-long investigation resulted. She noted that some professors, other students and

resources were supportive but that they did not have any ability to do anything about it. The professor was reinstated even after the finding that he was deemed to be a significant harm/threat to students. She was disappointed that the DOJ report is on UNM's radar and the professor was still brought back to the department.

Ronda Brulotte, professor of anthropology, UNM, believes that the broader issue of harassment on campus is being missed. She stated that this is not just about fraternity members or athletes raping younger students; in her experience, this goes on between staff and graduate students. The retaliation and fear of being on the campus have not been taken seriously by the university. Many students have left or are in the process of leaving. Professor Brulotte told the committee that she would not encourage students to come to graduate school at UNM because she does not feel like it is a safe environment.

Lizzy Small, alumnus, UNM, informed the committee that she is a survivor of sexual assault and the abuse of the administration. Ms. Small said she had amazing support from her professors, but the case was dealt with in the very same manner that the DOJ report expressed. The findings of the report are the same things that have been going on at UNM. Calling students' stories "anecdotal" is incredibly insensitive. Ms. Small also expressed disappointment that representatives of the administration did not remain in the meeting.

Rachel Levit, Ph.D. student, had three points to share with the committee. First, assuming that perpetrators are male students and victims are female students is faulty, as there have been many instances of faculty involvement in sexual assaults. Feminist faculty are left to support students at the risk of retaliation. Second, there are issues relating to transgender students, as 27% of transgender people experience sexual assault. They also tend to be repeatedly assaulted more than any other group. Third, the existence of homophobia, which has an impact on the reaction and judgment of the OEO.

Kyle Biederwolf, student president, ASUNM, talked about the work and outreach being done by the association. It held a student safety day and invited all students to come through and learn about campus resources. Mr. Biederwolf informed the committee that the ASUNM recently received capital outlay funding to install lights on the south side of campus. It is working directly with the policy office regarding the carrying of pepper spray on campus, and it has established a committee to address the campus weapons policy. Mr. Biederwolf stated that the ASUNM has worked with the OEO and wants to continue to work with it and wants to keep students involved. He said that he was involved with the student orientations and recognized the dean's office for its work to improve that. He added that UNM could do better but strides have been made to address these issues.

Jeff Devereaux, campus organizer, Planned Parenthood, questioned the lack of student engagement on these issues. He asked why the university does not have a student task force to address this issue. Students are a huge resource and these discussions need to take place.

Hunter Riley, Self Serve Sexuality Resource Center, talked about the organization's efforts on assault prevention. She believes that preventing sexual assault needs to be a priority of sex education. If youth are taught about what is healthy sexuality, it will make it easier for them to recognize what is unhealthy. Ms. Riley talked about a recent event held on campus with a section specifically for men. The administration came in and apologized for the event, according to Ms. Riley. The organization had brought in presenters that talked about pleasure-focused sex education, an approach that the World Health Organization has recognized. Ms. Riley stated that the center received feedback from those who saw the presentation that indicated that participants learned more about sex education in the five-minute presentation than they had in all of their past years of sexual education.

Forensic Evidence for Sexual Assault Survivor Services and Proceedings

Sarita Nair, chief government accountability officer and general counsel, Office of the State Auditor (OSA), addressed the committee regarding the issue of untested forensic evidence in sexual assault cases. The backlog of sexual assault forensic evidence kits, or rape kits, is not new or unique to New Mexico. The OSA oversees all law enforcement agencies in the state and got involved in the issue when the state was unable to apply for federal funding due to its unaccounted inventory of rape kits. As of December 2015, there were 5,410 untested kits in the state. Ms. Nair noted that calling this a "backlog" is a misnomer — in reality, there are kits all over the state that for various reasons have not yet been tested, and they are not all in a queue. The OSA issued a statewide survey to all law enforcement agencies and will be publishing a report of that survey this fall.

Several in-depth audits were conducted with various departments, and the OSA received a high degree of cooperation with each of those agencies. The OSA has identified some overarching needs:

1. adoption of best practices by law enforcement to ensure this does not happen again. Multidisciplinary teams of law enforcement coordinating with rape crisis centers can really help communities;
2. broader understanding of both the state and federal DNA databases;
3. greater funding and additional resources, particularly at the state crime lab. The City of Albuquerque has its own crime laboratory and is dealing with not only a backlog of rape kits, but also other evidence processing, such as ballistics; and
4. strategic planning for the future. With increased efforts to process rape kits, victims, rape crisis centers, police departments and court systems will need additional support and resources. It is important to be aware that as cases are reopened, there will be costs associated with prosecuting them.

Donna Richmond, director, La Piñon Sexual Assault Recovery Services of Southern New Mexico, noted that it will take at least three years to process more than 1,000 kits at its lab. From January to June of this year, La Piñon has generated 64 new kits. Labs are facing issues of prioritization, and each case has a different story. Ms. Richmond explained that it takes one

week to process a kit and a lab technician is able to process about seven kits per week. The lab is also responsible for having to process all other crime evidence, including DNA evidence in murder cases. Ms. Richmond also cautioned that victims may be re-traumatized when cases are reopened following the analyses of kits. Support services need to be in place to support victims years after the original event.

In response to questions from committee members, Ms. Nair and Ms. Richmond addressed the following:

- what can be done to help individuals navigate the experience of having cases reopened, particularly with limited budgets for services;
- how the survey process was conducted. It addressed policies and procedures of departments, statistics and resource needs of each department;
- comparison of other states on this issue;
- difficulty in attracting and retaining lab technicians;
- the requirement that the lab technician who tested the kit testify in person, preventing the possibility of outsourcing kit processing;
- questions about the various labs and their capabilities around the state;
- usage of a triage system to prioritize testing;
- hiring of additional staff;
- involvement and collaboration with tribal representatives;
- the statute of limitations in sexual assault cases;
- the importance of getting DNA profiles into the system to help stop repeat offenders; and
- the need to restore confidence in the system in order to continue to encourage victims to come forward.

Health Information Exchanges/Interoperability/Privacy and Security

Dale Alverson, M.D., New Mexico Health Information Collaborative (NMHIC), provided an update on the New Mexico Health Information Exchange (HIE). Dr. Alverson explained that the HIE provides "interoperability" between multiple systems allowing for secure information sharing when needed. According to Dr. Alverson, the HIE is a powerful tool that is improving the quality and safety of care every day in the state. There are currently more than 1,500 users with more than 3,000 patient documents accessed per month, with a total of 1.7 million patient records in the database. There have been statistically significant decreases in unnecessary procedures and testing because patient records housed in and accessible through the HIE indicate what has already been done. Not all health care providers are participating in the exchange, but the more that are, the more patient care should improve. According to Dr. Alverson, there is a big gap in the HIE with respect to recipients of patient health information available for Centennial Care recipients. These recipients exist in the system, but there no health records for them.

Dr. Alverson noted that health systems and facilities are not all using the same electronic health records information technology; providers within a health system can communicate only with others in the system. The HIE creates a central location for all of the records to be viewed. Exchanges are working together to negotiate contracts and improve data-sharing. The NMHIC is a member of a consortium with 18 other exchanges. Thomas East, CEO, chief information officer, LCF Research, explained that the NMHIC is using international standards for health records so data can safely and securely be delivered from other states through the exchange. Dr. East assured the committee that exchanges are secure and that few ransomware attacks have been successful, despite media reports.

Because New Mexico is an "opt-out" state, patient health information flows into the HIE without patient consent. However, patients can control which health organizations access their medical records. These records are only accessible to health care providers without patient consent in the event of a medical emergency or for reasons of public health. Dr. East discussed the current status of the NMHIC, whose current membership ranges from hospitals and provider groups to laboratories and a pharmacy. The NMHIC welcomes additional stakeholders, including home health, hospice, skilled nursing facilities, behavioral health, professional health care associations and ancillary service providers. The New Mexico Poison and Drug Information Center at UNM is a big utilizer of the system.

There is no recurring fee to contribute electronic patient records to the HIE, but there are set participation fees for hospitals, providers and health insurance companies. As of today, the NMHIC has a positive cash flow and a revenue stream that funds its day-to-day operations, and it is working with its software vendor on extended payment terms to allow time to build out statewide interoperability and to develop additional revenue sources. Projections show sustainability is dependent on full participation by large hospitals and health systems, regional hospitals/hubs, large provider groups, Centennial Care MCOs and other payers like commercial insurance and Medicare. The cost of interfaces is often a roadblock to sustainability — vendors do not want their clients to share data unless they get paid to work out interoperability. The NMHIC needs \$400,000 to get CMS matching funds to put every health record in the state into the HIE. Dr. East concluded the presentation with a request for the legislature to enact the New Mexico Health Information Exchange Interoperability, Standards and Authorization Act. This act would mandate participation of health care providers, MCOs and self-insured employer groups in a statewide interoperability solution.

On questioning, Dr. Alverson and Dr. East discussed the following topics with committee members:

- increased telemedicine opportunities with the HIE;
- whether the focus of the standard electronic health record is on coding, billing and data collections rather than patient care;
- avoiding duplication of effort in creating electronic health records;
- the need for a one-time funding match for federal dollars;

- sustainability from revenues with full participation; and
- information sharing with the IHS for tribal areas.

Nick Edwardson, assistant professor, School of Public Administration, senior fellow, Robert Wood Johnson Foundation Center for Public Health Policy, UNM, and Jon Law, executive director, Paseo del Norte Health Information Exchange, addressed the committee with a separate presentation on an economic analysis of the NMHIE. The DOH commissioned the New Mexico Health System Innovation (HSI) to specifically examine the return on investment (ROI) of the NMHIE. Dr. Edwardson presented the findings of that economic analysis to the committee.

The study looked at health care cost reduction over a 10-year period. The HSD provided the HSI with actual Medicaid claims data for a year to do this research. The HSI looked at high-cost utilizer groups, including behavioral health, diabetes, obesity and tobacco use. For example, poorly managed diabetes cases cost between \$41,000 to \$45,000 in additional Medicaid dollars. Dr. Edwardson explained the methodology and the models used, choosing the most conservative numbers and statistics. The study created an "outreach effect" that allowed the HSI to alter HIE adoption rates over time. The study assumed a 50% utilization rate by the tenth year. The resulting projections indicated that the cost goes down over time across all four utilizer groups (please see handout for detailed graphs). Dr. Edwardson concluded that under the assumptions of the study, the HIE generates positive ROI after its first year, despite conservative estimates, improves health outcomes for New Mexico Medicaid enrollees and lowers the total cost of state Medicaid.

Dr. Law added that the value of HIEs is in the early stages of being understood. Paseo del Norte is based in El Paso and is a Texas-funded community-based exchange. Dr. Law shared information on the model used by Paseo del Norte and its efforts for service outreach for providers and doctors. The use of electronic health records is still lagging in El Paso, with about 40% of practices still using paper documents. Paseo del Norte is interested in servicing areas in parts of southern New Mexico, including Dona Ana and Otero counties. Dr. Law requested legislators to consider communities on the edge of the state and indicated his organization's interest in connecting to the HIE.

From discussions with providers in Las Cruces, Dr. Law stated that provider liability related to the transfer and use of data in the HIE is of concern. He advised the committee of legislation passed by the Texas House of Representatives (House Bill 2641) in 2015 that gives providers immunity while taking part in the exchange. Dr. Law briefly mentioned that a revamp of Medicare is planned for 2017, with Medicare providers receiving either a 4% rate increase or financial penalties, based on the quality of care. By 2020, the increase will be 5% and will continue to rise over time. This could mean a \$162 million impact on hospitals, leading to greater reliance on electronic health records. CMS has not yet finalized this rule.

Following the presentation, the committee had the following inquiries and comments:

- different Medicare reimbursement rates, depending on the state;
- usage of research in marketing exchanges;
- the potential for the Medicaid program to benefit from the HIE;
- ongoing budgetary issues for New Mexico and the unlikelihood of state funding for the HIE;
- the number of health care practitioners not using electronic health records in Texas;
- the opt-out option for patients;
- the pros and cons of duplicative testing;
- the potential for integration of physical, behavioral health, dental and pharmacy records in the HIE; and
- the need for legislation to mandate health care providers to participate in the HIE, such as the law in place in Minnesota.

Public Comment

Richard Talley shared a letter he had sent to the secretary of health and the governor about the difficulty in getting a medical cannabis card. Mr. Talley has been trying to acquire a medical cannabis card for a family member suffering with chronic pain. According to him, it is taking 45 days to 55 days or longer for the DOH to issue cards. Because some medical conditions do not change from year to year, he does not understand why a yearly renewal is required. A member of the committee invited Mr. Talley to attend the Disabilities Concerns Subcommittee meeting being held the following week. The issue of the backlog is on the agenda, and representatives from the DOH are scheduled to be in attendance to address the issue.

Recess

The fourth day of the meeting recessed at 4:03 p.m.

Friday, July 29

The final day of the meeting was reconvened at 8:46 a.m. by Senator Ortiz y Pino. Members of the committee and staff were asked to introduce themselves.

SNAP; Human Services Program Efficiencies

Ms. Hager addressed the committee regarding what can be done to reconcile issues with SNAP. A federal court has recently appointed a special master to oversee the state's compliance with federal food programs. Unnecessary steps in the application process waste money and threaten the health of eligible families, according to Ms. Hager. She shared some examples of families affected by the problems with SNAP, which were often attributed to poor notification for eligibility renewals. Ms. Hager outlined the following "common sense" steps the HSD can take to improve accuracy and efficiency in SNAP and Medicaid.

1. Request only documents that are required by law. The HSD continues to require applicants to supply documentation that is not necessary to determine eligibility.

2. Make better use of the department's information technology systems. The HSD will request documents that are already electronically available in its system. Many states also automate renewals to eliminate paperwork.
3. Make client notices accurate and understandable.
4. Create a comprehensive, accurate online worker manual.
5. Collect and share data on enrollment and processing. Churn happens when eligible individuals lose benefits for a procedural reason. Churn creates an unnecessary increase in applications, which are more costly to the process than renewals.

Ms. Hager also listed the following procedures that the LHHS can implement now to improve the HSD's accuracy and efficiency.

1. Require data on renewal churn and track churn as a performance measure for the HSD in House Bill 2. The most direct way would be to track the share of clients up for renewal who experience an interruption in benefits but return to the program within 90 days of refiling an application.
2. Require data on the accuracy of expedited SNAP and track this information as a performance measure for the HSD in House Bill 2. According to HSD data, the rate of improper denial rose to 9.8% in 2014 from 1.8% in 2013. These data are tracked regularly, and the LHHS should request updated data sets.

Jon Courtney, program evaluator manager, LFC, detailed the timeline for special review in a memo to the LFC. Mr. Courtney summarized the financial impact of the *Hatten-Gonzales* lawsuit. The LFC estimated a General Fund financial impact from the lawsuit to be \$5.4 million, with an additional \$2.4 million in additional benefits and \$3 million in administrative costs since 2014. The HSD has a different interpretation of overdue application rules. In a comparison with other states, New Mexico's performance is not doing great: 25% of a state's determinations nationally are inaccurate; New Mexico's error rate is 50%. New Mexico's error rates skew toward overpayment. The United States Department of Agriculture has sent the HSD a letter saying that the state may be liable to repay federal funds improperly paid. According to Mr. Courtney, there is some conflict between federal law and the court order.

Christopher Collins, general counsel, HSD, provided the committee with a summary of the federal court order and appointment of a special master. A federal magistrate has adopted the HSD's proposal to appoint a special master through January 2018, who is accountable only to the court. The special master will provide the court with objective information regarding the HSD's compliance. Mr. Collins stated that the department is committed to resolving problems with the administration of benefits, and he believes that the special master is a good step in the right direction to help bring litigation to a close. The HSD has filed a motion asking the court to lift the order prohibiting the closure of cases so the department can comply with federal law. In response to the suggestion made by Ms. Hager, Mr. Collins said that these are things the HSD has also identified and is working to address.

The committee questioned the panelists about the following aspects of the presentation:

- changes since the April meeting of the LFC;
- the appointment of the special master;
- allegations that the HSD is pursuing families to recover overpayments;
- the absence of an HSD representative, except for HSD counsel, at the committee meeting;
- clarification on the current status of the litigation and case closure;
- the process to apply for SNAP benefits;
- the number of clients in SNAP and Medicaid;
- HSD staffing issues and the failure to meet the seven-day federal requirement for emergency food assistance;
- allegations that HSD staff altered applications to disqualify applicants from eligibility for emergency food benefits and that this has been a long-term systematic practice;
- details about the HSD's "tiger team" established to address the backlog of unprocessed applications;
- electronic benefit transfer card abuse and fraud; and
- criteria for expedited SNAP eligibility.

Food and Nutrition Programs

Tony McCarty, executive director, Kitchen Angels, shared the program's background and successes. Kitchen Angels was founded in 1992 and serves northern New Mexico's most vulnerable residents, which include those under the age of 60 who are living with chronic or terminal illness; the elderly in severe medical crisis with extreme dietary requirements; and dependent children under the age of 12 of clients who are single parents. Mr. McCarty explained that the meal delivery service depends heavily on donations, grants and volunteers. Often, volunteers provide the only social interactions their clients receive. Almost 98% of clients are classified as economically disadvantaged, and the majority of the referrals to the program come from health care providers.

Stephanie Gonzales, president, Kitchen Angels, talked about some of the members of the program and the structure of the organization. Kitchen Angels only has four paid staff members who oversee the 550 volunteers in the program. The organization works closely with the community, partnering with local farms and grocery stores. Ms. Gonzales added that Kitchen Angels has partnerships with health care providers to help patients with transitions after hospitalization. It also provides special, high-calorie meals to out-of-town individuals receiving chemotherapy or radiation treatment at Santa Fe cancer centers.

Kitchen Angels has an operating budget of less than \$730,000. Mr. McCarty informed the LHHS that in 24 years, it has never had a waiting list for services; however, it is seeing more and more need for services. The organization's client base has doubled since 2008. Last October, Kitchen Angels served its one millionth meal. A national organization, Feeding America, estimates overall food insecurity in northern New Mexico to be at 17.5%. Hunger is

one of the most important social determinants of health. Approximately 50% of seniors admitted to the hospital are malnourished. Food insecurity leads to non-adherence to treatment plans, behavioral health problems and higher rates of diabetes. Home-delivered meals can help reduce health care costs. Mr. McCarty added that without additional resources, the nonprofits that provide these services will be unable to continue to meet the needs of the community.

Cindy Howell, vice president of healthcare services, Molina, voiced her organization's excitement to have Kitchen Angels as one of its partners in its post-discharge meal program. Molina has begun providing nutritional meals to support Centennial Care members who are being discharged from an inpatient facility. Case managers work with the patient prior to release to determine whether there is a need for home meal delivery. Molina partners with Meals on Wheels and GA Foods in addition to Kitchen Angels. Ms. Howell described the services and characteristics of the three vendors. GA Foods is the newest partner, and it provides meals throughout the state by Fed Ex delivery, thus expanding the service area into rural parts of the state.

Catherine Sierra, manager, Transitions of Care, Molina, provided examples to the committee of how the program works, detailing the post-discharge meal referral process. Case managers are able to meet with the client at bedside and review service options with the client. They follow up with the client seven days later at the client's home to make sure that the client has been handed off to a physician and has medication and to ensure that the client's needs are being met. If a client has previously turned down food delivery service, this home visit allows the client to reconsider that decision. Ms. Sierra added that this service helps to decrease the likelihood of return to the hospital. She added that Molina can arrange for delivery to chapter houses on Native American reservations.

Members of the committee praised the presenters for their work and commitment to providing services to the homebound. In response to the presentation, the committee addressed the following topics with the panel:

- the program's overall benefit to the state in terms of cost savings and meeting the needs of vulnerable populations;
- the availability of service to both Medicare and Medicaid recipients;
- variety in meal and dietary options;
- successful training of volunteers;
- outcome data collection by Molina; and
- organizations around the country providing similar services and seeking Medicaid reimbursement.

Public Comment

Ruth Hoffman expressed concern for the high hunger rates around the state, particularly among children. Every week, more than 70,000 individuals seek assistance from food pantries and agencies; that is approximately the population of Santa Fe. Ms. Hoffman stated that the

efficient and accurate administration of SNAP is critical and is the responsibility of the state. She stated that the legislature has the responsibility to provide oversight of this program.

Bill Jordan, New Mexico Voices for Children, reminded the legislators that the state is number one in child poverty and number three in child hunger. He stated that churn in SNAP creates more work for the department and costs the state more money. He suggested that the state ought to be looking to save money in ways that do not hurt services for kids and families. In regard to the Medicaid issue from the first day of the LHHS meeting, Mr. Jordan noted that the Medicaid expansion is more than paying for itself through 2020. He stated that cutting Medicaid and losing federal funds is not helping anything, including the state's economy. According to Mr. Jordan, the state took in new revenue from the Medicaid expansion and spent it elsewhere, then cut the state's share of Medicaid by \$86 million, giving up over \$300 million in federal dollars. He believes the state needs to fully fund Medicaid.

Lisa Rossignol called attention to the larger issue of families with young children having programs systematically removed. New Mexico children are facing a crisis, and this is affecting their overall well-being. Health care is a civil right. Ms. Rossignol stated that there is no evidence that money has been misspent on Medicaid; the program was underfunded from the beginning.

Bill Miller, retired UNM faculty, volunteers with the homeless in Albuquerque. He works with Debbie Johnson, who founded the Tender Love Community Center. Ms. Johnson is originally from Africa and became homeless for three months. She noted that not every homeless person is suffering from addictions; sometimes it is just the person's circumstances. The Tender Love Community Center teaches individuals life skills like sewing. Currently, the program is only offering services to women because it does not have the resources to expand to men. Ms. Johnson invited the committee to learn more by visiting its facility and its website: tenderlovecommunitycenter.org.

Patty Keane, New Mexico Academy of Nutrition and Dieticians, spoke about how losing SNAP benefits impacts overall health and medical needs. SNAP impacts public health and chronic diseases through proper nutrition. Food insecurity is associated with poor health outcomes and increases the lack of adherence to medication, mental health problems and depression. Half of those hospitalized for low blood sugar lack sufficient food. Ms. Keane invited members to attend the upcoming New Mexico Hunger Summit on September 27, 2016.

Public Comment — Closure of Adolescent Treatment Center at Turquoise Lodge

Mr. Holland made the argument that the state cannot afford to close the adolescent treatment center at Turquoise Lodge. Commenting on the DOH's justification for this decision (because Turquoise Lodge has only been serving an average of five adolescents), he believes that this is tantamount to saying that these lives are an acceptable loss. Mr. Holland requested information on outreach by the state to market this program, the number of calls Turquoise Lodge received requesting services, and the procedure for admission to the center. He noted that

making the admission process difficult could discourage people from seeking help. Following his comments to the committee earlier in the week, Mr. Holland reported that he called several specialists in this area and not one of them reported receiving notification from the state about the difficulty filling beds at Turquoise Lodge. According to Mr. Holland, service providers were not given advance notice of Turquoise Lodge's closure. He stated that by closing the facility, the DOH is "cutting the legs off the system that has been created over years to provide continuity of care". If it is a matter of numbers, Mr. Holland urges, scale back but do not close Turquoise Lodge. The Endorphin Power Company has a contract with Turquoise Lodge for fitness and relapse prevention services while individuals are in treatment.

Bill Wiese, M.D., a former UNM faculty member, works in drug policy and has chaired many task forces to make recommendations on health policy. Dr. Wiese announced that opioid use is an epidemic and an emergency for the state. Dr. Wiese acknowledged the hard work of individuals like Mr. Holland who are making an incredible difference. However, he added, these successes are being overshadowed by systemic failures. According to Dr. Wiese, a survey revealed that 7.9% of school-aged kids admitted to using prescription opioids to get high within the last 30 days; another 2.8% admitted to using heroin in the last 30 days. He noted that these surveys are only of kids that are currently in school. Even so, there are thousands of kids in the state that need drug treatment services. If Turquoise Lodge could only average a census of five adolescents, that demonstrates "an outstanding example of the failure of the system". He reminded committee members that systemic changes were required to address the AIDS epidemic and that addressing the AIDS epidemic was not only a matter of money, but also of leadership.

John Dantis, a retiree with a background in social work and public safety, posited that changes need to be made to address root causes of teen drug abuse. He talked about the incredible work of a local adolescent recovery center. Mr. Dantis believes there needs to be a shift in priorities and funding and an examination of how much is being spent on local adult criminal justice programs, APD and the court systems. Altogether, over \$400 million is being spent locally on these agencies. Instead of increasing the number of beds at the metropolitan jail, he suggested that investment should be made to expand services at treatment facilities. The closure at Turquoise Lodge "is a travesty to adolescents and families in the state". After two years of operating the adolescent program at Turquoise Lodge, he stated that the DOH needs to look at its business plan, not just close it. Mr. Dantis offered to provide whatever help is needed. He added that without question, the increase in carjackings in Albuquerque is related to the opioid crisis.

Laura Hurd, social services coordinator, shared her experience with Turquoise Lodge over the last year and a half. She challenged the DOH's claim that beds were going unfilled. She stated that she has worked with kids whose parents injected them with heroin as a "rite of passage". Ms. Hurd stated that if these teens have nowhere to go and end up dying, the state needs to take responsibility for their deaths.

Ms. Weiss-Burke believes that the state and Turquoise Lodge could have done better outreach to fill those beds. She also called all of the providers of services on the list that the DOH provided to the committee for resources that could be accessed in lieu of Turquoise Lodge. She noted that these are IOP services and do not provide the same services that Turquoise Lodge offered. Two of the locations on the list — the location in Raton and Agave Health — are closed. Another location, Desert Hills, just discontinued its IOP services in June. Ms. Weiss-Burke found two places that will provide services on a case-by-case basis for adolescents: Mesilla Valley in Las Cruces and The Peak in southern New Mexico. The Peak only deals with severe mental health issues, but typically it refers individuals to Turquoise Lodge.

David Burke, director of programming, Serenity Mesa, talked about the difficulty in getting patients admitted to Turquoise Lodge. Serenity Mesa sends representatives to Turquoise Lodge to tell individuals about services and to have them come tour the facilities. Mr. Burke said Serenity Mesa has a waiting list for young men seeking help. He is unsure why Turquoise Lodge is having trouble filling beds. He feels it could fill all 20 beds, but even filling one is worth it. Serenity Mesa cannot accept anyone who needs detox, and now it has nowhere to refer people. Sending kids to the UNMH to detox is not an option.

Donald Hume is a person in long-term recovery. He expressed his disappointment with the closure of the adolescent unit. Mr. Hume works with young people every day through the Espanola program Inside Out. He witnesses the need for treatment on a daily basis and said there needs to be a continuum of care. Mr. Hume stressed the importance of removing young people from their environment and providing them with a safe place to detox.

Mary Salazar, private citizen, worked at Milagro, a residential program for pregnant women. Ms. Salazar shared her experience with her daughter's heroin addiction and the difficulty she experienced trying to get her help. Apart from treatment being the humane way to deal with adolescents, she reminded the committee that drug addiction affects everyone. She cautioned that drug addiction does not discriminate and affects people from all walks of life. There needs to be better marketing for services and outreach so members of the public know where to turn for help.

Laurie Magee lost her son to a heroin overdose. Her son took pills from her cancer treatment and got addicted, but heroin was cheaper. She was desperate to get him help and found Turquoise Lodge. She told the committee that any day that you can have a child alive and safe is a blessing as a parent. Ms. Magee stated that she cannot imagine not having this as an option for parents. She pleaded for Turquoise Lodge to remain open to give that opportunity to those children and parents.

Anne Romero, mental health advocate, lost a close friend to suicide, which led to her involvement in this area. She said that people have become so complacent with the status quo that they have forgotten about doing the right thing. The closing of Turquoise Lodge suggests that these children have become disposable people. Ms. Romero cited examples of young people

suffering and dying every day, and said, "We can do better as a state". She reminded the committee that this is about people and that it is everyone's responsibility to do better.

Chelsie McGuire, ViewPoint Rehabilitation Center, informed the committee that she had personally referred three mothers to Turquoise Lodge for services. All three of them called her back informing her that they could not get a bed for their children. The reason they were turned away is unclear to Ms. McGuire. The mothers were unable to find help elsewhere. She stressed the importance of getting individuals, particularly adolescents, help when they are willing. There are kids out there who want help but she has nowhere to refer them. She encouraged accountability in this matter.

Motion 2

Following the public testimony, a motion was made for a letter to be sent on behalf of the committee requesting the DOH to reconsider, or at least delay, the closure of the adolescent treatment center at Turquoise Lodge. It was suggested that the letter include information the LHHS has gathered from recent presentations and public testimony, survey numbers provided by Dr. Wiese, lack of medically assisted detox options, delays in the processing of applications, IOP as an insufficient option for detox needs, request for information on how the center receives referrals and issues with the services of the other locations provided in the announcement of closure. The motion was seconded and passed without objection.

Adjournment

There being no further business before the committee, the third meeting of the LHHS adjourned at 1:35 p.m.

Revised: August 19, 2016

**TENTATIVE AGENDA
for the
FOURTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**August 22-24, 2016
Taos County Commission Chambers
105 Albright Rd.
Taos**

This Meeting Will Be Webcast

Monday, August 22

1:00 p.m. **Welcome and Introductions, Approval of July 6-7, 2016 Minutes**
—Senator Gerald Ortiz y Pino, Chair
—Representative Nora Espinoza, Vice Chair

1:15 p.m. (1) **Update on Medical Cannabis**
—Timothy Keller, State Auditor
—Natalie Riggins, Medical Marijuana Registry Program Manager,
Colorado

Department of Public Health and Environment
—Yonette Hintzen-Schmidt, Medical Marijuana Registry Program Support
Manager, Colorado Department of Public Health and Environment
—Lynn Gallagher, J.D., Secretary-Designate, Department of Health (DOH)
—Duke Rodriguez, President and Chief Executive Officer, Ultra Health
—William Ford, Managing Director, Reynold Greenleaf & Associates
—Stephanie Waddell, President, New Mexico Medical Cannabis Patient's
Alliance
—Jason Barker, Medical Cannabis Patient and Organizer, LECUA Patients
Coalition of New Mexico

3:15 p.m. (2) **Public Comment**

4:00 p.m. **Recess**

Tuesday, August 23

8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair
—Representative Nora Espinoza, Vice Chair

- 8:40 a.m. (3) **PAX Good Behavior Game**
—Wayne Lindstrom, Ph.D., Director, Behavioral Health Services Division,
Human Services Department (HSD)
—Dennis D. Embry, Ph.D., PAXIS Institute
—Trina Raper, Executive Director of Curriculum and Professional
Development, Santa Fe Public School District
—Deborah Mitchell, Principal, Alcalde Elementary School,
Espanola Public School District
- 10:10 a.m. (4) **Proposed Changes to Local DWI Programs**
—Tasia Young, Lobbyist, New Mexico Association of Counties
—Kelly Ford, Director, Lea County DWI Program
—Yolanda Cruz, Coordinator, Sandoval County DWI Program
—Wayne Lindstrom, Ph.D., Director, Behavioral Health Services Division,
HSD
—Jeff Eaton, Financial Analyst, Legislative Council Service (LCS)
- 11:10 a.m. (5) **Analysis of Proposal to Increase Liquor Excise Tax**
—Peter De Benedettis, Director, Alcohol Taxes Save Lives & Money
—Jeff Eaton, Financial Analyst, LCS
- 12:00 noon **Lunch**
- 1:00 p.m. (6) **Local Behavioral Health Update — Judicial and Law Enforcement Panel**
—The Honorable Jeff McElroy, Chief District Court Judge, Eighth Judicial
District
—Jerry Hogrefe, Sheriff, Taos County Sheriff's Office
- 2:30 p.m. (7) **Local Behavioral Health Update — Provider Panel**
—Sue Mulvaney, Tri-County Community Services
—Lawrence A. Medina, Recovery Friendly Taos New Mexico
—Julie Blau, C.P.S., Substance Abuse Prevention Program Manager, Taos
Health Systems
—Beth Scott, B.A., Executive Director, Rio Grande ATP, Inc.
—Mike Hayes, M.S.W., L.C.S.W., M.H.A., C.C.M., Rio Grande ATP, Inc.
—Larry Herrera, L.A.D.A.C., Substance Abuse Counselor, Rio Grande
ATP, Inc.; Co-Chair, Recovery Friendly Taos New Mexico
—Dorothy Forbes, L.C.S.W., Program Director, Circle of Life Behavioral
Health Network
—Kathy Sutherland-Bruaw, M.A., Founder/Executive Director,
Inside Out Recovery
—Joshua Trujillo, C.P.S.W., Inside Out Recovery
- 4:30 p.m. (8) **Public Comment**

5:00 p.m. **Recess**

Wednesday, August 24

8:30 a.m. **Welcome and Introductions**

- Senator Gerald Ortiz y Pino, Chair
- Representative Nora Espinoza, Vice Chair

8:40 a.m. (9) **All-Payer Claims Database**

- Mike Nelson, Deputy Secretary, HSD
- Victoria Dirmyer, M.D., Health Systems Epidemiologist, DOH

10:00 a.m. (10) **Health Care Costs and Quality Case Study: Hip and Knee Replacements**

- Patricia Montoya, M.P.A., B.S.N., Executive Director, New Mexico Coalition for Healthcare Value

11:30 a.m. **Lunch**

1:00 p.m. (11) **Cardiac Calcium Scans**

- Philip Eaton, M.D., Professor Emeritus, Department of Internal Medicine (DOIM), University of New Mexico Health Sciences Center (UNMHSC)
- David Schade, M.D., Professor, DOIM, UNMHSC

2:00 p.m. (12) **Licensure for Doctors of Naturopathic Medicine**

- Catherine Stauber, D.C., N.D., D.H.A.N.P., President, New Mexico Association of Naturopathic Medicine
- Traci Hobson, J.D., American Association of Naturopathic Physicians
- Lilly-Marie Blecher, N.D., D.O.M.
- Denise Clark, N.D., Past President, Colorado Association of Naturopathic Doctors
- Juliette Mulgrew, N.D., Ayurveda

3:30 p.m. (13) **Public Comment**

4:00 p.m. **Adjourn**

**MINUTES
of the
FOURTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**August 22-24, 2016
Taos County Commission Chambers
105 Albright Rd.
Taos**

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on August 22, 2016 by Senator Gerald Ortiz y Pino, chair, at 1:09 p.m. in the Taos County Commission Chambers in Taos.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia (8/22, 8/23)
Sen. Gay G. Kernan (8/23, 8/24)
Sen. Mimi Stewart (8/22, 8/23)

Absent

Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members

Sen. Craig W. Brandt
Rep. James Roger Madalena (8/22, 8/23)
Sen. Cisco McSorley (8/22, 8/23)
Sen. Mary Kay Papen (8/22, 8/23)
Sen. Nancy Rodriguez (8/22)
Rep. Patricio Ruiloba
Sen. William P. Soules
Rep. Christine Trujillo

Sen. Jacob R. Candelaria
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Rep. Terry H. McMillan
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Sander Rue
Sen. Benny Shendo, Jr.
Rep. Don L. Tripp

Guest Legislator

Rep. Debbie A. Rodella (8/22, 8/23)

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

Staff

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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Monday, August 22

Welcome and Introductions

Senator Ortiz y Pino welcomed members to the fourth meeting of the LHHS. Members of the committee and staff were asked to introduce themselves. President Pro Tempore Papen appointed Senator Brandt as a voting member of the LHHS for the duration of the August meeting.

Update on Medical Cannabis

Panel 1

Natalie Riggins, Medical Marijuana Registry (MMR) Program manager, Colorado Department of Public Health and Environment (CDPHE), addressed the committee via teleconference about the past, present and future of the Colorado MMR. Ms. Riggins provided a general overview of the program and the organization of the medical marijuana industry in the State of Colorado (please see handout for more information). The CDPHE directly oversees the registry, but other components of enforcement and regulation fall under the purview of the Colorado Department of Revenue, Colorado Department of Regulatory Agencies and Colorado Bureau of Investigation. There is also a CDPHE Medical Marijuana Scientific Advisory Council and Retail Marijuana Public Health Advisory Committee. The Colorado Department of Revenue is tasked with overseeing the Marijuana Enforcement Division. Ms. Riggins briefly explained the roles of each division. The Constitution of the State of Colorado mandates that the MMR be a confidential database; patient-specific data are never shared with anyone other than the patient and the physician, except when required for law enforcement purposes. The MMR has multiple stakeholders, from patients and physicians to caregivers (individuals cultivating or transporting medical marijuana). The role of the MMR is to maintain the confidential database of registered patients; issue MMR cards to qualifying patients; and review petitions for adding debilitating medical conditions for medical use of marijuana. Ms. Riggins gave the committee an overview of the program's history, from inception to future goals. As of July 2016, there are 102,620 active patients, and the MMR processes 10,000 applications and 1,000 change requests per month. The MMR currently has six operations staff processing 500 to 1,500 requests per day. In Colorado, there are 154 physicians currently recommending medical cannabis to active patients. Ms. Riggins explained the registration process for the MMR. At this point, only paper applications are accepted, and the process is entirely patient-driven.

Yonette Hintzen-Schmidt, MMR Program support manager, CDPHE, also addressing the LHHS by teleconference, discussed the legal process for denying or revoking cards. Card revocation can occur when a patient has been convicted of a drug-related offense, a physician has revoked his or her signature on a patient's physician certification or a patient has violated the

provisions of the constitution or statute. Denied applications and revoked and voided cards are posted on the MMR website and shared with law enforcement and dispensaries. Denied patients must wait six months before reapplying, and revoked patients cannot reapply for one year. Per Colorado state statute, patients have the right to appeal the CDPHE's decision to deny their applications or revoke their cards. Ms. Hintzen-Schmidt explained the physician requirements and noted that Colorado requires an annual renewal, regardless of medical condition.

Ms. Riggins reviewed the process improvements that the CDPHE has made to make the MMR more user-friendly. The CDPHE has made several changes to its website, which has included making all resources available online. Anyone can now sign up for the new LISTSERV used for sharing program information. Ms. Riggins shared plans for the new online MMR System, which is scheduled to go live January 1, 2017. Some key new features of the MMR System will include offering: patients, physicians and caregivers online account access; online credit card payment capability; the ability to print patient cards at home or use a mobile device, similar to a boarding pass; and access to contact registry personnel online. After a one-year transition period, the goal for the CDPHE is to eliminate paper applications. Ms. Riggins emphasized that steps have been taken to ensure security and confidentiality of data, much like electronic health records. Her handout to the committee included illustrations of how to navigate the new website and the MMR System.

In response to the representatives from the CDPHE's presentation, members of the LHHS inquired about the following topics:

- the role of the Colorado State Laboratory in the medical marijuana program;
- a medical marijuana research grant program at several state universities;
- limiting prescriptive authority to physicians;
- registration changes for caregivers and plant limits;
- separation of retail sales of marijuana and sales of medical marijuana at dispensaries;
- wait time for processing of patient cards and how the CDPHE addressed former backlogs;
- potential revenue from medical marijuana programs;
- replication of the Colorado program in other states;
- patient authorization for viewing confidential information;
- registration of physicians in the new MMR System;
- explanation of how the Colorado Department of Revenue collects sales tax on marijuana, both retail and medical;
- the potential for growing and producing cannabis on Native American lands;
- the self-funding nature of the MMR System for system updates and maintenance; and
- residency requirements for cards and possession.

Panel 2

Lynn Gallagher, secretary-designate, Department of Health (DOH), informed the committee that the department is participating with a number of national workgroups regarding medical cannabis. The Medical Cannabis Program (MCP) was created under the Lynn and Erin Compassionate Use Act in 2007. The purpose of the act is to allow the beneficial use of medical cannabis in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatment. Unlike Colorado, New Mexico's MCP is administered solely under one agency, the DOH. Secretary Gallagher provided a handout to the committee that covered the recent growth in the program and the department's efforts to address issues (please refer to the handout for more information). In 2010, there were 3,818 patients in the program; now there are more than 29,000. Since December 2015, there has been an increase of 9,500 patients. Secretary Gallagher informed the committee that the department is now in compliance with the 30-day processing and five-day mailing period required by statute. According to Secretary Gallagher, some delays are due to a lack of proper information; the DOH now has checklists available to ensure that information is current and applications are complete. Another issue has been patients submitting renewals within 30 days of expiration.

There are currently 35 licensed nonprofit producers (LNPPs) in the state and 43 dispensaries in 15 counties. As of August 2016, there are 6,333 personal production licenses (PPLs). Secretary Gallagher contends that even with the increase in patients, there is more than enough product available. The plant count limit for LNPPs has been tripled from 150 to 450 plants. Secretary Gallagher explained some of the new rules adopted in 2015 and 2016 to increase patient access. Steps have been taken by the DOH to address issues with processing applications, and temporary changes have been implemented while program enhancements are put into place. Patients are urged to submit renewal applications well in advance of expiration to avoid delays and any potential lapse in access to medication. The MCP continues its outreach efforts to educate medical providers and law enforcement agencies about the use of medical cannabis. The fiscal year 2016 revenue from the MCP was \$1,979,953.

Timothy Keller, state auditor, summarized some of the information that was presented during his testimony to the Disabilities Concerns Subcommittee (DCS) of the LHHS on August 4, 2016. The Office of the State Auditor (OSA) had received various complaints about providers. Auditor Keller noted that the OSA has limited jurisdiction over the matter, which falls under the purview of the DOH. Some of the other complaints received by the OSA's 1-800 hotline included plant count increases, tensions between large and small growers, annual renewal requirements for cards and excessive delays in card issuance. According to testimony at the DCS and complaints filed with the OSA, patients were waiting up to 90 days to get their registry cards; statute allows the department 30 days to process applications and renewals. The OSA views the card renewal backlog as a public health issue and gave the department a deadline of August 23, 2016 to get into compliance with state statute. In the view of the OSA, this is not an issue of cost or red tape; these delays were avoidable and the growth in the number of persons participating in the MCP was foreseeable. Auditor Keller added that the state needs to be aware of liability exposure for failure to comply with laws that relate to public health, such as the Lynn and Erin Compassionate Use Act. The OSA will continue to monitor the DOH. Auditor Keller

was pleased to hear that the DOH had announced extensions on card validity for patients while the issue is addressed.

Duke Rodriguez, president and chief executive officer, Ultra Health, believes the increase in patients in the MCP illustrates the success of the program. With the program in its eighth year, Mr. Rodriguez believes it is too late to claim that problems with implementation of the program are the result of "growing pangs". Despite the DOH's assurances that production is better than in the previous year, with the increase in patient enrollment, the amount in the inventory would allow for 11.91 grams per patient statewide. Every patient has a legal right to 2.6 grams per day; the amount in the inventory is simply not enough to meet the need. PPLs provide a tremendous relief valve because commercial providers are not allowed to produce enough to meet the need. Producers recently paid \$2.8 million in licensure fees to the DOH. Mr. Rodriguez raised concerns about data tracking and reporting errors in the program. Currently, there are 21 conditions approved by the DOH for treatment with medical cannabis, including posttraumatic stress disorder (PTSD). Approximately 46.3 percent of the 26,568 patients in the MCP are being treated for PTSD. Mr. Rodriguez provided a presentation on the status of medical cannabis in New Mexico with statistics from both PPLs and LNPPs. In his view, the priorities of the state and the DOH are wrong, and it is the patients who suffer from the inadequate supply. Patient growth per quarter has shown increasing and steady growth; this is a predictable trend that will continue to grow (please see presentation for market analysis). Colorado dispensaries along the border have testified that 60 percent of their patients are from New Mexico. Mr. Rodriguez advocates for more producers at all levels. A chart was shared with the committee explaining the MCP's usage of "units" based on software company BioTrack's calculations. The allowable number of units is supposedly designed to meet the needs of the patients, yet every other state program uses grams as measurement. Mr. Rodriguez explained that patients often use different types of medical cannabis, and the use of units complicates how they are able to purchase their medicine. Ultra Health shared its recommendations for legislation to improve the program.

William Ford, managing director, Reynold Greenleaf & Associates, stated that 230 units is not enough for any patient when taking into account the different methods of ingestion. The spirit of the law was to allow a patient to possess enough medical cannabis to have an uninterrupted supply for 90 days. The DOH has changed the program, making it more restrictive and complex. Mr. Ford believes that a lot has been done to create stable partnerships with LPPs and the DOH. Extending the time that registry cards remain valid is a positive sign from the department. There have been many issues associated with the increase in patients and resulting growth of the program. The program could benefit from a committee that brings in experts from the field and stakeholders to discuss problems and come up with potential solutions. Mr. Ford thinks it is absurd to believe that some conditions like multiple sclerosis are going to go away; the state needs to eliminate the hassle and unnecessary cost of requiring annual renewal for some conditions. The DOH and members of the industry have a responsibility to provide for patients. Mr. Ford calls on the DOH to subsidize delivery systems or create incentives to reach out to patients in rural parts of the state.

Stephanie Waddell, president, New Mexico Medical Cannabis Patient's Alliance, expressed several concerns with the MCP in addition to those mentioned by the other presenters. The excessive wait for renewal of patient registry cards is a real problem. She suggested that the issuance of a letter can be used to access medicine while the patient waits for the registry card to arrive. Ms. Waddell noted that while the extensions by the DOH are helpful, they do not help first-time patients who are having to wait for approval. The suggestion of "lifetime" cards for lifetime conditions was made. Ms. Waddell also echoed concern about units as measurement for permissible amounts of medical cannabis. Some patients have also received cards with typographical errors, causing the need for cards to be reissued. Ms. Waddell says there is a shortage of medical cannabis supply in the state that continues to rise as the program grows. The alliance is asking the DOH to increase the plant count to address patient need. Frequent meetings are needed among the MCP administrators, patients and producers to learn what is working for patients and what needs improvement.

Jason Barker, patient and organizer, LECUA Patients Coalition of New Mexico, was unable to stay at the meeting, but his comments were sent to the committee.

Following the presentation from the panel, members of the LHHS had the following comments and questions:

- the purpose of the medical review process and role of the medical director for the MCP;
- the types of providers that are allowed under state law to recommend medical cannabis;
- a physician's ability to adjust the dosage and responsibility to work with patients to find the best dosage to manage pain;
- the ability of tribal governments to produce medical cannabis;
- what can be done by the DOH and the legislature to speed up the processing of registry cards;
- ensuring best practices for the program and for patients;
- the classification of cannabis as a Schedule I drug under the Controlled Substances Act;
- concern for patient confidentiality when collecting data;
- issues with email access for patients;
- steps being taken to increase communication with patients and producers;
- the potential for lifting some restrictions based on patient needs;
- the need for addressing the influx of patients coming into the program;
- information on additional staff, both temporary and permanent, hired by the DOH to address the backlog in processing requests for registry cards and renewals;
- changes in administrative rules;
- consideration of Colorado's move toward an online system;
- removal of the tetrahydrocannabinol (THC) limit in state law;
- the complexity associated with using units to measure allowable quantities of medical cannabis or products containing cannabis concentrates or extracts;

- questions about BioTrack and its involvement in the MCP;
- the impact of plant limits on the amount of raw material needed to conduct research;
- presumptive eligibility for patients;
- whether registry card renewals should be annual and whether exceptions should be made for those with certain chronic or incurable conditions; and
- a request that the DOH provide a list of program requirements (whether by statute or rule) to LCS staff.

Public Comment

Brian Cox, a patient in the program for five years, believes that the DOH does not listen to patients. His main concern is with alleged violations of patients' federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) rights. According to Mr. Cox, both Colorado and New Mexico are violating HIPAA by bringing in temporary employees and granting them access to patients' health information. Mr. Cox conducts audits on companies that violate HIPAA laws, and he is currently preparing a lawsuit against a medical facility for violations. Mr. Cox has Cushing's disease, a rare autoimmune condition. Individuals with autoimmune conditions tend to have more than one health issue. To him, the DOH is "a joke", and it is not appropriate for DOH employees with no medical background to be making decisions about what patients need. Mr. Cox wants to see these issues addressed or he will begin seeking legal action for HIPAA violations.

Scott Pleadwell, a veteran, was one of the first 3,800 patients in the MCP. Mr. Pleadwell treats his PTSD with medical cannabis, which has helped him quit two prescriptions of oxycodone. Mr. Pleadwell was a legal grower, but despite paying all fees and submitting necessary documentation, he never got his card renewed. His card is now a year and a half out of date. Taos County lacks the resources to help individuals dealing with opioid addiction. Due to the difficulty of getting a card, many individuals do not even attempt to get into the program, even though they need it. Mr. Pleadwell believes the program needs to be dismantled and started over.

Tori Moorman, patient, testified during the August 4 DCS hearing. Ms. Moorman believes that it is wrong and cost-prohibitive to require patients to see a doctor every year as part of the requirements to renew a medical cannabis registry card. Since Medicaid no longer covers the doctor's evaluation for the prescription of medical cannabis, the burden falls on the patient. The amount of time it takes to receive cards is a real issue. Ms. Moorman knew three cancer patients who passed away while waiting to receive their cards. She shared several academic papers that have been published in Canada on the dosing of medical cannabis, noting that there are evidence-based data to support its usage. States with medical cannabis programs have also seen significant savings in Medicaid expenses. Ms. Moorman shared that her previous medications cost over \$1,200 per month, but medical cannabis has replaced all of her prescriptions, which has been a savings to Medicaid. Ms. Moorman believes that the DOH needs to reevaluate the use of units and urges the addition of autism as a qualifying condition.

Garth Wilson, patient, drew attention to the fact that medicating outside one's home is still illegal. This is a real issue and an inconvenience for patients. Mr. Wilson has been asking the DOH to provide a medical exception for consumption outside the home. As his own producer, he feels he needs a higher plant count in order to properly manage his condition.

Nicole Morales expressed concern with producers not growing their full limit and the use of a 70 percent cap for THC levels. She stated that patients are getting organized with the New Mexico Medical Cannabis Patient's Alliance. Experts from the field need to be brought in to work with producers and the DOH. She believes that patients are not getting the help they need. Dispensaries are taking on the responsibility of educating patients.

Jonathan Sanchez, vice president, New Mexico Medical Cannabis Patient's Alliance, interacts with patients and LPPs on a regular basis and noted their agreement on these issues. Mr. Sanchez thanked the committee for acknowledging the problems that patients are having and for seeking more information. He recently spoke with Darren White, owner of Pure Life, about some of the issues that new producers face, including plant limits.

Tulima Mauga was present at the DCS meeting on August 4, but was too nervous to speak. Ms. Mauga shared her story with the committee about how PTSD and other conditions have dramatically altered her life and her ability to function. Because of medical cannabis, she is able to manage her medical conditions without having to take multiple prescriptions, including opioids. New Mexico might not be number one in a lot of things, but Ms. Mauga believes this is one area where the state should be excelling.

Victoria Bartlow urged the committee to support the removal of cannabis as a Schedule I drug, which would encourage research. Medical cannabis has helped her handle several surgeries.

Recess

The committee recessed for the day at 5:53 p.m.

Tuesday, August 23

Welcome and Introductions

The second day of the LHHS meeting was reconvened at 8:38 a.m. by Senator Ortiz y Pino. He welcomed all of those present and asked members of the committee and staff to introduce themselves.

PAX Good Behavior Game

Wayne Lindstrom, Ph.D., director, Behavioral Health Services Division (BHSD), Human Services Department (HSD), introduced members of the panel along with several teachers in the audience from around the state. The LHHS has received a previous presentation regarding the PAX Good Behavior Game (please see handouts for more information). Dr. Lindstrom provided a brief history of the program. The BHSD provided funding in March 2016 to launch PAX in

New Mexico elementary school classrooms during the spring of 2016. The goal, he said, was to improve academic success while simultaneously fostering self-regulation that has been proven to protect children from mental, emotional and behavioral challenges throughout life. The pilot project involved 3,300 students in school districts in Santa Fe, Espanola and Bloomfield. Each district's implementation of PAX was a little different, but, overall, the data and feedback from teachers and students were positive.

Dennis D. Embry, Ph.D., PAXIS Institute, stated that one out of two children will have a mental or emotional disorder by age 19, which is an epidemic in the country. Dr. Embry, who is a developmental and child psychologist, explained that what happens to a child during first grade has a significant impact on the rest of the child's life. PAX seeks to increase psychological safety and flexibility and reinforce pro-social behaviors while reducing or minimizing toxic influences and limiting problematic behaviors. Dr. Embry talked about the results of PAX in New Mexico following the pilot project. PAX uses "'spleem' counts", which are disruptive behaviors identified and counted discretely, to provide indications about various aspects of the mental health of individual students. "Spleem", Dr. Embry explained, is a made-up word to indicate disruptive behaviors without coloring them with known words like "bad", "disruptive" or "noncompliant". The project pilot, which involved 172 classrooms, saw a decline of approximately 40 percent in spleem counts. Students loved the game, and teachers reported changes in their classrooms that were characterized by more focused learning, ease and collaboration. New Mexico is the first state in the country to invest significantly at the state level in a program like PAX. In other areas that have tried PAX, there have been huge reductions in mental health issues in students, increased graduation rates, reductions in teen pregnancy and increased chances of college enrollment. PAX is also the only elementary school program proven to reduce suicide rates. The cost of PAX is about \$75.00 per child; in comparison, childhood vaccinations cost about \$2,500 per child. In his view, this should be treated as a "social inoculation", as positive behaviors instilled in children at this stage of development will carry through the rest of their lives. Dr. Embry added that students are taught that they are "PAX students" and when asked what that means, they respond, "I better my world and I better myself.". He urged the continued support and expansion of this program.

Deborah Mitchell, principal, Alcalde Elementary School, Espanola Public School District, noted that Espanola schools do have a certain reputation. She invited the committee to come to her school and see the impact that PAX has had on its students and teachers. Ms. Mitchell believes that the main concern should be the well-being of the children. In Espanola, a large number of students are being raised by their grandparents for various reasons. Ms. Mitchell shared a story about one child living with his grandparents because his parents were in jail. The child was a threat to the other students and had very low self-esteem. With the introduction of PAX to the school, the child began to realize that only he was responsible for his behavior. The child is now doing significantly better and making great progress in school and at home.

Trina Raper, executive director of curriculum and professional development, Santa Fe Public School District, advocates on behalf of her teachers. The teacher is the most important

person in the classroom, and time on task is a crucial part of the educational process. Ms. Raper explained that PAX shortens the time a teacher spends on corrective behaviors, which increases the amount of time the teacher can spend on instruction. The program gives teachers clear strategies on how to manage spleems. Ms. Raper provided a demonstration for the committee on how the program's games are incorporated during instructional time with the use of a harmonica. PAX does not call out children or shame individuals. In the Santa Fe Public School District, 120 teachers have been trained in PAX. The district hopes to have more trained during the next round of funding. Ms. Raper explained that one cannot prepare educators for everything they will encounter in the classroom during college; this is the type of support they need during their second year in the classroom.

Following the presentation from the panel, the chair invited educators present in the audience to share their experiences with PAX.

Jodie LaRue, early childhood specialist, Farmington, has been using PAX for six years. Ms. LaRue admitted to some initial reluctance regarding PAX, thinking the games seemed too good to be true and yet another training to endure. She shared her experience with the program and a story about one student who was in foster homes who has now become one of the top students in the school. She feels like PAX handed her the key to success. PAX instills lifelong skills in students that will benefit their lives far beyond graduation. The committee is welcome to visit her classroom and see how PAX is benefiting students.

Tina Hudson, sixth grade teacher, Bloomfield, stated that she previously had a very chaotic classroom. Students lacked the discipline and regulation to function neither in a classroom setting, she said, nor in the "real world". Ms. Hudson was interested in PAX and conducted a preliminary spleem count, which revealed an overwhelming issue. There was a lot of frustration in the classroom and instruction was hampered. Ms. Hudson told the committee that she had called into question her career choice during that time. Then she implemented PAX in her classroom, and students began working together, were more engaged and were more excited about coming to class. Ms. Hudson shared several examples of changes and demonstration of leadership by her students, adding that PAX saved her students and helped her regain control of the classroom.

Sadie McDaniel, licensed social worker, Bloomfield, conducts the initial spleem testing in schools and then follows up to measure improvement. During the presentation, Ms. McDaniel conducted a spleem count on the committee to demonstrate how it works. She noted that spleems are also moments of distraction or lack of attention to what is being said. She conducted an assessment on 524 fifth and sixth grade students. Of those students, 72 were identified with behavioral, emotional or social issues. Some had severe concerns, including self-mutilation and suicidal tendencies. With the introduction of PAX, there was a decrease in office referrals and calls home, and spleem counts went down significantly. The reactions of the teachers were very telling, and she noted that teachers were leaving the classrooms smiling and on-time. More teachers have wanted to get involved in the program. Two students have even told her they have

stopped cutting themselves as a result of PAX. Ms. McDaniel invited the committee to come to the school and see the program in action.

In response to the presentation, the committee addressed the following topics with the panel:

- the current status of the PAX program in schools;
- lack of money to continue funding the initiative;
- commitment by teachers and presenters to continue the program, regardless of funding;
- the state budget crisis and impact of pending budget cuts on school districts around the state;
- the current number of trained teachers and site implementations;
- outside funding through grants;
- a suggestion to present before the Legislative Education Study Committee;
- efforts to incorporate parents to reinforce techniques in the home;
- concern with the tendency of behavior modification models to change frequently;
- questions about the cost and copyrights on the program;
- a distinction that PAX is a skill set, not a curriculum;
- the long-term positive impacts on Medicaid, law enforcement and the criminal justice system;
- long-term costs to the state if early predictors go untreated;
- the use of the system in ethnically diverse classrooms; and
- the potential for universities to develop courses based on the PAX model.

Turquoise Lodge Letter

The committee discussed the letter from Secretary Gallagher regarding the closure of the adolescent treatment program at the DOH's Turquoise Lodge specialty hospital in Albuquerque. The letter addressed various questions raised by the LHHS at its previous meeting. In response to questions from the committee, Dr. Lindstrom stated that the closure falls within the context of the overall issue the state is dealing with in terms of the budget crisis. Departments are having to make some difficult decisions on priorities, he said, and he believes that the DOH would have looked at this differently if the financial environment were different. Dr. Lindstrom stated that there is an opioid crisis in this state and there is a need for medical substance dependence detoxification (medical detox) capability. Under Medicaid, medical detox is a benefit and emergency departments are doing appropriate screenings and teaching hospital officials on the appropriate management of individuals. The need for medical detox is likely to grow with the continuation of drug usage in the state. Dr. Lindstrom noted that he was not consulted about the closure.

Members of the committee expressed their concern with individuals, particularly adolescents, undergoing medical detox treatment in emergency departments. Members questioned the referral process, the amount of time it was taking to get an individual into treatment at the facility and the use of Suboxone for the medically assisted substance dependence

treatment of adolescents. The issue of the closure was set to be discussed further during the next meeting of the LHHS with representatives from the DOH. The committee requested staff to send a follow-up letter to the DOH regarding statistics on the success and completion rate for adolescents in the Turquoise Lodge program. Members also wanted to know what the Legislative Finance Committee had said about Turquoise Lodge in its recommendations on budget cuts. Staff was directed to draft the letter and send it to committee members for approval.

Local Behavioral Health Update — Judicial and Law Enforcement Panel

Sarah Backus, district court judge, Eighth Judicial District Court, discussed the beneficial use of drug courts in the area. There are four drug courts in the Eighth Judicial District, which includes portions of Taos and Colfax counties. In addition to hearing adult and juvenile cases, the courts also handle competency hearings. Judge Backus explained that with funding from drug courts, the district is able to fund intensive outpatient treatment programs for nonviolent offenders. These year-long programs are effective, life-saving and an inexpensive alternative to incarceration. Individuals in the area are in a habitual state of addiction and the only detox facility in the county closed in March. There is no place for individuals to detox from drugs and alcohol. Also making things difficult, there are few resources for long-term drug and mental health treatment. Judge Backus expressed concern about the potential five percent budget cuts during the upcoming special session of the legislature. These cuts will largely affect salaries and possibly the operation of the drug courts; she believes this is a vital service to protect. Judge Backus urged the committee to keep drug court funding intact. Barbara Arnold, court executive officer, Eighth Judicial District Court, previously managed the drug courts. She testified to witnessing several heroin addicts and multiple offenders turn their lives around during the year they spent in the drug court program. Ms. Arnold recognized several representatives present from the community involved with drug courts.

Jerry Hogrefe, sheriff, Taos County Sheriff's Office, is a first-term sheriff with over 20 years of law enforcement experience with numerous agencies. Sheriff Hogrefe recently attended the annual conference of the New Mexico Sheriffs' Association. He shared what he considered to be the following "wish list" of priorities for law enforcement.

1. Lapel cameras. Equip every law enforcement officer with a lapel camera and provide training for use through the New Mexico Law Enforcement Academy of the Department of Public Safety. Lapel cameras protect officers and strengthen evidence in cases.

2. Usage of Narcan by law enforcement officers. Recent legislation allowing law enforcement to carry and administer Narcan has been very successful, demonstrating that death from overdose is preventable. Taos County sheriffs were among the first to be trained under the new legislation. The training is only two hours long. Sheriff Hogrefe explained how Narcan is administered during an overdose and shared several success stories. Legislation to make carrying Narcan by law enforcement mandatory should be supported.

3. Tourniquets. Law enforcement personnel should carry tourniquets in their kits at all times. These are inexpensive and life-saving.

4. Shark gloves. These gloves are used to replace latex and are puncture resistant. The use of these gloves would protect officers from harm and diseases during searches.

Following the presentation from the panel, the committee had several comments and questions, including:

- effects of the massive changes in the behavioral health system on programs in the area;
- the large turnover of providers, which complicates the system for offenders;
- the crucial services jeopardized by changes;
- the drug court program as a proven effective model;
- gaps in the system of care for individuals with mental illness and the lack of options for law enforcement when dealing with these individuals;
- the passage and implementation of the assisted outpatient treatment legislation;
- the likelihood of budget cuts during the upcoming special session;
- the jail diversion program in Santa Fe;
- the need to view addiction as a public health issue instead of a public safety issue;
- DOH funding for Narcan, which was not renewed;
- rates of utilization of Narcan during the last year;
- the closure of the adolescent detox treatment facility at Turquoise Lodge;
- the impact that the closure of the local detox facility has had on the community and law enforcement; and
- the need for a local medical and social detox center in Taos.

Local Behavioral Health Update — Provider Panel

Sue Mulvaney, Tri-County Community Services, addressed the committee along with other providers about the status of behavioral health in the state. Ms. Mulvaney discussed some of the services the organization provides. Tri-County Community Services provides behavioral health and drug addiction services in Union, Colfax and Taos counties. The provider offers a nine-month intensive outpatient program for substance abuse treatment with a step-down component for those who want to continue. Assertive community treatment is available for individuals with severe mental illness. Individuals who are very disabled have access to comprehensive community support services and opportunities for socialization through Tri-County Community Services. Ms. Mulvaney explained that some conditions can be maintained with proper medication. Through the use of telemedicine and a traveling provider, individuals have greater access to services. Tri-County Community Services offers the "Roadrunner Program", which helps individuals with developmental delays get the socialization they need. A new program, in partnership with the counties, is working to provide jail diversion. Ms. Mulvaney explained that her organization was working with LDWI but lost funding for the program. In a new pilot program, the organization will work with individuals in jail to start them on Medicaid and provide case management to aid with support services after they are discharged.

Larry Herrera, substance abuse counselor, Rio Grande ATP, Inc., co-chair, Recovery Friendly Taos New Mexico, noted that there is a stigma for these individuals, and organizations are working to shine a light on recovery in hopes of reducing that stigma. In 2012, a summit was hosted with more than 300 attendees and representatives from law enforcement, legal, mental health and faith-based organizations and youth groups. The summit provided a networking opportunity for the various organizations and professional fields. The initial intention was to make the summit a yearly event, but one has not been held since. In 2014, Recovery Friendly Taos New Mexico premiered the movie *Anonymous People*, a film reaching out to individuals in recovery and encouraging them to "come out". Last year, the organization hosted a recovery walk with more than 200 participants promoting recovery and attempting to address the stigma. In September, the organization will be hosting the Night of Hope featuring a film by Jimmy Santiago Baca, documenting his experiences and journey to recovery. Mr. Herrera spoke of clients that are in need of detox now but there is no place to send them. He explained that some individuals in need of help commit crimes to get immediate help through the jail. There has been an increased use of heroin and methamphetamines in the area. Hoy has been working to open up a detox facility, but the need in Rio Arriba County alone would fill up a facility. The state needs a long-term residential treatment program in northern New Mexico.

Julie Blau, manager, Substance Abuse Prevention Program, Taos Health Systems, shared information regarding some of the federal and state funding sources that support prevention programs in the community. Taos Health Systems assists medical providers and law enforcement in acquiring Narcan, funded through the DOH's Epidemiology and Response Division. Taos Health Systems assesses the community, youth risk and resiliency data yearly and then examines capacity to see what already exists in the community. Ms. Blau believes that it is about fostering cooperation among different services and discouraging organizations from working in silos. Different organizations are working together to build a coalition and trying to make connections with services that already exist. Increasing communication between different departments to address issues is key. Alcohol and prescription drug use are the top two priorities for the organization.

Beth Scott, executive director, Rio Grande ATP, Inc., stated that the area is in need of both social and medical detox. There is also a need for residential programs with varying length of stay options. Rio Grande ATP, Inc., has been in business for 25 years and is currently serving 50 clients in Taos and 40 in Las Vegas. Some individuals have been through the program more than once. Most of the clients are court-committed and there are some self-referrals, but there is no place to send individuals for detox. Ms. Scott noted that addiction is a chemical disease of the brain. One program offered through the BHSD is grief and loss support. In many instances, addiction can be tied to the loss of employment, a spouse or children. Ms. Scott cautioned that the state cannot continue to rely on revenues from oil and gas.

Dorothy Forbes, program director, Circle of Life Behavioral Health Network, stated that one in five Americans is diagnosed with a mental illness. When government cuts funding from behavioral health, it exacerbates the problem and affects every other system.

Kathy Sutherland-Bruaw, founder/executive director, Inside Out Recovery, was present to advocate for detox and treatment. Inside Out Recovery serves between 80 and 90 people per month in Taos alone. She shared a folder with the committee containing the obituaries of individuals who have died of overdoses in the last 10 weeks from Rio Arriba County and who had come to her organization seeking help, only to learn that resources were not available for them. Ms. Sutherland-Bruaw stated that programs were full or had long waiting lists for treatment, specifically Turquoise Lodge. The detox facility that used to be open in Taos was wonderful and served people from Taos and Rio Arriba counties; even though it only offered social detox, it saved lives. She added that addiction has no barriers and affects people from all walks of life. Without detox, New Mexico will face an epidemic of overdose deaths.

Joshua Trujillo, Inside Out Recovery, is a former heroin addict and is now in recovery serving as a certified peer support worker. Mr. Trujillo likes to challenge the notion that a person cannot come back from addiction and become a productive member of society. Many people like himself are in long-term recovery and are making amazing contributions to their communities. Addiction is a disease and it is progressive, but with the right support and treatment, it can be put into remission. Mr. Trujillo works with a group in jail, adding that 80 percent of individuals in jail are not criminals but are there because of an addiction. People are dying as they wait for services or they end up committing additional crimes to get back into jail. A high percentage of individuals with addiction are being treated as criminals. Mr. Trujillo made the comparison that a diabetic does not have to wait 12 weeks to get the help the diabetic needs.

Ms. Mulvaney expressed frustration when persons seeking help are denied services. These individuals do not have the opportunity to create a free life for themselves because they lack the tools. She noted that the ability to recruit competent professionals is a major challenge, particularly in rural areas. While telemedicine is helpful, individuals are unable to receive the human interaction that they crave. These areas are lacking the resources to pay for psychiatrists and Suboxone prescribers. The immediate solution for providers to address issues of funding has been to share resources, which is the only possible way for providers to survive. She closed by adding that none of the providers want to come back next year to inform the committee that they are shutting down.

Members of the committee thanked the panelists for their dedication and Mr. Herrera and Mr. Trujillo for sharing their recovery stories. Following the presentation, members of the LHHS discussed the following points and issues with the panel:

- potential legislation that would require counseling of patients taking prescription opioids along with a companion prescription of Naloxone;
- the need for getting individuals immediate help when they are ready for it;
- the need to diversify state revenue sources;
- the ability for local governments to increase gross receipts taxes to fund substance use disorder programs;

- urging managed care organizations (MCOs) to make timely reimbursements to providers;
- reservations of behavioral health providers to relocate to the state due to the recent allegations of fraud against several providers;
- what would be required to reopen the Taos detox facility; and
- concern that the state is not maximizing Medicaid funding.

Public Comment

Senator Kernan read a statement from Ben Maddox requesting the consideration of installing a net under the Rio Grande Gorge bridge to prevent individuals from committing suicide at the location. This has been done in San Francisco. It is unclear what the cost for such a project would be, according to Mr. Maddox, but he wished to suggest using capital outlay funding for the project.

Yale Jones, a resident of Taos, is an attorney who works with the drug court team. He recognized that Taos has a great community with individuals committed to recovery services. Mr. Jones believes that the key is prevention; more needs to be done in terms of education early on to prevent long-term issues. He hopes to see ways to address the lack of opportunity as well as poverty in communities.

John Gonzales has a passion for the electoral process and believes that without good elected officials, communities are unable to serve the needs of people. Mr. Gonzales helped coordinate the legislative agenda for a previous Taos mayor and was part of the homeless coalition. He noted that mental health is an illness and should not be stigmatized in the manner it is. The majority of people in prison and jail are there because they made a few wrong choices. Private prisons are good because they ensure that inmates receive the medical attention they need along with proper nutrition, according to Mr. Gonzales. He spoke about the 2013 credible allegations of fraud by the HSD and the impact that had on the local behavioral health system. There is a tremendous need for education, economic opportunities, support and treatment in the community.

Silvia Romero shared the personal story of her daughter who is addicted to heroin. Her daughter received services at Tri-County Community Services, where Ms. Romero believes her daughter fell through the cracks of the system due to the lack of counselors. Ms. Romero expressed frustration that her daughter has spent more time in jail for heroin than the individuals responsible for murdering her brothers. Her daughter has four felonies for not complying because she is an addict. Her daughter is currently in drug court, which Ms. Romero hopes will help her. The state needs more services for individuals battling addiction.

Senator Ortiz y Pino requested individuals who attempted to get adolescents into Turquoise Lodge to send information to the committee and staff via email or mail. The next meeting of the LHHS in Farmington will address the closure of adolescent services. The committee wants to know the scope of the issue and to find out how many individuals were unable to get into the facility before its closure.

Recess

The committee recessed for the day at 4:03 p.m.

Wednesday, August 24

Welcome and Introductions

The third day of the LHHS meeting was reconvened at 8:43 a.m. by Senator Ortiz y Pino. Members of the committee and staff introduced themselves.

All-Payer Claims Database (APCD)

Mike Nelson, deputy secretary, HSD, provided an overview of New Mexico's APCD. In 2015, the HSD was awarded a planning grant from the Centers for Medicare and Medicaid Services (CMS) to improve patient experience and health while reducing costs. The development of an APCD is one of the components of New Mexico's State Innovation Model Design plan and a critical tool for promoting transformative changes in the health care delivery system. A council was assembled and worked with stakeholders to conduct a feasibility study in March 2016. Mr. Nelson shared the outcome of that study (please see executive summary handout). After two periods of extensive stakeholder input to determine basic issues related to APCD development and implementation, New Mexico is in a strong position to move forward with an APCD. The DOH's rulemaking authority and Health Information System Act Advisory Committee structure provide the foundation for moving forward, at least for initial data collection. Mr. Nelson detailed the immediate next steps that the state should take, adding that many of the steps can occur in tandem. The main challenge will be funding. The planning grant from the CMS was approximately \$2 million. The CMS will not provide implementation funding for New Mexico because the state came into the process later than others. The state will need to engage a vendor to determine the cost of the project. A full copy of the feasibility study will be provided to LCS staff.

Victoria Dirmyer, M.D., health systems epidemiologist, DOH, is a member of the Health Information System Act Advisory Committee. The rules for the creation of the Health Information System Act Advisory Committee were adopted in February 2016. The advisory committee has met twice and has been looking at what other states are doing to implement APCDs. Pursuant to the Health Information System Act (passed in 2015 as Senate Bill 323), the DOH is required to create a website by January 2018 that contains data relating to cost and quality. The advisory committee is planning to meet again on August 30, 2016.

Following the presentation, members of the committee discussed the APCD and the results of the feasibility study. Some key points addressed were:

- next steps for implementation, including creation of a work group;
- clarification about types of data maintained in the database and how the data are collected;
- benefits of tracking data;
- what type of information can be derived from the data collected;

- ability to gather data from New Mexico residents receiving medical attention from surrounding states;
- creation of a standardized document for data collection;
- concerns with the coding system and the need to ensure compliance with HIPAA;
- membership of the Health Information System Act Advisory Committee;
- use of data by other states as a transparency tool for consumers that provides the ability for consumers to shop for services;
- the need for data to be used for informing public policy;
- update to the committee regarding the closure of obstetric and gynecological (OB/GYN) services in Las Vegas;
- how the APCD fits in with the health information exchange (HIE);
- agreement and interest from stakeholders, with no opposition at this point;
- the cost for the database moving forward; and
- a request for a full list of health indicators that can be collected through coding and data collection.

Patricia Montoya, executive director, New Mexico Coalition for Healthcare Value, explained that using the HIE and the APCD would provide better information and insight. Ms. Montoya discussed what other states are doing with their APCDs to increase transparency. Medicare has recently freed up available data for usage by states. The key is getting designated organizations and agencies that work with sensitive data to work together.

Marla Shoats, lobbyist, Blue Cross and Blue Shield of New Mexico (BCBS), stated that BCBS has been involved in the process of developing the APCD. BCBS has some concerns about the cost of implementation and the recent U.S. Supreme Court decision in *Gobeille v. Liberty Mutual*, which allows self-insured entities to opt out of providing data to APCDs. In light of the current budget crisis, Ms. Shoats does not believe the APCD is something that should be a priority at this time. New Mexico should wait to see what other states are doing before proceeding.

Brent Moore, legal representative for America's Health Insurance Plans, voiced appreciation for the efforts of working toward this database. When individuals shop for coverage, they are looking at the overall cost of a plan, not necessarily for a particular procedure. The most affordable coverage and the ability to have provider choice are typically the main drivers for the consumer. Mr. Moore believes the APCD represents a big unknown at this time.

Ellen Pinnes noted that despite claims about Medicaid being characterized as a "runaway" program in terms of costs, there has been only a one percent increase in cost to the state since the expansion of Medicaid. At the same time, there has been a one percent decrease per enrollee over the last year. There are more people in the system, which Ms. Pinnes stated is a positive thing.

Health Care Costs and Quality Case Study: Hip and Knee Replacements

Ms. Montoya presented to the committee about a recent health care costs and quality case study on hip and knee replacements (please see handout for full details of the presentation). As part of the CMS Comprehensive Care for Joint Replacement Model, the CMS designated over 500 hospitals across the country to participate in this mandatory delivery system reform. The mission was to foster health care transformation by finding new ways to pay for and deliver care that can lower costs and improve care. The goal is better care, healthier people and smarter spending. Ms. Montoya provided a brief history of Medicare hip and knee replacements. Hip and knee replacements are the most common inpatient surgery for Medicaid beneficiaries; however, there are a growing number of young people seeking these procedures as a result of sports injuries. There were more than 400,000 procedures in 2014, costing more than \$7 billion just in hospitalizations alone. Ms. Montoya noted that the cost of the same procedure can range greatly from one geographical area to another. The average cost for a knee replacement in New Mexico is \$32,600; the average range in Santa Fe is \$23,800 to \$36,500; and the average range in Albuquerque is \$29,000 to \$37,300. There have not been enough incentives to coordinate care from surgery to recovery. The Comprehensive Care for Joint Replacement Model seeks to address multiple issues, including high cost and low quality and hospital accountability for related care post-procedure. The episode of care would have one "bundled payment" that would include all pre-operation, operation and post-operation services. The CMS has designed a payment structure to provide hospitals with an incentive to work with physicians, home health agencies, skilled nursing facilities and other providers. In New Mexico, Albuquerque and its three main hospitals were designated: Lovelace Health System, Presbyterian and University of New Mexico Sandoval Regional Medical Center, Inc.

In July, an educational seminar was held for employers around the state that addressed many questions that the New Mexico Coalition for Healthcare Value had posed. Ms. Montoya discussed some of the participants, panels and highlights from presentations at the seminar. Seminar participants were able to voice concerns and gain a better understanding of the objectives of the initiative. At the seminar, a representative from the CMS shared some of Medicare's goals. The CMS is moving toward value-based payment. Additionally, 85 percent of Medicare fee for service (FFS) will be tied to quality or value by the end of 2017 and 90 percent by 2018. Providers and suppliers will continue to be paid via Medicare FFS. Ms. Montoya explained that participating hospitals will receive prospective episode target prices that reflect spending for an episode. After the performance year, actual episode spending will be compared to the episode target price. If the aggregate target is greater than actual episode spending, hospitals will receive a reconciliation payment, pending their quality performance. If the aggregate target price is less, hospitals will be responsible for making a payment to Medicare. The idea is shared savings and shared risk. Hospitals and medical providers will have to make some changes in how they handle medical procedures before, during and after. One of the biggest changes and challenges for providers will be having the hospital delivery system strongly connect and communicate with post-acute providers. Ms. Montoya concluded that during this time of budget challenges, the state and agencies should aim at not just cutting budgets across the board, but assessing what is working and supporting those efforts.

On questioning, Ms. Montoya and the committee members discussed the following topics:

- clarification about bundling payment and how entities receive payment;
- an explanation of payment distribution;
- issues with using only one type of device for replacements;
- the possibility of doctors not wanting to participate in this type of program;
- the importance of patient responsibility post-operation;
- across-the-board move from FFS to value-based pricing;
- the need for coordination of care after procedures;
- concern with loosening restrictions on home health care;
- the need for examining best practices and ensuring that the right programs and systems are being funded; and
- the overall reconceptualization of health care and the creation of a culture of health.

Representative Trujillo introduced her niece, Erica Parra, who is an emergency medical services (EMS) provider in Taos County. Ms. Parra requested that providers in the community get taken care of. The EMS provider in Taos is a county agency and private agencies have not been allowed to come into the community. She stated that there are many fixed-income or low-income persons for whom an ambulance ride is very expensive and who would not be able to afford this service if it was private. Ms. Montoya and the committee discussed the use of EMS throughout the state and the need for increased coordination of care to reduce usage by "frequent flyers" who tie up resources for individuals in need.

Cardiac Calcium Scans

Philip Eaton, M.D., professor emeritus, Department of Internal Medicine (DOIM), University of New Mexico (UNM) Health Sciences Center (HSC), presented to the LHHS about creating healthy hearts for all New Mexicans. There have been rapid advances in medical science to understand the nature of heart attacks. Heart attacks are the leading cause of death, killing more people than all cancers combined. Heart attacks are an acute event of a chronic disease. By dealing with the disease, the acute event can be prevented. Until now, there has been no way of identifying individuals who had the hidden chronic disease. Dr. Eaton shared the medical breakthrough known as a coronary calcium scan that now allows doctors to identify individuals at risk for heart attacks. Coronary calcium scans allow heart attacks to be prevented. The coronary artery calcium virtual biopsy scan uses an old-fashioned scanner to obtain a bladeless biopsy. The scan is totally non-invasive and only takes 10 minutes, providing multiple three-dimensional x-ray slices through the heart depicting plaque. Dr. Eaton shared several images in a handout of what the scan produces and explained what happens during a heart attack. The scan calculates the amount of calcium: the higher the score, the greater the risk of heart attack. The cost of the scan is \$150, which is an inexpensive test compared to the costly expense of other procedures that are required with an untreated problem.

David Schade, M.D., professor, DOIM, UNMHSC, helped bring the coronary artery calcium virtual biopsy scan to the UNMHSC with the hope to provide access to the working

poor. The UNMHSC has paired with the UNM Foundation to make the coronary artery calcium virtual biopsy scan available to everyone. Medicare now covers the cost of the scan, and New Mexico Health Connections will begin coverage in 2017. Texas is the only state that has passed legislation to allow coverage for the scan. The goal of the presenters is to create legislation to add a \$150 benefit for a cardiac calcium scan to all appropriate insurance programs. They are requesting that the LHHS endorse the proposed legislation they have included for the upcoming regular legislative session.

Representative Trujillo requested staff to prepare legislation for endorsement during the November meeting of the LHHS. She expressed desire to sponsor the bill. Committee members inquired about the following information:

- the benefit of legislation in terms of cost-effectiveness;
- the low-cost advantage of the scan;
- support from national associations for the use of this technology;
- potential opposition from MCOs of adding scans as a benefit;
- use of the scans for the last 10 years was widely accepted and was not experimental;
- hospitals in New Mexico currently performing the scans;
- the need for recognizing heart attack as a chronic disease;
- how the technology for the scans is added to existing computed tomography (CT) scanning equipment;
- advantages of the scan over other available tests; and
- the ability to create risk assessments for patients and determine treatment and management options.

Licensure for Doctors of Naturopathic Medicine

Catherine Stauber, D.C., N.D., D.H.A.N.P., president, New Mexico Association of Naturopathic Physicians (NMANP), stated that her organization is not actively seeking licensure but is looking at the feasibility of introducing legislation in the near future. Ms. Stauber explained that there is a difference between naturopathic physicians and "naturopaths", describing the schooling and clinical hours required. Naturopathic physicians, or naturopathic doctors, attend four years of pre-medicine and four years at an accredited naturopathic school, fulfill clinical hours and take a national licensing examination. Naturopaths do not receive any formal training. In 2003 and 2005, the NMANP sought legislation for licensure, but efforts were stalled due to confusion between the two groups. In 2009, the passage of the Unlicensed Health Care Practice Act allowed naturopathic doctors to practice in the state, but with limitations. There are currently 20 states that license naturopathic physicians. The NMANP would like to be governed under its own board, but recognizing fiscal challenges, Ms. Stauber stated that the NMANP would consider being under the oversight of an existing related board. Ms. Stauber noted the scope of practice in various states (see handout). The benefit of naturopathic physicians is illustrated best in the area of preventative care prior to formation of chronic disease. Naturopathic physicians have been involved in integrated medicine, working with different types of medical doctors and conducting research at Yale University and the Mayo Clinic.

Traci Hobson, J.D., American Association of Naturopathic Physicians (AANP), has a background in indigenous people's policy. Ms. Hobson stated that the AANP is advocating for licensure in all 50 states. She believes licensure helps differentiate between naturopathic physicians and naturopaths.

Denise Clark, N.D., past president, Colorado Association of Naturopathic Doctors (CAND), noted that Colorado is one of the newest states to grant licensure to naturopathic doctors, passing legislation in 2013. The lack of distinction between the two groups is at times problematic. The Colorado law allows naturopathic doctors the ability to diagnose and treat patients. Ms. Clark informed the committee that she orders cardiac calcium scans for individuals and performs minor office procedures. The CAND carries malpractice insurance up to \$1 million. In 2015, two more bills were passed, one adding the ability to treat infants. The legislation comes up for sunset review in 2017, and the CAND is looking at the possibility of further expanding the scope of practice.

Lilly-Marie Blecher, N.D., D.O.M., opened her practice in Taos back in 2012. She provided some of her personal and professional background for the committee. Ms. Blecher carries malpractice insurance under her D.O.M. license but does not believe it is enough to cover all of the services she can provide. Chronic care is one of her biggest treatment areas. She is able to provide guidance with lifestyle choices and collaborate with other doctors of medicine, massage therapists, healers and chiropractors. Ms. Blecher believes there is a large demand for holistic medicine, particularly in northern New Mexico, and she would like patients to have more access to this type of care.

Juliette Mulgrew, N.D., Ayurveda, cited the growing recognition of naturopathic doctors at the national level. Individuals seeking education as a naturopathic doctor are eligible for the same educational loans as students in other medical fields. Medicaid in Oregon covers naturopathic medicine, but it is not yet covered by Medicare. Naturopathic doctors can provide consultation to patients about potential interactions between pharmaceuticals and supplements. Ms. Mulgrew highlighted programs that aid in veteran care and work with the Indian Health Services (IHS). Naturopathic medicine seeks the treatment of mind, body and spirit, and the use of herbs as medicine is in alignment with native philosophies. She lives in Jemez Springs, but because the center in Jemez Springs is no longer contracted with the IHS, she is unable to provide services in her community. Naturopathic doctors are the bridge between western medicine and alternative medicine with the ability to communicate with professionals on both sides. Naturopathic doctors can work to create integration and help patients get the care they need.

In response to the presentation, the committee addressed the following topics with the panel:

- further clarification between the two groups;
- examples of scope of practice of naturopathic doctors;

- educational requirements for licensure in other states, including information about the national licensing exam;
- growth of the field with the passage of legislation around the country;
- the number of naturopathic doctors in New Mexico and the increasing number of individuals leaving the state due to lack of licensure;
- the ability of naturopathic doctors to address needs in rural areas;
- potential for job creation with the opening of practices in communities;
- prescriptive authority in different states;
- the increasing number of females in the field of naturopathic medicine;
- work with midwives and birthing centers;
- the prevalence of traditional communities in the state with a interest in holistic approaches;
- prescriptive authority for medical cannabis; and
- the ability of naturopathic doctors to work more closely with patients than most medical doctors, thus providing education and communication.

Senator Ortiz y Pino encouraged the panel to keep seeking licensure and explained how to get help from staff to draft potential legislation. He suggested looking at existing legislation from other states and modeling a program after one that fits best for New Mexico. A member of the committee expressed interest in sponsoring future legislation.

Public Comment

Janet Gabriel shared her story of trying to find sustainable methods of managing her chronic illness. After many years of trying different types of medicine, Ms. Gabriel began treatment with a naturopathic physician. Her daughter is now a naturopathic physician and would like to return to New Mexico to practice medicine, but she is unable to practice in the state under existing laws. Ms. Gabriel questioned why the state would not welcome doctors to work within their scope of practice to help people cope with chronic illness without dangerous drugs. Letters from Charles "Mac" Powell, president, Bastyr University, and Celeste Griego (Ms. Gabriel's daughter) were distributed to the committee.

Joan Krohn shared her letter to the editor of the *Las Vegas Optic* regarding the closure of OB/GYN services at Alta Vista Regional Hospital. Ms. Krohn stated that where you are born matters, which is something that is being overlooked during the closure of obstetric services. She believes that the hospital in Las Vegas abandoned patients and has the responsibility to make sure expectant mothers get the help they need. Ms. Krohn took the issue to the Attorney General's Office, where it is currently under examination to determine if the discontinuation of services is illegal.

Nina Scolera and Irene Loy, Dream Tree Project, addressed the committee regarding behavioral health issues discussed during the previous day's meeting. Youth needs are not being met and teens are facing significant barriers. There are limited openings for residential treatment for youth. The Children, Youth and Families Department (CYFD) frequently struggles to meet the need for beds in emergency situations. Dream Tree has been working with the CYFD to

attend to the matter while exploring other ways to better serve children in New Mexico. Dream Tree will also be part of the CYFD's Pulling Together Initiative.

Julia Klause spoke about the challenges she faced to get insurance coverage after a surgery. She traveled to other states and Mexico to receive cancer treatment from alternative providers. She is now cancer free and in better health than ever before. Ms. Klause urged support of legislation allowing licensure of naturopathic doctors in New Mexico.

Adjournment

There being no further business before the committee, the fourth meeting of the LHHS adjourned at 3:43 p.m.

Revised: September 20, 2016

**TENTATIVE AGENDA
for the
FIFTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**September 20-23, 2016
San Juan College
4601 College Boulevard
Henderson Fine Arts Center
Conference Room 9008/9010
Farmington**

Tuesday, September 20

- 8:30 a.m. **Welcome and Introductions; Approval of Minutes**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human
Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (1) **Home Care Workers and Federal Fair Labor Rules**
—Maryann St. Germaine, Home Care Provider
—Caitlin Connolly, Campaign Coordinator, Home Care Fair Pay, National
Employment Law Project
—Adrienne R. Smith, New Mexico Direct Caregivers Coalition
—Joie Glenn, R.N., M.B.A., C.A.E., Executive Director, New Mexico
Association for Home and Hospice Care
—Nancy Smith-Leslie, Director, Medical Assistance Division (MAD),
Human Services Department (HSD)
—Angela Medrano, Deputy Director, MAD, HSD
- 10:00 a.m. (2) **J. Paul Taylor Task Force Update**
—Kim Straus, Foundation Manager, Brindle Foundation
- 11:00 a.m. (3) **Public Comment**
- 11:30 a.m. **Lunch** (provided to members)
- 12:30 p.m. (4) **Reporting Pursuant to Senate Memorial 52 (2015): Domestic Violence**
—Pamela Wiseman, Executive Director, New Mexico Coalition Against
Domestic Violence

- 2:00 p.m. (5) [Child Welfare Matters: Annie E. Casey KIDS COUNT Report](#)
—Amber Wallin, Director, KIDS COUNT, New Mexico Voices for Children (NMVC)
—Bill Jordan, Senior Policy Advisor/Government Relations Officer, NMVC
- 3:30 p.m. (6) [Girls in New Mexico's Juvenile Justice System](#)
—Denicia Cadena, Policy and Cultural Strategy Director, Young Women United
- 5:00 p.m. **Recess**

Wednesday, September 21

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:45 a.m. (7) [Update on Access to Community Behavioral Health and Substance Use Disorder Services](#) (Local Panel)
—Krista Lawrence, Court Programs Coordinator, Drug Court, Treatment Court, Juvenile Specialty Courts and Pretrial Services, Eleventh Judicial District
—Erin Hourihan, Chief Executive Officer (CEO), Childhaven; Board Member, Behavioral Health Planning Council
—Kim DuTremaine, L.C.S.W., L.A.D.C., S.A.P., CEO/Clinical Director, Adult and Adolescent Behavioral Health and Substance Abuse Programs, Cottonwood Clinical Services
—Laura Ann Crawford, R.N., Director, Northwest Region, Presbyterian Medical Services (PMS)
—Megan Hill, L.C.S.W., Clinical Services Supervisor, Totah Behavioral Health Authority, PMS
—Julie Young, M.D., Diplomate, American Board of Psychiatry and Neurology; Director, Behavioral Health, San Juan Regional Medical Center
- 11:00 a.m. (8) [Pregnancy Accommodation and Family Leave](#)
—Representative Gail Chasey
—Pamelya P. Herndon, Executive Director, Southwest Women's Law Center
- 12:00 noon **Lunch**

- 1:30 p.m. (9) [Update from Medicaid Managed Care Organizations on Statewide Access to Behavioral Health and Substance Use Disorder Services](#)
—Quinn Glenzinski, Director, Network Operations for Government Programs, Blue Cross and Blue Shield of New Mexico
—Lisa Mortensen, L.C.S.W., M.B.A., Director, Behavioral Health, Government Programs, Blue Cross and Blue Shield of New Mexico
—Liz Lacouture, Executive Director, Behavioral Health, Presbyterian Health Plan
—Marcello Maviglia, M.D., Medical Director, Molina Healthcare of New Mexico
—Adan Carriaga, Program Manager, Molina Healthcare of New Mexico
—Dr. Denise Leonardi, Chief Medical Officer, UnitedHealthcare Community Plan of New Mexico

- 3:00 p.m. (10) [Proposed Changes to Hours of Sale for Packaged Liquor](#)
—Jackie McKinney, Mayor, City of Gallup
—Fran Palochak, City Councilor, City of Gallup
—Jeff Kiely, Executive Director, Northwest New Mexico Council of Governments

- 4:00 p.m. (11) [Public Comment](#)

4:30 p.m. **Recess**

Thursday, September 22

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS

- 8:40 a.m. (12) [Community Paramedicine](#)
—Andres Mercado, Mobile Integrated Health Officer, City of Santa Fe Fire Department
—David Burke, Deputy Fire Chief, Farmington Fire Department
—Darren Braude, M.D., EMT-P, Professor of Emergency Medicine and Anesthesiology, University of New Mexico (UNM) Health Sciences Center (HSC)

- 10:00 a.m. (13) [San Juan County Juvenile Justice Services](#)
—Traci M. Neff, Administrator of Juvenile Services, San Juan County

- 11:00 a.m. (14) [Public Comment](#)

11:30 a.m. **Lunch**

- 1:00 p.m. (15) [Department of Health \(DOH\) Programs Update](#)
—Gabrielle Sanchez-Sandoval, DOH
—Shauna Hartley, Administrator, Turquoise Lodge Hospital, DOH
—Carmela Sandoval, Administrator, Sequoyah Adolescent Treatment Center, DOH
—Judith Parks, Deputy Director, Division of Health Improvement, DOH
- 3:00 p.m. (16) [Aging and Long-Term Services Department \(ALTSD\) Update](#)
—Myles Copeland, Secretary, ALTSD

4:30 p.m. **Recess**

Friday, September 23

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (17) [Chiropractic Physician Scope of Practice](#)
—Steve Perlstein, D.C.
- 9:30 a.m. (18) [Occupational Therapy: Scope of Practice Update](#)
—Carla Wilhite, O.T.D., Assistant Professor, UNM HSC
- 10:30 a.m. (19) [New Mexico Trauma System Overview](#)
—Razvan N. Preda, M.S.N., R.N., Student, Doctorate of Nursing Practice Program, UNM HSC
—Kim McKinley, D.N.P., R.N., Executive Director, Clinical Information/Stroke/Trauma, UNM Hospital
—Stephen Lu, M.D., Former Trauma Medical Director, UNM Hospital
—Liana Lujan, R.N., Trauma System Coordinator, DOH
- 12:00 noon (20) [Public Comment](#)
- 12:30 p.m. **Adjourn**

**MINUTES
of the
FIFTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**September 20-23, 2016
San Juan College
4601 College Boulevard
Henderson Fine Arts Center
Conference Room 9008/9010
Farmington**

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order as a special subcommittee on September 20, 2016 by Senator Gerald Ortiz y Pino, chair, at 9:04 a.m. at the Henderson Fine Arts Center in Farmington.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong (9/20, 9/21,
9/22)
Sen. Mimi Stewart

Absent

Rep. Nora Espinoza
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members

Rep. Gail Chasey (9/21)
Rep. James Roger Madalena (9/21, 9/22,
9/23)
Sen. Cisco McSorley
Sen. Howie C. Morales (9/20)
Sen. Nancy Rodriguez (9/22)

Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Rep. Terry H. McMillan
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
Sen. William P. Soules
Rep. Don L. Tripp
Rep. Christine Trujillo

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)

Shawn Mathis, Staff Attorney, LCS

Rebecca Griego, LCS Staff

Alexandria Tapia, Contractor, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at [https://www.nmlegis.gov/Committee/Interim Committee?CommitteeCode=LHHS](https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS).

Tuesday, September 20

Welcome and Introductions

Senator Ortiz y Pino welcomed members to the fifth meeting of the LHHS. Members of the committee and staff were asked to introduce themselves.

Home Care Workers and Federal Fair Labor Rules

Caitlin Connolly, campaign coordinator, Home Care Fair Pay, National Employment Law Project (NELP), provided the committee with background on the NELP and its efforts to promote good jobs and opportunities for work. The NELP is a nonprofit organization that focuses on laws both at the federal and state levels affecting home care workers. According to Ms. Connolly, 90 percent of older adults want to stay in their homes, which is often less costly than institutional care. Home care accounts for between 70 percent to 80 percent of hands-on care for the elderly. In 2010, there were seven family caregivers for every one adult that needed care; by 2050, that number will drop to three for every one. At the same time, the aging population is growing, with more than 10,000 Americans turning 65 every day. With fewer individuals to meet this need, Ms. Connolly contended that a paid workforce will help address this issue. During the presentation, Ms. Connolly discussed recommendations for the creation of a home care task force requiring interagency collaborations, compliance with new federal rules and funding and extending wages and overtime to home care workers based on state regulation. The NELP is a willing resource for the committee and the state on this issue.

Ms. Connolly provided several handouts detailing recent changes to U.S. Department of Labor (USDOL) Home Care Rules and the federal Fair Labor Standards Act (FLSA). First, the FLSA changed the scope and definition of "companionship services". Second, third-party employers are now excluded from getting companionship exemption and overtime exceptions. Third-party employers must now pay overtime for individual consumers and workers must be paid for all time worked, including travel time between clients. Ms. Connolly noted that good examples of implementation of these rules are being seen all over the country, citing several states as examples. The best examples include allowing for a robust exception to capped hours if

it is in the best interest of the client and efforts to keep professionals in the field. The Centers for Medicare and Medicaid Services (CMS) is reimbursing for overtime and travel time cost; in New Mexico, that reimbursement rate is 71.13 percent. States are responsible for making sure individuals are not at risk for institutionalization. Ms. Connolly noted that correct classification of workers as employees is key to securing their legal protections and ensuring fair competition by law-abiding businesses. Referring to home care workers as "independent contractors" is a misclassification that leads to the denial of basic workplace protections and benefits. The NELP calls on states to invest in their home care programs and New Mexico legislators to help ensure the implementation of new rules with the passage of a memorial creating a task force. In closing, Ms. Connolly urged the committee to extend state and overtime wage protections to home health care workers, adding that it is not just good social policy, but also good fiscal policy.

Adrienne R. Smith, New Mexico Direct Caregivers Coalition (NMDCC), informed the committee about direct care workers in New Mexico. The NMDCC advocates for direct care workers' education, training, benefits, wages and professional development so that they may better serve people who are elderly and those with disabilities. The direct care workforce is the fastest-growing sector in the state and the second-fastest-growing sector in the country. There are currently 47,963 wage-earning direct caregivers in New Mexico, including personal care assistants, home health aides and nursing assistants. Ms. Smith shared some demographics of caregivers, who are primarily women and face educational barriers (see handout for more information). Ms. Smith stated that many caregivers often work as "contract workers" and are frequently in need of more hours to support themselves, working two and even three jobs. The NMDCC would like to play a part in drafting a memorial to create a task force and to work with disability rights groups.

Joie Glenn, executive director, New Mexico Association for Home and Hospice Care (NMAHHC), described her organization, which is made up of members that are skilled home health, hospice health and non-skilled home health agencies. Home health care is a high-value, low-cost provider with experience in caring for complex patients. Ms. Glenn stated that skilled home health care and personal care services (PCS) save Medicaid money by assisting managed care organizations (MCOs) with care coordination in many aspects. Ms. Glenn focused on the multiple unfunded mandates imposed by the federal Patient Protection and Affordable Care Act (ACA) and Medicaid expansion that have created an additional burden to PCS providers. These agencies have also been affected by the one percent budget cuts in response to the current state budget crisis. Additionally, a new ruling, effective in December 2016, will add a required supervisory service that is considered non-reimbursable. Agencies have been under-reimbursed for a long time and continue to have further requirements placed upon them. Several agencies are conducting studies to understand what the impact will be from the cuts, rule changes and mandates. The NMAHHC supports the creation of a task force.

Nancy Smith-Leslie, director, Medical Assistance Division (MAD), Human Services Department (HSD), recognized that all four Centennial Care MCOs were present in the audience. Ms. Smith-Leslie proceeded to discuss the two key policy changes, which became effective in

January 2014, that are driving increased utilization and expenditures for home- and community-based services (HCBS): approval of the Centennial Care waiver allowing any individual enrolled in Centennial Care who meets a nursing facility level of care to receive HCBS waiver services, including PCS, without having to wait for a waiver slot; and Medicaid adult expansion, which allows newly eligible adults also able to receive HCBS services without a waiver slot if they meet nursing facility level of care. Ms. Smith-Leslie shared data illustrating the effect of the two policy changes on PCS utilization and expenditures (see handout). Angela Medrano, deputy director, MAD, HSD, added that the community benefit program, or HCBS, continues to grow as more people are qualifying for the program. More than 1,000 individuals have been added to those slots since the beginning of 2016 alone, and it is likely that this increase will continue. Centennial Care also added the requirement for MCOs to implement an electronic visit verification system (EVV) to verify that PCS are being delivered as authorized. Ms. Smith-Leslie stated that MCOs are working closely with providers and are bearing the total cost of the system. As part of Medicaid cost-containment efforts, the Provider Payments Cost-Containment Subcommittee was charged with making recommendations for reducing provider reimbursement rates effective July 1, 2016 in accordance with the General Appropriation Act of 2016. Recommendations from the subcommittee included a one percent reduction for community benefit providers. Despite the need for additional reductions to achieve a savings goal of \$30 million in General Fund dollars, the HSD elected not to increase the one percent reduction for community benefit providers.

In response to committee members' questions, the following points were discussed with the panel:

- new rules and implementation time lines;
- the USDOL as the enforcement agency for new rules;
- coordination efforts with the CMS;
- the need for updated state regulations and potential legislation;
- the lack of alternatives for agencies to cover cost of overtime pay increases;
- a proposed memorial creating a task force to be brought for committee endorsement based on language in Senate Bill 222 (2016);
- the need for rewarding models of care that reduce hospital admittance while keeping individuals healthy;
- the impact of Medicaid expansion on providers;
- challenges associated with serving the Medicaid expansion population;
- collaboration with universities for training programs to expand the home care workforce;
- the potential impact of workforce development on rural communities; and
- a recent op-ed discussing cost savings regarding long-term care.

Representatives from the four Centennial Care MCOs were invited to respond to the panel's remarks. Consensus among the MCOs was a willingness to work with the panelists and continue to explore options for saving costs while reducing the number of hospitalizations. It

was stated that from a cost-containment perspective, serving patients in their own community is a best practice. It also benefits members by improving their health and quality of life.

J. Paul Taylor Task Force Update

Kim Straus, chair, foundation manager, Brindle Foundation, provided the committee with an update on the J. Paul Taylor Task Force. The task force was established in 2013 with the goals to improve collaboration among early childhood development stakeholders, to better identify children at risk of child abuse and neglect, to develop an early childhood mental health plan, to improve the early childhood services system and to promote evidence- and community-based early childhood programs throughout the state. Mr. Straus applauded the work of the legislature for the investment in New Mexico children and discouraged any future cuts to early childhood programs. The task force recognizes the budget challenges faced by the state, but at the same time, the task force emphasizes the urgent need to preserve the integrity of existing, foundational early childhood and family support services and infrastructure. The potential for leveraging Medicaid funding to expand home visiting programs should be explored in the future. The following recommendations were made as a result of the last four years of work by the task force (please see handout for full details).

1. *Increase funding for early childhood programs.* The task force encourages the legislature to maintain or increase General Fund appropriations for early childhood programs. Further, the task force recommends that the legislature and administration enact policies that leverage current state investments in evidence-based health programs, such as home visiting and postpartum visits, including Medicaid financing and other strategies.

2. *Expand screenings to identify young children at risk.* These screenings include continued compliance with the existing Medicaid Early Periodic Screening, Diagnosis and Treatment federal regulations and the inclusion of adverse childhood experiences in health risk assessments administered by Medicaid Centennial Care MCOs.

3. *Promote and expand postpartum visiting programs to assist families with newborns.* These visiting programs assist with breastfeeding issues, conduct screenings, offer information on family well-being and ensure that families are connected with community resources and opportunities. This is particularly important in rural communities.

4. *Increase access to early childhood mental health services.* The task force again recommends that the requirement of a serious emotional disturbance (SED) diagnosis for access to mental health services be eliminated and that definitions needed to access mental health services be expanded.

5. *Support and coordinate training community health workers in assisting families with young children.* This recommendation urges the continued support from the HSD, the Department of Health (DOH) and MCOs for expanding the number of community health workers

in the state along with implementation of programs assisting families in connecting with needed services while identifying at-risk children and families.

6. *Align information and referral systems.* The task force recommends support for aligning existing information and referral systems in an online, shared, accessible, statewide, comprehensive, community-based resource directory to link families with young children to needed resources.

7. *Continue the task force.* The task force will be seeking continuation by the legislature for its work in 2017 with the passage of a memorial.

Following the presentation from Mr. Straus, members of the committee discussed the findings and asked various questions regarding the recommendations set forth by the task force. With the current state budget situation, Mr. Straus believes that leveraging Medicaid funding for home visiting programs would save money spent by other departments such as the Children, Youth and Families Department (CYFD). The state should also consider alternative sentencing options in order to reduce costs to the overall state budget. A question was raised regarding the Early Learning Advisory Council and the potential sunset of legislation authorizing its continuation; LCS staff will follow up with the CYFD on this matter. The LHHS also requested LCS staff to draft a bill that increases the dialogue between the HSD and its Behavioral Health Services Division (BHSD) and looks at the potential for broadening the definition of medical necessity for children.

Public Comment

Brenda Parker, executive director, San Juan Center for Independence, explained that PCS providers such as her organization work to keep people in their communities. Ms. Parker addressed how the new rules, one percent rate reduction and the roll-out of the EVV, according to which home care workers must check in and out when delivering in-home care, have affected the organization. Having just received the last of the electronic tablets required for the EVV, the San Juan Center for Independence has not been able to fully implement usage. The EVV presents many challenges in rural communities, including poor service signals and lack of data access to operate tablets. San Juan Center for Independence pays \$9.50 per hour, which is one of highest wage payers in the county. As a nonprofit organization, there are limited areas where the center can save money. Ms. Parker stated that PCS providers are working for the benefit of the state but the more regulations that are placed on them, the more likely it is that they will have to shut down services. The closure of organizations like San Juan Center for Independence will result in more individuals being institutionalized in nursing facilities.

Carol Maestas advocated for families of children with Rett syndrome. Ms. Maestas is asking that Rett syndrome be added as a qualifying condition for the developmental disabilities waiver. Senate Memorial (SM) 81 was sponsored by Senator Michael Padilla last year but it did not make it to the floor for a vote in the senate. Ms. Maestas stated that her son has a daughter living with Rett syndrome and described to the committee the challenges faced by individuals

with this condition and their families. The level of severity of the condition varies from individual to individual, with some requiring 100 percent dependence on care. Early intervention can help reduce the severity of the condition, she explained, but commercial insurance will only pay a portion of the required therapy. Senator Padilla has requested the drafting of a duplicate memorial, and Ms. Maestas is requesting the support of the LHHS for its passage. Senator Ortiz y Pino requested that Ms. Maestas prepare a one-page summary for the committee and informed her of the committee's endorsement process. Members of the committee also encouraged Ms. Maestas to work with other developmental disabilities organizations in the state to support the effort.

Reporting Pursuant to SM 52 (2015): Domestic Violence

Pamela Wiseman, executive director, New Mexico Coalition Against Domestic Violence, provided the LHHS with a summary of findings and recommendations from the Batterer Intervention Program (BIP) Task Force created in 2015. SM 52 charged the task force with studying the effectiveness of BIPs in New Mexico by reviewing the current state of batterers' intervention services; offender assessment; curricula and implementation; research; and the criminal justice system response. There are currently 40 BIPs across New Mexico, 22 of which receive CYFD funding. BIPs are a court-ordered sentencing alternative to jail requiring participation in a 52-week group education program. Judges can use the programs as a sorting mechanism, identifying individuals who want to change and individuals who will be likely to commit future domestic abuse. Ms. Wiseman explained that BIPs can make a real difference for children. When children witness that a violent parent has changed, not only does it stop the negative effects on the child, but it also helps reverse some of the damage, thus providing for a better outcome for their future. Children who are exposed to violence begin to see the world as a dangerous place, instilling in them an aggressive response. Ms. Wiseman believes that BIPs are also a valid method of combating recidivism rates in the state. Programs are in need of facilitators, which cost between \$9.00 and \$14.00 per hour. Programs also need the support of the court systems to remain viable and to hold individuals accountable. The courts must have a uniform process of enforcing consequences for individuals who drop out of programs.

Ms. Wiseman shared the findings and recommendations of the task force with the committee (please see handout for full report). In 2013, *Forbes Magazine* reported the annual costs of domestic violence nationwide to be \$8.3 billion. A small subgroup of domestic violence offenders is responsible for most of the re-offenses: 20 percent to 25 percent of offenders commit 75 percent to 80 percent of re-offenses. Ms. Wiseman acknowledged rumors on the national level about the inefficiency of BIPs, adding that research on the programs is confounded by inconsistencies in implementation and the criminal justice system response. One example of this is the Duluth model. The Duluth model had a component of BIP, but it was part of a large program. When it was determined that the Duluth model did not work, the belief that BIP did not work was largely accepted. The task force recommends that the state establish an advisory group to consider and recommend specific curricula to the CYFD and to develop training and supervision sufficient to implement select curricula.

Wendy Buchanan, Family Crisis Center, shared what is being done locally to address issues of domestic violence in Farmington. The Family Crisis Center found that there were no measurable ways to demonstrate if individuals were making changes under BIP and that offenders were only required to attend the groups. The center has been working with a different program called HEAL, developed by a group in Michigan. Ms. Buchanan explained the difference between the two programs and the benefits found with HEAL in the community. The more the facilitators are able to keep individuals coming and participating in the program, the more changes in attitudes and motivation are seen. Individuals in the program are integrated with others at various stages, inspiring them to continue. The Family Crisis Center has ongoing interaction with the program creators, and facilitators receive ongoing training.

In response to the presentation, the committee addressed the following topics with Ms. Wiseman and Ms. Buchanan:

- reach and scope of the two programs;
- statewide incident reports of domestic violence;
- other services available to address the issue of domestic violence;
- the need for comprehensive statistics on domestic violence and other crimes to better understand correlations;
- development of criminal justice system strategies to reduce recidivism and promote the safety of victims;
- enforcement of BIP referrals and disconnect with courts;
- the lack of reporting and accountability;
- the need for prioritization of domestic violence as a major issue for the state;
- reoccurring issues with lack of funding for program staff, current programs and increased quality training;
- the cost of incarceration versus the cost of funding prevention programs;
- predispositions to violence due to other conditions, such as traumatic brain injury;
- program availability for female offenders;
- occurrence of intimate partner violence; and
- a desire for a memorial during the upcoming session to continue the task force's work and address issues with referrals from the court system.

Child Welfare Matters: Annie E. Casey KIDS COUNT Report

Amber Wallin, director, KIDS COUNT, New Mexico Voices for Children (NMVC), addressed the committee regarding child welfare matters in the state. KIDS COUNT is an initiative based on government-collected data that calls attention to child well-being issues. New Mexico is ranked forty-ninth overall for child well-being, with next-to-bottom rankings for economic well-being, education, health and family and community. Ms. Wallin shared statistics relating to those four categories (please see handout for full details). Each category has seen significant improvements for both short- and long-term trends. One big issue for the state is food insecurity among children. Twenty-seven percent of New Mexico's children, roughly 145,000 children, are food insecure. Supplemental Nutrition Assistance Program (SNAP) benefits are not

adequate to address food insecurity in the state. On average, 80 percent of SNAP benefits are used up within the first half of the month, affecting children's test scores in school and increasing chances for hospitalizations and behavioral issues in the classroom. New Mexico children also have increased exposure to trauma, and abuse cases are on the rise. Ms. Wallin noted that ethnic disparities exist in every indicator, with Hispanic and Native American children facing increased challenges. While New Mexico faces many issues in addressing child well-being, research shows that policy matters and that positive and comprehensive support systems lead to better outcomes for children. Progress is possible and the state is making some important gains in the four categories, notably: 74,000 more New Mexicans have health insurance this year as compared to the previous year; nearly 5,000 more kids gained access to pre-kindergarten since 2010; 2,000 more New Mexican families receive home visiting; and big improvements in teen drug use and birth rates have been seen.

Bill Jordan, senior policy advisor/government relations officer, NMVC, provided some background on the tax policy and spending cuts that have led to the current issues facing the state. According to Mr. Jordan, tax cuts have made New Mexico's tax system even more regressive and less revenue is available for essential services. New Mexico families with the lowest incomes pay the highest rates in state and local taxes. Mr. Jordan discussed how the current tax system is punitive for working families and suggested the reversal of several tax policies that have been implemented under the promise of job creation. In the face of impending state budget cuts, the state needs to reconsider some of the failed tax cuts while raising new revenue through increased taxes on tobacco, alcohol and internet sales. At the same time, some initiatives, such as raising the minimum wage and expanding paid sick leave and family medical leave, could have big impacts on working families without any additional cost to the state's General Fund. Mr. Jordan believes that the state should fully fund early childhood care and learning programs through a 1.5 percent investment from the Land Grant Permanent Fund. In addition, the state could draw down federal Medicaid funds for home visiting, which has been proven to improve parent involvement in education and decrease child abuse. Mr. Jordan concluded that the budget is a moral document and a reflection of the state's values, and New Mexico children should not have to sacrifice their well-being as a result of budget cuts.

Following the presentation, members of the committee discussed the findings of the KIDS COUNT report. Some key points addressed were:

- various questions about statistics in the presentation with a request for additional statistics and data in the four categories;
- a request for comparisons with the national average;
- potential effects of repealing or "freezing" tax credits;
- the impending special session addressing the budget crisis;
- future presentations to other committees and ongoing collaboration with the Revenue Stabilization and Tax Policy Committee;
- the need to create a "family friendly" state in order to attract jobs and companies to the state;

- the potential for creating an early childhood development department;
- issues and challenges under the current education policy;
- recent issues with SNAP administration and the impact on the state; and
- the CYFD's Pull Together Campaign and potential for allocation of funds for other programs.

Girls in New Mexico's Juvenile Justice System

Denicia Cadena, policy and cultural strategy director, Young Women United, presented on the challenges facing girls and young women in the juvenile justice system. Young Women United leads policy change and community organization for women of color and families most impacted by challenging issues facing New Mexico communities. Ms. Cadena provided background on the creation of the Juvenile Detention Alternatives Initiative (JDAI) in Bernalillo County. The JDAI seeks to reduce reliance on incarceration without sacrificing public safety through program reform in partnership with community agencies and government at the state and local levels. There has been collaboration from over 40 community agencies and leaders, families and youth, mental health providers and justice system stakeholders. The JDAI has focused on reducing racial and ethnic disparities, but has recently been examining gender disparities in the system. Ms. Cadena explained that a "Deep End youth" is a young person who has been identified as waiting for placement in out-of-home placements such as group homes, treatment foster care, residential treatment and long-term commitment. Youth stay an average of 17.5 days in the Bernalillo County Youth Services Center, where as Deep End youth stay up to three times longer. Deep End youth are consistently close to 30 percent of the total juvenile detention population in the youth services center. These youth tend to have more complex needs, but have not always committed more serious offenses.

Esperanza Dodge, Mamas Justice organizer, Young Women United, shared an overview of girls and young women in the juvenile justice system based on Bernalillo County and national data. In the last 15 years, the JDAI has safely reduced the unnecessary use of detention by 74 percent. Between fiscal year (FY) 2012 and FY 2014, there was an eight percent decrease in the number of girls detained, compared to a 26 percent decrease for boys. During the same time period, there was a 12 percent increase in girls' average length of stay compared to a 22 percent decrease for boys. Girls of color make up the majority of those booked and held, as well as those who are committed. Young Women United recognizes that there are needs specific to girls and young women in the juvenile justice system. Girls in the juvenile justice system have disproportionately high rates of past physical and sexual abuse and trauma. Girls reported sexual abuse at 4.4 times the rate of boys. Approaches to dealing with this population must be trauma-informed, gender-specific and culturally relevant.

Ms. Cadena stated that diversion is effective, but New Mexico lacks programming options, especially for girls. There are only five residential treatment centers in the state and only one in Albuquerque that accept girls and young women. Ms. Cadena noted the additional challenges facing members of the lesbian, gay, bisexual, transgender and questioning (LGBTQ) community. Girls who identify as lesbian or bisexual are at a significantly greater risk than

straight peers of being expelled from school, stopped by police and subjected to juvenile arrest and conviction or adult arrest and conviction. Nearly 14 percent of boys in the juvenile justice system identify as LGBTQ; for girls, that figure jumps to almost 40 percent. Ms. Dodge highlighted the need to consider the needs of young parents and expectant young women. There are more young mothers and expectant young women in the juvenile justice system than in the general population of the same age group. Ms. Cadena outlined the objectives of the Deep End girls group and recommendations by Young Women United, which include: exploration of mechanisms for youth other than detention; refocusing on family engagement and crisis intervention; increasing diversion prior to youth entering the system; consideration of specific needs for girls and young women; and listening to the experiences and expertise of girls and young women in the system.

Lyssa Lopez, youth leader, shared her personal experience with the juvenile justice system. Now 19 years old, Ms. Lopez entered the system at age 15 following domestic violence charges. Due to probation violations for running away, she finally ended up in commitment. During the commitment, staff assumed she was LGBTQ; she was subsequently treated differently and harassed by other girls and staff. Ms. Lopez shared various stories of mistreatment that she and other girls experienced. She believes that she would not have ended up in a commitment if there had been other programs available. She stated that the only benefit she received from the experience was the knowledge of not wanting to go back. If there were more places and options for girls, there would be different and better outcomes for individuals.

Members of the committee and the presenters discussed several topics, including:

- the historic decline in the number of residential treatment centers for adolescents in the state;
- the lack of options for alternatives to detention;
- the prevalence of gender disparities;
- inquiries about medication usage in facilities;
- efforts to gather information from individuals in detention regarding their experience and treatment;
- the lack of funding for diversion programs and initiatives;
- an explanation and the benefit of tools like a "stress pass", which allows for a cooling-off period without probation violation;
- collaboration with the CYFD, probation and parole entities and other law enforcement entities;
- inquiries about what is being done statewide and the potential to expand the JDAI;
- efforts to host culturally competent trainings around the LGBTQ community;
- the expansion of programs for sheltering and reintegration for youth;
- the frequency of juveniles arrested on alcohol-related charges; and
- efforts being made to reduce the number of people being entered into the system on minor, nonviolent charges.

Recess

The first day of the LHHS meeting in Farmington recessed at 5:24 p.m.

Wednesday, September 21

Welcome and Introductions

The second day of the LHHS meeting was reconvened at 8:52 a.m. by Senator Ortiz y Pino. Members of the committee and staff introduced themselves.

Update on Access to Community Behavioral Health and Substance Use Disorder Services (Local Panel)

Krista Lawrence, court programs coordinator, drug court, treatment court, juvenile specialty courts and pretrial services, Eleventh Judicial District, works with both adult and juvenile populations. Ms. Lawrence shared the struggles facing the community from a lack of psychiatric providers, therapists and independent living programs for both adults and juveniles. There has been an increase in heroin and opioid abuse in the region. A new program for medically assisted treatments has been started, but it is struggling to find providers who can prescribe methadone and Suboxone.

Laura Ann Crawford, R.N., director, Northwest Region, Presbyterian Medical Services (PMS), noted that behavioral health services start as early as local Head Start programs because they have seen an increase in need due to parental problems. Ms. Crawford described some of the programs in the area, including Farmington Health Services, psycho-social rehabilitation, comprehensive community support services, substance abuse programs and various therapy options. The community does its best to partner within the field to address needs, but it continuously struggles with the lack of providers. Ms. Crawford noted that she has been trying to recruit psychiatric providers for the last several months. When successful in recruiting, psychiatric professionals average about three years in the community before moving. The same challenges exist in recruiting mental health therapists to the area. A few years back, the field experienced several providers not only leaving the area but the profession itself for various reasons. As a result, the wait time for mental health assessments went from one week to up to five weeks. In a tri-county partnership, San Juan County has opened an 11-hour sobering center to help get intoxicated persons off the streets and into a safe environment. Since its opening in March, the facility has served more than 3,100 individuals. This facility is part of the Totah program — a year-long program housed on a three-building campus. Totah is not a detox facility, but the sobering center does have medical staff through its partnership with San Juan Regional Medical Center (SJRMC).

Kim DuTremaine, chief executive officer (CEO)/clinical director, Adult and Adolescent Behavioral Health and Substance Abuse Programs, Cottonwood Clinical Services, discussed some of the services her organization provides in the area. Cottonwood Clinical Services contracts with the CYFD, federal probation and parole and most MCOs and private insurances. It offers intensive outpatient services for adolescents and adults, DWI court and behavioral health

services. Cottonwood Clinical Services has nine clinicians who are dually licensed with both substance abuse and independent practice licenses. On average, 500 people are seen each week in group therapy; this does not include any individual services. There has been an issue with heroin and opioid use in the community; however, only three providers can accept private insurance, making referrals difficult. Ms. DuTremaine expressed frustration with the constant issue of understaffing. Programs at state colleges are graduating students, but graduates are facing difficulty passing licensing examinations and meeting the requirements from MCOs. Responding to a question from a committee member, Ms. DuTremaine explained that the disconnect with graduates gaining licensure is unclear, and she does not know whether graduates are not prepared to pass licensure tests or if they are just not seeking licensure. Additionally, access to service has been severely hampered by a lack of providers. Unless it is an emergency, it takes between three and five weeks to receive care. PMS has been unable to provide some of the substance abuse services it had previously offered. Cottonwood Clinical Services has nowhere to refer patients. Efforts have been made to refer patients to primary care providers who are able to prescribe psychotropic medications, but many primary care physicians will not take Medicaid. Ms. DuTremaine reported no difficulties in working with OptumHealth.

Erin Hourihan, CEO, Childhaven, and board member, Behavioral Health Planning Council, described some of the trends seen locally. According to the CYFD's Protective Services Division, the three main reasons children come into custody are parental substance abuse, mental or behavioral health issues and domestic violence. Alcohol abuse is still the number one reason that children are placed in protective custody in the county. There has also been an increase in the number of newborns testing positive for opioids. More than 150 children have been placed in out-of-state residential treatment centers, limiting their access to family visits and community. This increased number indicates major systemic issues facing the child care system. Ms. Hourihan attributes the start of this issue to the behavioral health disruption in 2013. It is difficult to quickly rebuild a dismantled system, and there is less access to services for children at all levels of care. Overall, there is a reduction in the number of beds for treatment, including those for mental health, foster care and substance abuse. Ms. Hourihan frequently receives calls from all over the state seeking placement for children, but she noted the concern with mixing populations in a shelter facility.

Since 1969, Childhaven has been providing shelter services to children from birth to age 18. It is consistently working with children needing a higher level of care, making it increasingly difficult to find homes with people able to care for the children. Due to financial issues, Childhaven was forced to close its comprehensive community support services in July. While it does serve some urban populations, Childhaven also provides services to rural areas of the Navajo Nation, Shiprock and Kirtland. It does not receive reimbursements for travel to rural areas or for the planning of wraparound services. Ms. Hourihan stated that there is not enough flexibility in funding to provide necessary services. Childhaven has a child advocacy program that works with the courts and law enforcement to determine the best placement options for children. Ms. Hourihan also noted the difficulty her organization experiences in hiring therapists. She believes that one issue adding complexity to the system is having four MCOs.

According to Ms. Hourihan, this has reduced the direct care workforce, as providers compete with the MCOs offering higher salaries to these workers to serve in administrative positions. There is also added complexity due to the lack of uniform billing and credentialing requirements across the four MCOs. Childhaven and other providers have met with partners and state agencies to suggest solutions for addressing problems, with little success. Ms. Hourihan referred to less-than-cordial relations with the CYFD while serving more than 210 children in state custody. She explained how parents are trained to accept more challenging children into foster care. The \$350,000 in cuts by the CYFD this year to shelters and regular foster homes is short-sighted and not in the best interests of New Mexico's children. She asked that legislators keep in mind during the upcoming special session the vital work that organizations like Childhaven do for the state.

Julie Young, M.D., diplomate, American Board of Psychiatry and Neurology; and director, behavioral health, SJRMC, addressed the lack of psychiatric services for children and adolescents in the area. The SJRMC has recently contracted for telepsychiatry, an approach favored by both parents and adolescents. Young people do not mind receiving services through a video link; however, face-to-face sessions are still preferred. Dr. Young noted that these services have not been advertised because there are issues getting the MCOs to credential the telepsychiatrists. The closest inpatient facility for adolescents is in Albuquerque; if it is full, adolescents are sent to Las Cruces. This creates an additional hardship on families. The SJRMC has problems linking inpatient and outpatient services due to the lack of record tracking and communication. The community lacks a substance abuse facility, despite tremendous need. The closest residential treatment facility is in Gallup, but the wait is several weeks long. In addition to alcohol abuse treatment, there is additional need for treatment for other substances like methamphetamine and opioids. Dr. Young noted other issues of concern, such as: cases of cannabis-induced psychosis that she attributes to Farmington's proximity to the Colorado border; parental substance abuse; misuse by individuals of social security disability; misuse of emergency rooms by the same individuals on a monthly basis, tying up resources and exhausting medical professionals; patients using inpatient services to avoid law enforcement; absorbing the overflow when United States Department of Veterans Affairs facilities deny services; and the hassle of obtaining prior authorization from health insurers for common medications and dosage changes. Due to privacy laws, Dr. Young explained that some of these issues are not reported.

Following the presentation from the local provider panel, committee members had several comments and questions, including:

- the failure of recent counseling graduates to sit for licensure and efforts to encourage growth in the field;
- compensation and other incentives for hiring and retention of professionals in the community;
- the capacity and limited services offered by the sobering center;
- funding sources and potential cuts for treatment centers and specialty courts;
- additional licensing requirements for working with adolescents;

- the potential for hospitals to add residency slots;
- expansion of the telepsychiatry program;
- prescriptive authority for psychologists and clarification on supervision requirements;
- the impact of the 2013 behavioral health disruption on morale and recruitment;
- the increase in the incidence of mental illness in the juvenile justice population;
- collaboration between providers and the creation of work groups and multidisciplinary teams to problem solve;
- the lack of Suboxone prescribers;
- medical detox in emergency rooms;
- issues with SED and the medical necessity requirement for Medicaid reimbursement; and
- the benefits of early intervention and home visiting programs.

In response to an invitation from the chair, the panel made the following recommendations.

1. *Independent living options.* Sending youth and adults, post-treatment, back to the same environment that contributed to the initial problem increases the likelihood for relapse.

2. *Expansion of the Treat First Program.* PMS is a pilot site for this program, which allows providers to get individuals in crisis help without requiring a behavioral health assessment. The program allows a patient to have four sessions. By engaging patients in the first session, the likelihood for them to continue to seek services and help is increased. There are six sites around the state that have this program.

3. *Reduction of caseloads.* The managed care system's overabundance of care coordinators is not improving care, and the additional paperwork requirements are burdensome on providers.

4. *Decreasing the number of MCOs.* Fewer MCOs would decrease the administrative burden on providers and be more efficient and cost-effective.

5. *Increasing flexibility of coverage.* Allowing reimbursements for services, such as follow-up calls, would have a tremendous effect on patient satisfaction and improve health outcomes. It would decrease the number of face-to-face visits, allowing providers to see more patients.

Pregnancy Accommodation and Family Leave

Representative Chasey gave a presentation regarding legislation she intends to carry in the 2017 legislative session that would extend pregnancy accommodation and family leave to New Mexicans. Representative Chasey shared some background on the issue and a United States Supreme Court case involving a postal worker who was fired from her job due to limitations during her pregnancy. Under current federal law, pregnancy accommodation requirements exist,

but only for employers with 50 employees or more. During the 2015 legislative session, Representative Chasey sponsored the Pregnant Worker Accommodation Act (House Bill 37), a bill requiring employers to make reasonable accommodation for an employee's or a job applicant's pregnancy, childbirth or related condition. The bill was meant to be friendly to small businesses, but those opposed claimed that it would place an undue hardship on businesses, and the bill ultimately died in committee. Representative Chasey considers this legislation to be very "pro-family" by potentially decreasing terminated pregnancies.

Pamelya P. Herndon, executive director, Southwest Women's Law Center, provided the committee with several statistics related to women in the workplace. The top employers in the state are the University of New Mexico (UNM), Los Alamos National Laboratory, Sandia National Laboratories, UNM Hospital and the State of New Mexico. There are more than 67,000 state employees, the majority of whom are women. In New Mexico, working women are the breadwinners in 41 percent of families; 72 percent of single mothers work; 48 percent of women in the state are of child-bearing age; and approximately 880,000 households are living at or below the poverty line. With the high rates of poverty, working women need to work throughout their pregnancies. Losing employment during this period only makes the issue harder for women and New Mexico families. Ms. Herndon shared several examples of women who were terminated from their workplaces during pregnancy due to requests for reasonable accommodations. The proposed legislation, in its current form, would amend the human rights statutes to allow women to provide a doctor's note allowing for additional bathroom breaks, exemption from heavy lifting and options for temporary reassignment of work. Ms. Herndon added that input is currently being sought on this legislation for improvements and to increase the likelihood of passage. Representative Chasey stated that amendments made to the original bill have been taken into consideration, and several employment law attorneys will have an opportunity for input prior to requesting LHHS endorsement.

Sarah Coffey, staff attorney, Southwest Women's Law Center, noted some of the differences between the legislation proposed for the 2017 legislative session and legislation introduced in the 2015 legislative session. The term "reasonable accommodation" is being added with the intent of generalizing the bill. By not listing specific accommodations in the legislation, women and employers would be able to adjust to any potential complications that may arise during a pregnancy. The accommodation would be based on a health care provider's recommendation and would apply to any business with more than one employee. The legislation includes a provision stating that if the accommodation creates an undue hardship on the employer, it would not be required to provide it.

In the ensuing discussion, committee members raised the following ideas and concerns:

- disagreement with classifying pregnancy as a disability;
- the potential for legislation to include the term "health conditions" as a reference to short-term conditions like pregnancy and other illnesses;

- amending the Human Rights Act to include pregnancy accommodation and other potential statutes;
- other states that have passed similar legislation;
- a comparison to the federal Family and Medical Leave Act of 1993;
- other language suggestions for the proposed legislation; and
- the cost benefit of extending protection to employees of small businesses.

Update from Medicaid MCOs on Statewide Access to Behavioral Health and Substance Use Disorder Services

Quinn Glenzinski, director, Network Operations for Government Programs, Blue Cross and Blue Shield of New Mexico (BCBS), shared the current status of BCBS's provider network (please see handout). Mr. Glenzinski noted that MCOs calculate the provider network based on the number of actual providers and the number of practice locations; therefore, counts may vary and providers may be counted multiple times if they have multiple practices. BCBS monitors the provider network on a monthly basis and meets frequently with larger providers. Mr. Glenzinski addressed the recent transition with core service agencies (CSAs) in the state. He noted that the collaboration among MCOs, providers and state agencies as CSAs were leaving the state was an impressive feat. BCBS continues to work to fill those gaps, but he believes it will have a stronger network than before.

Lisa Mortensen, director, Behavioral Health, Government Programs, BCBS, discussed the clinical side of what the company offers to members. There are 200 care coordinators across the state. Of those, 33 are behavioral health care coordinators who are licensed clinicians or psychiatric nurses. Some members with mental health or substance abuse disorders do not self-report due to the fear of being stigmatized. These members can be identified due to the efforts of post-discharge complex care intervention and through community care medicine. BCBS is contracted with emergency medical technician (EMT) and ambulance services that follow up with patients to ensure that they understand discharge orders and have necessary medication. Another program used by BCBS is to send care coordinators to larger hospitals to discuss discharge plans and inquire about any potential health barriers the patient might face. A new pilot project sends a peer coordinator to UNM Hospital and Turquoise Lodge to work with patients and to help reduce the fear of being stigmatized.

Liz Lacouture, executive director of behavioral health, Presbyterian Health Plan, noted that there are some similarities among the four MCOs. In cases where patients have multiple diagnoses, the providers frequently do not code mental health and substance abuse, making it difficult to collect complete data sets. Ms. Lacouture suspects that the number of substance abuse disorders is underrepresented. Presbyterian has 289 general psychiatrists; 20 of those are child psychiatrists or are eligible for board certification. In terms of medically assisted treatment, there are 22 Suboxone prescribers who have a psychiatric specialty and more than 200 more who do not. There are 800 members per month receiving Suboxone. Presbyterian has care coordinators who are licensed or have significant experience in the field, as well as peer support specialists who work to divert individuals from emergency rooms. Ms. Lacouture explained that

work continues with the providers through contractual relationships to eliminate barriers to access. Presbyterian is working to improve its delivery system and responsiveness to substance abuse disorders. All MCOs have been working with the CYFD on systems of care grants to target some of the more complex needs of some youth. The MCOs are collaborating to increase services.

Marcello Maviglia, M.D., medical director, Molina Healthcare of New Mexico, stated that the Treat First Program is a good concept. The majority of dropouts happen during the beginning stages of treatment. By making the process more swift and less cumbersome, individuals are engaged from the start and retention rates are increased. Dr. Maviglia is a psychiatrist specializing in addiction and behavioral health. Molina believes that recovery is a holistic process that includes many components. The goal is building and sustaining a recovery community using an evidence-based approach. Access to care requires a solid plan that includes care coordination and good resources. Dr. Maviglia described different methods that Molina uses to screen patients for substance abuse disorders. About 45 percent to 60 percent of members admitted for care have a substance abuse disorder. He stressed that while heroin is a big issue, Molina sees many patients who abuse stimulants and alcohol. About 10 percent to 15 percent of those admitted for behavioral health issues show signs of substance withdrawal. Statistics reflect wait times for Suboxone in more concentrated urban areas to be between four and six weeks. There are also not enough child psychologists. Molina is working to address some of these issues by providing ongoing training for care coordinators and transitional coaches on recovery methods. Medical surgery providers and staff are being trained in recovery-based approaches to step down its members with substance abuse disorders, referring them to lower levels of care. This is about creating ties between Medicaid and non-Medicaid programs. The first training will take place in October at Memorial Hospital. Molina will also be assisting UNM hospitals with recovery approaches. In addition, care coordinators and peer support specialists are working with specific methadone clinics on ease of access. Dr. Maviglia also explained the pilot project that Molina is launching with the Bernalillo County Metropolitan Detention Center (MDC) offering incentives to providers to follow up with individuals post-release within seven to 10 days and efforts to expand the Inside-Out Prison Exchange Program.

Adan Carriaga, program manager, Molina Healthcare of New Mexico, provided information about a recent joint project in Albuquerque initiated by all four MCOs. The HSD provided a mini-grant for the event, which had more than 700 attendees and 45 booths from people providing services not covered by Medicaid. With some individuals wanting detox coming into the system, Mr. Carriaga explained that the MCOs decided to network with other organizations, including faith-based programs. He expanded on Molina's usage of peer support and partnership with the MDC. Molina has identified frequent users of emergency services and has been working with them to get them into long-term support. Mr. Carriaga emphasized that recovery is a very individual decision and the person has to want it. As an MCO, Molina can provide members with options and develop an atmosphere of recovery for when they are ready. Molina is also working to identify individuals with hepatitis C to encourage them to stay in programs to get help and also address addiction issues. Additionally, Molina is working with the

federal Department of Housing and Urban Development, the New Mexico Coalition to End Homelessness and faith-based recovery homes to establish supportive housing.

Dr. Denise Leonardi, chief medical officer, UnitedHealthcare Community Plan of New Mexico (UHC), is a family physician who has seen many patients come for care with substance abuse disorders. While substance abuse is a large problem for New Mexico, it is also a national problem. UHC differs from the other MCOs because it serves a larger portion of the Medicaid expansion population. The average member is 45 years of age. Approximately 21 percent of UHC's members have a severe mental illness or a substance abuse disorder. UHC has 108 psychiatrists in its network and offers similar services to the other MCOs. Dr. Leonardi stated that UHC does offer some intensive outpatient services for members age 13 and older. In terms of inpatient services, most patients are admitted through the emergency room. UHC uses accredited residential services and has contracts with four health centers. Methadone clinics can only treat people over the age of 19. There are about 400 methadone providers in the state; about 137 of those are contracted providers and the rest are cash-only providers. The number of Suboxone providers fluctuates from quarter to quarter. Dr. Leonardi discussed some of UHC's efforts in working with patients on treatment goals, emergency room diversion and reducing barriers to treatment by attempting to address stigma associated with, and lack of information about, substance abuse disorders. UHC recognizes that social determinants of health have a big impact on outcomes for these members. The challenge of addressing substance abuse goes beyond Medicaid and providers. Some issues that UHC is facing are the lack of providers to treat this population, a shortage of other health care workers and licensing barriers, particularly for licensed alcohol and drug abuse counselors. UHC is also actively involved in National Recovery Month to educate the public about addiction and recovery. It continues to work in the development of peer certification and to provide mental health first aid training.

Dr. Wayne Lindstrom, director, BHSD, HSD, joined the panel during questioning by committee members regarding:

- clarifying data presented on the number of providers within networks;
- concern about duplication of provider counts and types of providers included in the data;
- the benefits of the Treat First Program, including increased retention rates;
- expansion of the Treat First Program pilot;
- arrangements with the Corrections Department for Medicaid-eligible inmates preparing for release and a pilot program with the MDC for tracking new Medicaid members;
- collecting data across all state departments and agencies, eliminating existing silos;
- the HSD's Medicaid Management Information System;
- the number of behavioral health professionals, detox beds, methadone providers and Suboxone providers still needed in the state;
- support for hospitals in training medical staff on substance abuse and detox;
- wait times for treatment;

- the importance of step-down programs and community support services following detox;
- gathering data by ethnic group and the need for cultural sensitivity;
- the difficulty in recruiting behavioral health professionals;
- provider credentialing by the MCOs;
- the need for providers to notify MCOs if they have moved or switched practices to improve tracking data;
- changing the focus of an MCO's role from demonstrating network adequacy to identifying deficiencies in the health system;
- the complexity of rate setting;
- the need for data on the number of deaths of those members diagnosed with SED;
- other examples of pilot programs, including partnerships with the CYFD and peer support specialist home visiting; and
- the effect of the budget deficit on the state planning process.

Proposed Changes to Hours of Sale for Packaged Liquor

Jackie McKinney, mayor, City of Gallup, addressed the committee seeking support for a local option district to change the hours of sale for packaged liquor. The City of Gallup wants to delay sales until after 11:00 a.m. by referendum, and the change would only affect the city and McKinley County. Senator George K. Munoz has requested that a bill be drafted for the upcoming legislative session creating the local option district. Mayor McKinney provided some background on the issue and recent measures taken to get public support. A recent bond election asking residents whether they would support restricting sales to after 11:00 a.m. received over 70 percent approval. Gallup has had a detox center for several years with a great model. After the center closed due to lack of funding, the city entered into an agreement with the Navajo Nation to keep it open. Following a recent Navajo Nation election, this agreement is no longer in effect. Mayor McKinney stressed that the first step to recovery is detox. The city has service aides who go out nightly to pick up intoxicated individuals who are a danger to themselves and others. They are taken to the detox center, where they can be held for up to 72 hours. On average, 45,000 people per year are taken to the center, and some are the same individuals with multiple visits. The City of Gallup is working with Dr. Lindstrom on creating some new programs at the detox center and wants to commit to behavioral health investment zone funding. Currently, the detox program is funded through the local liquor excise tax on a year-to-year basis. The intent is to discontinue the revolving door policy at the detox center and provide individuals with options for treatment. Nearly half the population of Gallup is Native American, and Gallup is surrounded on three sides by tribal lands. The City of Gallup has been working with the Native American community on this proposal.

The situation in Gallup has placed an overwhelming burden on law enforcement. The City of Gallup has 68 certified police officers, which is two-and-a-half times the national average for its population. On average, police officers handle between 400 and 500 calls per month. Mayor McKinney noted that this number is more than the number of calls handled by the Albuquerque Police Department. Last year, there were 20 exposure and alcohol poisoning deaths

per month, along with multiple cases of violence among homeless individuals. The goal of the proposal to limit liquor sales to after 11:00 a.m. is to save lives. If the bill passes, the city will have the ability to hold a referendum. Mayor McKinney is confident that the community will support the measure, and the impact will be significant. He is asking for the support of the committee to pass this legislation to allow the community to make a positive social change.

Fran Palochak, city councilor, City of Gallup, has witnessed the impact of alcohol abuse in her community over the course of her life there. Ms. Palochak works in a Catholic-run soup kitchen serving breakfast to more than 100 people per day during the winter months. The soup kitchen tries to feed them during the summer but as the weather gets warmer, individuals do not want to come in at 6:30 a.m., and by 8:00 a.m. they are already intoxicated. The soup kitchen will not allow them into the building to eat if they are drunk. As a citizen and public official, Ms. Palochak believes that reducing morning hours of liquor sales will result in more individuals coming to the soup kitchen to receive a meal and increase the likelihood that they will seek help.

Mark Fleischer, lobbyist, City of Gallup, stated that people outside of Gallup do not understand how endemic public intoxication is in the area. Gallup city officials want the ability to determine how to best address this problem in their community.

Following the presentation from the panel, questions from committee members addressed the following:

- reduced detox center funding due to state budget cuts;
- increasing the liquor excise tax by \$0.25;
- the burden of alcohol misuse on all taxpayers;
- the incidence of DWI in Gallup;
- the Navajo Nation's termination of its agreement to support the detox center; and
- the role of the Indian Health Service in addressing this issue and providing better health care to Native Americans.

Ruben Baca, lobbyist for the New Mexico Grocers Association, requested to see the proposal and asked to be included in discussions regarding the proposal. Mr. Baca wants to see whether the association and the City of Gallup can work together on this.

John Thompson represents liquor distributors in the state. Mr. Thompson stated that he had not heard about the proposed changes to hours of sale for packaged liquor, but he would take the information back to his clients. He expressed interest in working with the City of Gallup leadership on any potential legislation.

Mayor McKinney noted that the City of Gallup asked for voluntary help from local liquor licensees but got a very limited response. Senator Ortiz y Pino indicated that this legislation would be added to the agenda during the November meeting for potential endorsement by the LHHS.

Public Comment

Kay Peters, occupational therapist, is the director of the Occupational Therapy Assistance Program at San Juan College. Ms. Peters discussed the current scope of practice of occupational therapists, which includes working with recent stroke patients and individuals with autism. Occupational therapists will be seeking to expand their scope of practice during the 2017 session; the terminology has not been updated in 15 years. Ms. Peters requested the support of the committee for the legislation. Representative Armstrong sponsored a similar bill in 2015 that modernized the language of the practice, but upon passage by both chambers, the bill was vetoed. Representative Armstrong expressed interest in sponsoring the bill during the upcoming session.

Senator Ortiz y Pino called the members' attention to a letter sent to the committee from Torrey Moorman regarding the medical cannabis program discussed during the LHHS meeting in Taos.

Recess

The second day of the LHHS meeting recessed at 5:15 p.m.

Thursday, September 22

Welcome and Introductions

The third day of the LHHS meeting in Farmington was reconvened at 8:53 a.m. Members and staff introduced themselves.

Community Paramedicine

Andres Mercado, mobile integrated health (MIH) officer, City of Santa Fe Fire Department (SFFD), presented to the committee about the growing field of community paramedicine. In 1965, more Americans died on the roads than in combat. This caused the United States to create the emergency medical services (EMS) system. The EMS system has since become a mainstay in communities all around the country. Originally, the system was designed to stabilize and transport patients, but over the last several years, the role has changed to dealing with more general medical issues. Health care and health insurance have faced a restructuring with the implementation of the ACA. Mr. Mercado explained some of the challenges in misuse of the system that EMS personnel frequently see. People more readily call 911 for non-life-threatening illnesses, and paramedics are required to respond to calls in the same manner that they would for a vehicle accident. In Santa Fe, 0.3 percent of the population accounts for 90 percent of the emergency calls. One individual was transported to the hospital by EMS 65 times in one year, plus several additional emergency room visits. This individual had mental health and substance abuse issues and bounced between the jail, hospital, emergency room and fire department. Mr. Mercado explained the steps that the SFFD took to engage the individual to get him the services he needed. Since his needs were met, he has not called 911 once. While the SFFD cannot provide this level of service to everyone in the community, when it engages with particular individuals — known as "hotspotting" — great results occur.

Mr. Mercado explained that there is an international trend for expanding the EMS system. There are two terms being used in the field: community paramedicine and MIH. Community paramedicine has been around for a long time in rural environments, and the licensure level has higher clinical responsibilities. Community paramedicine is now being deployed in less rural areas. By comparison, MIH has a team focus where EMTs work with clinicians, social workers and pharmacists. More robust programs have physician assistants as part of the team. MIH has the ability to identify some of the individuals tying up emergency resources and to work to get them the help they need. Since these are individuals with interdisciplinary problems, they need interdisciplinary teams. Mr. Mercado stated that the hotspotting program is just the beginning; MIH can provide an alternate response to calls instead of ambulance deployment and help with emergency room diversion. The SFFD is exploring follow-up care, response to senior falls, flu clinics and presentations on health and safety. Mr. Mercado recognized telemedicine as a tremendously powerful tool. The way communities are delivering health care is evolving, and the SFFD is taking measures to transform its services by integrating physical and behavioral health, while addressing the social determinants of health.

David Burke, deputy fire chief, Farmington Fire Department, stated that Farmington is still in the beginning stages of implementing community paramedicine and MIH, but it is moving toward MIH to address similar issues in the community as Mr. Mercado described. Deputy Chief Burke said the city is looking at community data to see what can be done proactively. Financially, it makes good sense to strategically employ services without tying up critical resources. Deputy Chief Burke explained that the SJRMC provides regional EMS, and the fire department also responds to all calls. The first responder community continues to build relationships among hospitals, law enforcement and EMS, he stated.

Darren Braude, M.D., professor of emergency medicine and anesthesiology, UNM Health Sciences Center (HSC), noted that as with all other programs, funding is a big issue. However, there are creative ways that fire departments and counties are making these programs work. Rio Rancho has a program where personnel are required to proactively go out and make at least one visit instead of waiting for a 911 call. Albuquerque has expanded this to include visits to hospice patients. Other departments have been doing programs like these for some time, just without an official name. Now that it has a name, Dr. Braude believes that entities can collaborate better.

The committee thanked the panelists for their contribution to comprehensive care and discussed the following points:

- the ability to add members to the team based on the needs of the patient and the community;
- state and local involvement;
- state oversight by the DOH's EMS Bureau and medical committee membership;
- inquiries about the scope of practice for MIH;
- acknowledgment that every community has different needs and how MIH can be adapted to address those;

- details about training and curriculum through UNM and community colleges;
- the issue of coverage and expanding services into the more rural regions of the state;
- explanation of how transportation and emergency service costs are billed and reimbursed;
- budgetary limitations of individual departments;
- the goal to reduce utilization while meeting needs of the community;
- the lack of return from MCOs despite costs savings by departments;
- MCOs' claims of similar use of care coordinators;
- the prevalence of volunteer EMS and fire services in the state;
- Medicaid expansion impact on emergency services;
- potential termination of the NurseAdvice New Mexico line;
- data collection and tracking currently being conducted to demonstrate program value;
- utilization of existing infrastructure; and
- the paradigm shift of placing emphasis on preemptive care.

San Juan County Juvenile Justice Services

Traci M. Neff, administrator of juvenile services, San Juan County, provided the committee with an update on juvenile justice services in the region (please see handout). The juvenile facility began operations at its new location in January 2004. Since opening, the facility has received several awards and continues to add to its array of services. Ms. Neff emphasized that just because agencies are closing their facilities for juveniles does not mean the need is not there. She provided an overview of services and challenges that the county faces. San Juan County currently offers the following services.

1. *Crisis shelter.* To date, the crisis shelter has served a total of 3,034 adolescents in San Juan County, with an average of 253 per year. Adolescents being referred are high need/high risk due to the system seeking alternatives to detention. By design, the crisis shelter is a short-term option, and adolescents stay in this placement between three and six months. Education is a requirement during an individual's stay and the individual must be enrolled in school. San Juan County funds the crisis shelter at 100 percent.

2. *Residential treatment center.* The residential treatment center has served a total of 646 adolescents from San Juan County and other surrounding counties, averaging 54 clients per year. San Juan County provides this service through a contract with PMS on an annual basis. PMS provides treatment services and staffing, and the county provides the building, utilities, maintenance, meals for clients and education of residents. This allows PMS to only focus on treatment and care. It currently receives more than 30 referrals a month, but it has only 12 beds.

3. *Detention/community safety.* San Juan County has served a total of 5,864 juveniles in detention, with an average of 451 per year. While in detention, juveniles receive education, mental health (including psychiatric) care and programming focused on life skills, budgeting and overall health and wellness. While the detention population has decreased, the number of high-need juveniles being detained more frequently and for longer periods of time has increased. The

detention facility is challenged by the "revolving door" of juveniles who continue to violate conditions of release by the court or conditions of probation.

4. *Committed juveniles to the CYFD.* In January 2007, the CYFD contracted with San Juan County to provide regional long-term care for committed juveniles. San Juan County is the only county in the state serving youth under a long-term contract. By design, the facility is only able to serve a male population. Regionalization has proven to be more beneficial to juveniles so that they can engage in face-to-face family therapy and continue to engage with community providers for their schooling, cultural services and juvenile probation officers. Transition back into the community is more seamless and allows the juvenile a better opportunity to succeed.

Ms. Neff stressed the importance of education for these individuals. For most of these juveniles, their education has been fragmented. The Farmington Municipal School District provides the same curriculum and testing that students would receive in a traditional classroom. Online programs and college courses through San Juan College are also available to juveniles in the facility. San Juan County has strong partnerships with many community providers, law enforcement and the juvenile justice system in the region.

Matthew Kaufman, public defender, Eleventh Judicial District, represents the majority of juvenile delinquency cases in the area. He is proud of the work that San Juan County has done, and he recognized Ms. Neff's many accomplishments. The community partnerships are very cohesive and a great model for other communities. However, there are still gaps and institutional challenges that the system faces. In response to a question about the length of commitments, Mr. Kaufman explained that time served is not taken into account. The court defers to recommendations from professional need and risk assessments to determine the length of commitment. If the recommendation is for longer than a year, then a two-year commitment is ordered to provide for services. Other states have more alternatives for detention. In New Mexico, juveniles end up in detention because it is the best place for them to receive the services they need, including more access to Medicaid benefits.

Nick Costales, deputy director of field services, CYFD, joined the panel to respond to inquiries from the committee. In response to questions from committee members, the panel addressed the following issues:

- Medicaid benefits for juveniles while in detention;
- the need for more alternatives to detention and for building up detention programs in other parts of the state;
- long-lasting negative effects of detention, including stigma and damaged self-image;
- the critical need for support services after release to prevent reentry from violations;
- the value of having a facility under contract with the CYFD;
- recommendations by the Legislative Finance Committee to terminate the contract with the CYFD;
- alternative funding mechanisms for programs;

- limitations with Juvenile Justice Advisory Committee funding;
- the state to scale initiative in collaboration with the New Mexico Supreme Court, the CYFD and the New Mexico Association of Counties;
- contributions from the Annie E. Casey Foundation for staff training;
- explanation of the layout and capacity of the facility;
- more violent juveniles and sexual abuse cases;
- committee requests for recidivism rates;
- the need for supportive housing programs throughout the state;
- collaboration with the Navajo Nation and efforts to address the needs of the Native American population;
- referrals to treatment facilities like Sequoyah Adolescent Treatment Center (SATC);
and
- the need for a facility specifically for females.

Public Comment

Glenn Ford advocates for families of those who have a brain injury. Brain injuries can have both a cognitive and a behavioral health effect on an individual. Mr. Ford stated that MCOs do not know how to service these individuals. The number of people living with brain injuries is comparable to those who have behavioral health conditions. Nationally, 60 percent of individuals who have experienced abuse have a brain injury; yet screening is not being conducted. The Centers for Disease Control and Prevention has screening tools, and there are tools for states to use. Mr. Ford stated that unfortunately, brain injury was relegated to the Aging and Long-Term Services Department (ALTSD) and was inadequately funded. Currently, brain injuries are within the purview of the developmental disability community and are being handled in the same manner as intellectual and developmental disabilities. This is not the appropriate place for them, according to Mr. Ford. The New Mexico Brain Injury Alliance has been working with people for over 30 years, and one of the leading surgeons in the world, Dr. David Durham, is in Farmington. The New Mexico Brain Injury Alliance board is composed of individuals with brain injuries and their family members. Mr. Ford noted that schools are not screening for brain injuries, and Disability Rights New Mexico has been filing lawsuits against schools. Carrie Tingley Hospital in Albuquerque is a tremendous resource for children with brain injuries.

Mr. Ford expressed concern that the state is regressing rapidly in this area and that people are suffering. Detention centers are increasingly becoming the de facto place to deal with these individuals. With proper diagnosis and treatment, individuals can become valuable, contributing members of society. Members of the committee discussed other potential agencies to oversee this condition and what other states are doing. The potential for a Medicaid waivers was raised, but it was noted that only 10 percent of individuals with brain injuries would qualify for Medicaid. Members were interested in learning more about the model created in New York to address screenings. Mr. Ford agreed to send information to LCS staff for potential drafting of a memorial to study the need for screenings and implementation.

DOH Programs Update

A panel of representatives from the DOH testified to the committee regarding updates on Turquoise Lodge Hospital, SATC and boarding home licensure (please refer to handout for details of the presentation). Both Gabrielle Sanchez-Sandoval, deputy secretary, DOH, and Judith Parks, deputy director, Division of Health Improvement, DOH, participated in the panel via teleconference.

Turquoise Lodge

Shauna Hartley, administrator, Turquoise Lodge Hospital, DOH, provided the committee with background on the facility and the decision to close the adolescent treatment wing. Turquoise Lodge was founded in 1952 for adults in need of substance abuse treatment and both medical detox and social rehabilitation. An adolescent program began in June 2013. The program for adolescents was designed by community stakeholders from various organizations, including the CYFD, the juvenile justice system, CSAs, Bernalillo County and other concerned community partners. According to Ms. Hartley, the average number of days from request for treatment to offer of a bed was five days, and nine days from request to admission. Approximately 20 percent of all referrals were not assessed due to the DOH's inability to contact the individuals after three attempts, the individuals were no longer seeking treatment or referral sources chose other options for detox and treatment. Of all referrals assessed, 17 percent were not approved because they did not meet admission criteria. Ms. Hartley added that other intensive outpatient programs must be attempted prior to inpatient committal. The adolescent program at Turquoise Lodge contained 20 beds and was designed as a voluntary treatment program for youth ages 14 to 18. No waiting list was ever established for the adolescent program due to underutilization of available beds. The highest level of utilization that the wing experienced was 10 to 12 individuals at one time, according to Ms. Hartley. From January to June 2016, the hospital underwent a heating, ventilation and air conditioning (HVAC) renovation, which required closure of one wing of the unit. The boys' wing remained open due to greater utilization of services. In July 2016, the unit for girls was reopened, and girls were admitted at that time. Ms. Hartley explained that there has always been a greater need for adults seeking detox. For FY 2016, the adolescent program had 198 requests for treatment and 98 admissions. Conversely, the adult program had 2,922 requests for treatment and 1,002 admissions. Both the medical detox and social rehabilitation programs for adolescents were ultimately shut down in August.

Dr. Babak Mirin, medical director, Turquoise Lodge and SATC, testified that an individual seeking detox at an emergency room would receive service if the individual is actively experiencing withdrawal. Insurance companies do not reimburse for planned detox. There is an issue with people not being properly diagnosed by primary care providers and, therefore, not properly treated. Dr. Mirin stated that the majority of adolescents seeking detox have issues other than behavioral health conditions. The system is fragmented, and access to care is a real issue in the state.

Members of the committee expressed outrage and disappointment over the DOH's decision to close the adolescent program at Turquoise Lodge. The following points and inquiries were made in regard to Turquoise Lodge:

- details about admission criteria for the facility (the DOH will send a full list of criteria to the committee);
- justification by the DOH of underutilization;
- inquiries regarding considerations and attempts to remain open, including a reduction in the number of beds;
- a description of the layout and design of the facility;
- safety reasons and the practical need for separation of populations within the facility;
- the funding source for the HVAC upgrade;
- medical detox practices and procedures at the facility for both adolescents and adults;
- emergency rooms and outpatient programs as the only available options for adolescents seeking detox;
- contradictions with provider testimony about the availability of medical detox at emergency rooms;
- extensive testimony previously given to the LHHS from individuals and providers seeking adolescent beds at Turquoise Lodge prior to closure;
- the juvenile justice system as the largest referrer to the program and issues the facility witnessed with youth wanting to avoid detention;
- efforts for outreach to increase utilization;
- the decrease in referrals following the credible allegations of fraud in the behavioral health system;
- difficulty in treating and retaining adolescents;
- the benefit if one provider stays with the individual throughout the process, creating a level of consistency and continuum of care;
- the original intent and design of the facility to serve adults;
- partial response to financial issues of the state and the need to look at what services are reimbursable;
- no statutory mandate for the facility;
- the collective decision to close the adolescent program following evaluation of the department budget and examination of utilization data;
- the Office of the Governor was informed of the decision;
- concerns about the reappropriation of funding from the adolescent program to the adult program and the intent of the legislature for the initial allocation of funds;
- medical detox is reimbursable by Medicaid, whereas social rehabilitation is not;
- programmatic system gaps created by leveraging federal Medicaid funding;
- attempts made to combine services and funding with other providers in the state;
- Turquoise Lodge as the only facility in the state that provided specific services, namely medical detox; and
- an official request for a list of individuals that the DOH consulted with on the closure.

SATC

Carmela Sandoval, administrator, SATC, discussed the admission criteria for the facility and highlighted some improvements since the 2015 summit with the LHHS. SATC operates a male adolescent 36-bed facility in Albuquerque for individuals who are violent or have a history of violence, have a mental disorder and are amenable to treatment. The facility has increased its services to male adolescents from 58 admissions in FY 2014 to 98 admissions in FY 2016. SATC has decreased its usage of physical holds and is no longer using mechanical restraints. As part of the model of care improvements, SATC has five certified teachers providing education in core subjects, including a physical education and health component. Ms. Sandoval noted some of the successes of the educational program and improved communication with parents. As part of the recommendation from the SATC, a task force was established pursuant to SM 15 in 2015, and a "Clinical Learner's Circle" was developed with membership of local entities that provide psychiatric care to adolescents in a residential treatment setting. The group meets quarterly to discuss challenges in facilities.

In response to a question from the committee, Ms. Sandoval explained that due to the current structure of the facility, SATC is unable to offer services to female adolescents. Desert Hills is another facility in the state that offers similar services to females. SATC averages 30 individuals per month, with the average length of stay between six and nine months. A member of the committee requested a breakdown of utilization by month. Ms. Sandoval confirmed that community referrals are consistent, and SATC is working on an active referral list daily. SATC is always recruiting staff and is currently maintaining a steady budget. An admission committee determines if an individual meets the criteria, but the number of rejections or how many adolescents are being sent out of state is not tracked.

Boarding Homes

Ms. Parks provided the committee with information regarding the licensure of boarding homes in New Mexico. The DOH does not license any facility that does not provide health services. The DOH's role is purely regulatory, and it does not contract with facilities to provide care. If a complaint is filed, the DOH will investigate the complaint and will refer nonjurisdictional complaints to the appropriate oversight entities. Ms. Parks noted that the DOH can seek a cease and desist order if an entity is providing health care and operating without a license. Because boarding homes typically have a landlord-tenant relationship, they do not fall under the purview of the DOH. However, if the facility is providing health care, it is licensed by the DOH as an "assisted living facility". Under New Mexico statute, an assisted living facility is a facility operated for the care of two or more adults who need or desire assistance with one or more activities of daily living (ADLs). Ms. Parks listed several examples of ADLs and made the distinction between ADLs and instrumental activities of daily living (IADLs), which are activities related to independent living.

As previously requested by the LHHS, Ms. Parks shared data relating to assisted living facilities in the state. As of June 2, 2016, there were 204 assisted living facilities in New Mexico. The DOH has six surveyors and has completed 53 surveys from January to June 2016.

Since 2011, only one cease and desist order has been issued for operating without a license. According to Ms. Parks, the following data are not retrievable from the database in a usable format: the number of assisted living facilities closed by the DOH; owner/operator name and address; and affiliation with a corporation or chain. The number of people residing in each facility is not tracked or collected because the numbers change daily.

Members of the committee had the following inquiries:

- the purpose of tracking data if data cannot be accessed as a report;
- inconsistencies between the number of Board of Pharmacy permits for medication assistance and the DOH's list of facilities;
- the issue of substandard and inadequate care in boarding homes;
- reconsideration of the DOH's role in overseeing boarding homes;
- the inaccurate description of boarding homes as a landlord/tenant relationship; and
- the critical need to define terms accurately.

ALTSD Update

Myles Copeland, secretary, ALTSD, discussed the strategic plan for the agency (please see handouts). Secretary Copeland acknowledged Homer Post from the Farmington Senior Center, noting the important role of volunteer service in improving the daily lives and functions of seniors. The primary goal of the ALTSD is to promote lifelong independence and healthy aging. Secretary Copeland provided an overview of the multiple functions and initiatives of the department while addressing some of the major challenges in the state, including poverty, isolation, a growing elder population, disabilities and language and cultural barriers. The department's strategic priorities are derived from assessments of need, trends and challenges associated with the increasing number of older New Mexicans, as well as compliance with multiple governmental acts and statutes. These priorities include the following.

1. *Safeguard vulnerable adults and elders.* The ALTSD has four programs to protect vulnerable adults and elders: the Adult Protective Services Program (APS), Long-Term Care Ombudsman Program, Senior Medicare Patrol Program (SMP) and Legal Services. The APS responds to situations in which functionally incapacitated adults are being harmed, are in danger of mistreatment, are unable to protect themselves and have no one else to assist them. Self-neglect accounts for 53 percent of all substantiated allegations investigated by the APS in FY 2016. The Long-Term Care Ombudsman Program works to educate people on their rights and has the ability to refer cases to the APS with strict guidelines for confidentiality. The ombudsman program is operated by 80 volunteers who work with individuals, families and staff in facilities. The SMP helps to identify instances of Medicare fraud by educating beneficiaries on identity theft and other fraudulent practices. The ALTSD contracts with organizations for the provision of legal assistance to older New Mexicans for a wide variety of legal issues, such as landlord/tenant issues and powers of attorney.

2. *Support caregivers.* Approximately one in five New Mexicans serves as a family caregiver during any given year, which is an annual total of 419,000 people. Family caregivers provide 80 percent of all long-term care, with an average of 18.4 hours of care per week. The total economic value of this care is estimated to be \$3.1 billion annually. The Aging and Disability Resource Center works with family caregivers to assess needs, gather information, make plans and find support. Classes are provided to teach caregivers on how to deal with a loved one's condition such as Alzheimer's disease. These classes are taught by volunteers in the community, so issues of cultural competency are addressed. The Senior Services Bureau helps provide meals, transportation and respite for caregivers.

3. *Encourage healthy and independent aging.* The ALTSD has multiple programs to promote independence and empowerment of elders: health promotion, transportation, volunteer programs, senior employment, care transitions, prescription drug assistance program, state health insurance assistance program and veteran-directed HCBS program. The senior employment program works with seniors to help them present their value to employers and connect them with opportunities for employment. The ALTSD also supports and contracts with the New Mexico Senior Olympics.

4. *Combat senior hunger.* Over 75 percent of health care costs are due to chronic conditions, and food insecurity is an indicator for some chronic conditions. More than 42,000 New Mexico seniors are estimated to be living with food insecurity. Due to the commitment of combating this issue, New Mexico is now the seventh-best in the nation in senior food security, up from second-worst in the nation. Multiple partnerships around the state have aided in addressing this issue by increasing access to food pantries, home delivery of meals and expanding meal programs at senior centers. About 92 percent of seniors believe home delivery of meals is what allows them to be able to live independently.

Following the presentation, members of the committee discussed the strategic plan presented by Secretary Copeland. Some key points addressed were:

- the potential impact of the state budget on ALTSD programs;
- collaboration with the 19 pueblos and two tribes in the state;
- intergenerational programming;
- details about the transportation program and how seniors can request services;
- performance measures and inquiries about how surveys are conducted;
- issues with calculating data on food insecurity to gain an accurate picture of need;
- the need for continuation of food programs as a priority despite tremendous improvements;
- the types of facilities visited by the Long-Term Care Ombudsman Program;
- training of ombudsmen and other volunteers;
- a request for more information regarding past undercover evaluations of facilities;
- usage of the New Mexico MEDBANK Program;

- a previous presentation on home care workers and encouragement for the use of senior companions;
- SNAP benefits supplements for seniors; and
- how the department continues to deal with budget cuts and efforts to reduce effects on seniors and programs.

Public Comment

Doris Husted noted that some adolescents with developmental disabilities are violent and would not be able to qualify for SATC. These are the individuals being sent out of state for needed treatment. She believes that not only is this more costly, it is unhelpful for the individual and the family. More services need to be made available for adolescents, she stated.

Recess

The third day of the LHHS meeting recessed at 4:50 p.m.

Friday, September 23

Welcome and Introductions

The fourth day of the LHHS meeting in Farmington was reconvened at 8:45 a.m. Members of the committee and staff introduced themselves.

Chiropractic Physician Scope of Practice

Steve Perlstein, D.C., practices chiropractic medicine in Santa Fe. Dr. Perlstein explained that previous legislation afforded chiropractors prescriptive rights and allowed chiropractic physicians to provide additional services to patients. Traditionally, this has been a drugless profession, but the ability to prescribe muscle relaxants as part of a treatment program has proven to be very effective for patients. There have been no recorded adverse effects of chiropractic physicians having prescriptive authority. Dr. Perlstein shared several stories of patients who experienced success and pain relief through the combination of chiropractic and medication treatment. For example, the use of injections for knee issues to reduce inflammation has been an effective approach for patients. Given the primary care shortage in the state, chiropractic physicians are seeking to expand their scope of practice through legislation during the upcoming session.

Dr. Robert C. Jones noted that there is a national and state shortage of primary care physicians. Chiropractic education is a doctorate degree program, and chiropractors receive the same graduate level of medical education as any other medical doctor. Dr. Jones acknowledged that there are some deficiencies in their training; for example, chiropractors do not currently receive pharmaceutical training. Educational programs are working on addressing training deficiencies and integrating these components into the profession. Neck pain and lower back pain continue to be the leading reasons for individuals seeking medical attention. Because of ongoing shortages, it is difficult to get patients the help they need. Dr. Jones believes that chiropractors are being left out of the medical profession because other providers are concerned

with the lack of prescriptive authority. He summarized a statement from the Federal Trade Commission: while state legislators and policymakers are rightly concerned with patient safety, an important goal is to foster quality competition in the medical field. Lack of access to medical care is also a safety risk. Dr. Jones stated that chiropractors are conservative prescribers and can be a beneficial contribution to the continuum of care.

Dr. Perlstein presented an outline of the legislation being proposed, highlighting the key components. Current law has certified the advance practice of chiropractors as "level 1". There are about 120 providers with this certification; however, that provision sunsetted in 2012. Dr. Perlstein explained that "level 2" certification has plenary prescriptive authority, but one has to first obtain level 1 certification. The proposed legislation would bring back level 1 certification, eliminating the sunset. The training for chiropractors would be comparable to a certified nurse practitioner in terms of core requisites and would require 650 hours of clinical rotation. Two accredited medical schools have agreed to oversee the clinical rotation program. Addressing the concern of adding more prescribers of opioids, Dr. Perlstein noted that 25 states have naturopathic programs, 19 of which allow prescriptive authority.

Several local chiropractors were in the audience and stood in support of expanding the scope of practice to include prescriptive authority. The group of chiropractors agreed that this expansion would help them to provide care to more individuals in their communities. Dr. Ezekiel Brimhall voiced concern about individuals being unable to get appointments with primary care doctors. As a result, more individuals are using urgent care to get necessary treatment. Chiropractors are doing what they can to help patients but they are limited by law on what they can provide. Dr. Brimhall believes this would be a huge asset to the community and the state. Dr. Ryan T. Rowe added that many chiropractic practices are intergenerational, and professionals remain in their communities. Chiropractic treatment programs can be very beneficial to patients due to alternative approaches to health and wellness.

Following the presentation, members of the committee posed the following questions and concerns:

- inquiries about the proposed legislation;
- ensuring proper credentialing for recognition by the MCOs;
- the opportunity to meet needs in communities;
- prescriptive authority requested as a plenary license;
- currently, prescriptive authority is limited to formulary and injections;
- concern over opioid usage in the state;
- the ability of chiropractors to have time to understand the needs of the patient, allowing for early intervention through diet and lifestyle changes;
- the use of electronic medical records and issues with electronic prescribing;
- the medical professional shortage in the state at all levels of care;
- the expansion of authority as voluntary for chiropractors; and
- the potential for Medicaid reimbursement.

Senator Ortiz y Pino informed the presenters of the committee endorsement process and invited them to present a draft of the proposed legislation during the November meeting of the LHHS.

Occupational Therapy: Scope of Practice Update

Carla Wilhite, O.T.D., assistant professor, UNM HSC, stated that occupational therapists are seeking a refinement of their scope of practice. With the ACA, there have been many changes to the profession and the types of service occupational therapists provide. Ms. Wilhite provided background on the founding of the profession, noting that the field of occupational therapy has been in existence for almost 100 years with origins in mental health. A recent independent study published efficacy outcomes citing skilled occupational therapy as the only one of 19 total distinct spending categories to effectively and statistically reduce readmission rates to hospitals. Through the use of everyday activities, occupational therapy practitioners promote mental health and support full participation in life for people with or at risk of experiencing psychiatric, behavioral and substance abuse disorders.

Rachel A. Gillespie, O.T.D., provided the committee with a fact sheet along with a draft of the proposed legislation (please see handouts). The scope of practice for occupational therapy is over 11 years old and the update would refine the scope while addressing typographical and grammatical changes. In 2015, the scope of practice bill was pocket vetoed. Ms. Gillespie stated that the issue with the 2015 legislation regarding the definition of supervision aids has been removed. She provided an overview of the draft legislation, highlighting key aspects. The refined scope of practice includes definitions of both ADLs and IADLs, evaluation and assessment processes and various language updates.

The panel discussed the following aspects relating to the scope of practice expansion and the field of occupational therapy:

- patient successes with occupational therapy;
- a willingness to collaborate with the New Mexico School for the Deaf;
- differences between the 2015 legislation and the current proposed draft;
- limitations by the current scope in providing supports for mental and behavioral health;
- the benefit of hands-on therapy for rehabilitation; and
- the potential to help address the deficit of providers in the state.

Senator Ortiz y Pino informed the presenters of the committee endorsement process and invited them to present a draft of the proposed legislation during the November meeting of the LHHS.

New Mexico Trauma System Overview

Razvan N. Preda, student, Doctorate of Nursing Practice Program, UNM HSC, stated that trauma is the leading cause of death for ages one to 44 in the United States. One person dies every three minutes from trauma, and the associated medical costs are \$671 million every year. The goal is to fund and sustain a statewide system of trauma centers. In 2007, New Mexico developed its trauma system. Hospitals are designated as trauma centers by the DOH and the American College of Surgeons. There are four levels of trauma centers; level 1 provides the most comprehensive care while also conducting research and providing education. UNM Hospital is the state's only level 1 trauma center, and there are six level 3 and five level 4 hospitals also in the state. Mr. Preda stated that funding for the system comes from the state budget. In recent years, the funding has decreased by almost 50 percent while the number of centers has quadrupled. Mr. Preda added that this presentation is meant to provide information to the committee about the role and importance of the trauma system for New Mexico.

Liana Lujan, trauma system coordinator, DOH, assesses facilities around the state and explained how a hospital becomes designated. A hospital seeking designation sends a letter of intent to the DOH, and a site verifications survey is scheduled following submission of the hospital's application. The DOH evaluates the site for compliance with state regulations and the need for a center in the community. Following completion of the survey by a trauma surgeon and a trauma system coordinator, recommendations for designation are made to the secretary of health. Money appropriated by the legislature goes to the state Trauma System Fund, established pursuant to the Trauma System Fund Authority Act, where funds are distributed based on the level of designation. Ms. Lujan noted that the trauma center in Lubbock has let its designation by New Mexico lapse, but it is still seeing New Mexico patients.

Kim McKinley, executive director, clinical information/stroke/trauma, UNM Hospital, explained that the purpose of the Trauma System Fund Authority Act was to encourage smaller rural hospitals to develop and improve services in their communities. This allows for patients to remain within their communities, making it easier on patients and families. These small hospitals have grown in number from three to 12 with very little funding. A trauma center must have an operating room, a surgeon and an anesthesiologist available 24/7. Funds go toward the purchase of big equipment items for these centers.

Dr. Stephen Lu, former trauma medical director, UNM Hospital, talked about what the trauma system means for patients. Dr. Lu explained how patients are airlifted and transferred to centers following accidents. The system involves a huge amount of resources spread over the fifth-largest state. When someone is hurt, hospitals have resources to treat them regionally, and few individuals have to leave their community. Improvements in communication and the transportation system have been helpful for the system. Stroke and trauma response are both time-critical emergencies, requiring excellent coordination to get patients the resources they need quickly. Dr. Lu expressed the need to continue to expand the trauma system to all four corners of the state.

Dr. Duane Gibbs, present as a private citizen, works at the SJRMC and noted that not all trauma centers are equal in capabilities, even within the same designation level. The SJRMC receives patients from the Four Corners area, including patients from other states. After UNM Hospital, the SJRMC is the second-busiest trauma center in the state. Dr. Gibbs shared a few examples of trauma patient care, emphasizing that coordination among hospitals is key to saving lives. UNM Hospital is consistently inundated with patients; at least 50 percent of trauma patients from a level 3 hospital get transferred to UNM Hospital. It is critical to develop trauma centers that are robust and able to care for patients without requiring transfers.

Committee members engaged in discussion with the panel about the presentation, noting the following:

- the need to eliminate cuts to funding;
- trauma centers in surrounding states and coordination as part of the overall system;
- the lack of level 2 trauma centers in the state;
- recognition of regional efforts to develop comprehensive care;
- a request for statistics regarding patients, cause of admittance and success rates;
- the need for education about the system and its importance;
- the absence of federal funding for trauma centers;
- the diversity of medical specialties at trauma centers;
- emergency rooms around the state with excessively long wait times and the need for additional beds for patients; and
- suggestion of the documentary "Code Black" on Netflix.

Adjournment

There being no further business before the committee, the fifth meeting of the LHHS adjourned at 11:58 p.m.

Revised: October 26, 2016

**TENTATIVE AGENDA
for the
SIXTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 25-28, 2016
State Capitol
Santa Fe**

Tuesday, October 25 — Room 322, State Capitol

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (1) **Strategies to Reduce Maternal Mortality and Morbidity**
—Stacie Geller, Ph.D., M.P.A.; Director, Center for Research on Women and Gender; Director, National Center of Excellence in Women's Health; Department of Obstetrics and Gynecology, University of Illinois at Chicago College of Medicine
—Sharon Phelan, M.D., Department of Obstetrics and Gynecology, University of New Mexico (UNM) School of Medicine
—Eirian Coronado, Program Manager, Maternal and Child Health Epidemiology, Department of Health (DOH)
- 10:00 a.m. (2) **Update on Family Planning Initiatives**
—Erin Armstrong, Reproductive Rights Attorney, American Civil Liberties Union of New Mexico (ACLU-NM)
—Jody Camp, Section Manager, Family Planning Unit, Colorado Department of Public Health and Environment
—Janis Gonzales, M.D., Family Health Bureau Chief, DOH
—Megan Pfeffer, Quality Bureau Chief, Medical Assistance Division (MAD), Human Services Department (HSD)
—Nathan Eckberg, Program Evaluator, Legislative Finance Committee (LFC)
—Elaine Sena, Executive Director, MyPower, Inc.
—Abigail Reese, C.N.M., M.S.N., Program Director, New Mexico Perinatal Collaborative
- 12:00 noon **Lunch**

- 1:30 p.m. (3) **Children, Youth and Families Department (CYFD) Update**
—Monique Jacobson, Secretary, CYFD
—Maria Griego, Program Evaluator, LFC
—Brian Hoffmeister, Program Evaluator, LFC
- 3:00 p.m. (4) **Children's Court Improvement Commission Recommendations**
—The Honorable Petra Jimenez-Maes, Senior Justice, New Mexico Supreme Court
—The Honorable Jennifer E. DeLaney, Judge, Sixth Judicial District Court
—Ezra Spitzer, Executive Director, New Mexico Child Advocacy Networks
- 4:00 p.m. (5) **Paid Family Leave**
—Representative Deborah A. Armstrong
—Pamelya Herndon, Esq., Executive Director, Southwest Women's Law Center
- 4:30 p.m. (6) **TriCore Reference Laboratories (TRL)**
—Khosrow Shotorbani, Chief Executive Officer, TRL
—Michael Crossey, M.D., Chief Medical Officer, TRL
—Dina Hannah, Chief Compliance Officer, TRL
- 5:00 p.m. **Recess**

Wednesday, October 26 — Room 307, State Capitol — Joint Meeting with the Tobacco Settlement Revenue Oversight Committee

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
—Senator Cisco McSorley, Co-Chair, Tobacco Settlement Revenue Oversight Committee (TSROC)
—Representative John L. Zimmerman, Co-Chair, TSROC
- 8:45 a.m. (7) **Tobacco Settlement Revenue Expenditures in New Mexico and in Other States**
—Ari Biernoff, Esq., Litigation Division, Office of the Attorney General
- 9:15 a.m. (8) **Winnable Battles: Tobacco Use Prevention and Control Program (TUPAC) and Other Department of Health (DOH) Programs Funded from Tobacco Settlement Revenues**
—Benjamin Jacquez, TUPAC Program Manager, DOH
—Daniel Burke, Infectious Disease Bureau Chief, DOH
—Beth Pinkerton, Breast and Cervical Cancer Early Detection Program Manager, DOH

—Judith Gabriele, Diabetes Prevention and Control Program Manager,
DOH

—Cathy Rocke, Deputy Director, Public Health Division, DOH

10:00 a.m. (9) [Centennial Care Tobacco Prevention and Cessation Services](#)

—Megan Pfeffer, Quality Assurance Bureau, MAD, HSD

11:00 a.m. (10) [Tobacco Prevention, Cessation and Regulation Legislation](#)

—Representative Deborah A. Armstrong

12:00 noon **Lunch**

1:30 p.m. (11) [New Mexico Allied Council on Tobacco — Tobacco Prevention Coalition](#)

—Laurel McCloskey, M.P.H., C.P.H., Executive Director, Chronic Disease
Prevention Council

—Janna Vallo, Commercial Tobacco Control and Prevention Coordinator,
Albuquerque Area Southwest Tribal Epidemiology Center

—Lacey Daniell, M.P.A., New Mexico Grassroots Manager, American
Cancer Society Cancer Action Network

2:30 p.m. (12) [Update on Tobacco Cessation Programs Funded Through the Indian Affairs Department \(IAD\)](#)

—Suzette Shije, Deputy Secretary, IAD

—Allie Moore, Project Manager, IAD

3:30 p.m. (13) [Public Comment](#)

4:00 p.m. (14) [Long-Term Leveraging Medicaid Subcommittee \(LTLMS\) Recommendations](#)

—Carol Luna-Anderson, Executive Director, The LifeLink; Chair, LTLMS

—Angela Medrano, Deputy Director, MAD, HSD

—Nick Estes, Health Action New Mexico; Member, LTLMS

5:00 p.m. **Recess**

**Thursday, October 27 — Room 307, State Capitol — Joint Meeting with the Courts,
Corrections and Justice Committee**

8:30 a.m. **Welcome and Introductions**

—Representative Zachary J. Cook, Co-Chair, Courts, Corrections and
Justice Committee (CCJ)

—Senator Richard C. Martinez, Co-Chair, CCJ

—Senator Gerald Ortiz y Pino, Chair, LHHS

—Representative Nora Espinoza, Vice Chair, LHHS

8:45 a.m. (15) [Corrections Health Care: Report of the Corrections Health Care Task Force; Federal Prison Rape Elimination Act of 2013 \(PREA\)](#)
—Maria Martinez Sanchez, Staff Attorney, ACLU-NM
—Jody Neal-Post, Attorney at Law
—Matt Coyte, Coyte Law, P.C.
—Gregg Marcantel, Secretary, Corrections Department (NMCD)
—Wendy Price, Psy.D., Behavioral Health Bureau Chief, NMCD
—Jillian Shane, PREA Coordinator, NMCD
—Steve Jenison, M.D.

11:00 a.m. (16) [Corrections Medicaid Enrollment and Suspension](#)
—Kari Armijo, Deputy Director, MAD, HSD
—TBD, NMCD
—Gabriel Nims, Special Projects Coordinator, Bernalillo County Metropolitan Detention Center

12:00 noon **Lunch**

1:30 p.m. (17) [Solitary Confinement and Custodial Segregation](#)
—Jerry Roark, Director, Adult Prison Division, NMCD
—Steve Allen, Director of Public Policy, ACLU-NM
—Stuart Grassian, M.D. (via video conferencing)
—Matt Coyte, Coyte Law, P.C.
—Grace Philips, General Counsel, New Mexico Association of Counties

4:00 p.m. (18) [Public Comment](#)

4:30 p.m. **Recess**

Friday, October 28 — Room 307, State Capitol — Joint Meeting with the CCJ

8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS
—Representative Zachary J. Cook, Co-Chair, CCJ
—Senator Richard C. Martinez, Co-Chair, CCJ

8:45 a.m. (19) [Adverse Childhood Experiences in Juvenile Offenders in New Mexico and What We Can Do About It](#)
—Amir Chapel, Research Scientist, New Mexico Sentencing Commission
—George Davis, M.D., Director of Psychiatry, CYFD

10:00 a.m. (20) [Sharpening Prescribing Practices for Pain Management](#)
—Michael Landen, M.D., State Epidemiologist, DOH
—Demetrius Chapman, M.P.H., M.S.N. (R.), R.N., Executive Director, Board of Nursing
—Ben Kesner, Executive Director, Board of Pharmacy (BOP)
—Shelley Bagwell, Prescription Monitoring Program Director, BOP

- Sarah Trujillo, Licensing Manager, BOP
- Sondra Frank, J.D., Executive Director, New Mexico Medical Board
- Ralph McClish, Executive Director, New Mexico Osteopathic Medical Association; Member, Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council
- Joanna Katzman, M.D., M.S.P.H., UNM Health Sciences Center (HSC); Associate Professor, UNM; Director, UNM Pain Center; Director, UNM Project ECHO Chronic Pain and Headache Program

- 11:30 a.m. (21) [Non-Pharmaceutical Treatment for Chronic Non-Cancer Pain](#)
 —Michael Pridham, D.C.-A.P.C., N.R.C.M.E., Member, Executive Board, New Mexico Chiropractic Association
 —Juliette Mulgrew, N.D., M.S.A.Y., Vice President, New Mexico Association of Naturopathic Physicians

12:30 p.m. **Lunch**

- 2:00 p.m. (22) [Medication-Assisted Treatment](#)
 —Eugenia Oviedo-Joekes, Associate Professor, School of Population and Public Health, University of British Columbia
 —Lindsay LaSalle, Senior Staff Attorney, Drug Policy Alliance
 —Miriam Suzanne Komaromy, M.D., Associate Director, ECHO Institute; Associate Professor of Medicine, UNM
 —Andrew Hsi, M.D., Principal Investigator, FOCUS Programs at CDD UNM HSC; Principal Investigator, Reflejos Familiares Project; Professor of Family and Community Medicine

- 3:30 p.m. (23) [Economic Burden of Prescription Opioid Abuse](#)
 —Alan G. White, Ph.D. in Economics, University of British Columbia; M. Litt. in Economics and Mathematics, and B.A. in Economics and Mathematics, University of Dublin, Trinity College; Managing Principal, Analysis Group, Inc.

4:30 p.m. (24) [Public Comment](#)

5:00 p.m. **Adjourn**

**MINUTES
for the
SIXTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**October 25-28, 2016
State Capitol
Santa Fe**

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on October 25, 2016 by Senator Gerald Ortiz y Pino, chair, at 8:50 a.m. in Room 322 of the State Capitol in Santa Fe.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia
Sen. Gay G. Kernan (10/25, 10/26, 10/28)
Sen. Mimi Stewart

Absent

Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members

Sen. Craig W. Brandt
Rep. Gail Chasey (10/26, 10/28)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Bill B. O'Neill (10/27, 10/28)
Sen. Nancy Rodriguez (10/27, 10/28)
Rep. Don L. Tripp (10/25)
Rep. Christine Trujillo (10/25, 10/26, 10/27)
Sen. James P. White (10/25)

Sen. Jacob R. Candelaria
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Howie C. Morales
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
Sen. William P. Soules

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

Staff

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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Tuesday, October 25

Welcome and Introductions

At 8:56 a.m., Senator Ortiz y Pino welcomed members to the sixth meeting of the LHHS. Members of the committee and staff introduced themselves.

Strategies to Reduce Maternal Mortality and Morbidity

Stacie Geller, Ph.D., director, Center for Research on Women and Gender; director, National Center of Excellence in Women's Health; Department of Obstetrics and Gynecology, University of Illinois at Chicago College of Medicine, presented some lessons learned from Illinois' maternal mortality and morbidity studies. According to Dr. Geller, the decline in rates of maternal mortality achieved over the last 35 years in the United States has ended; rates are now trending upwards (please see handout for more information). The rate of maternal deaths per 100,000 live births in New Mexico is currently 23. However, huge racial and ethnic disparities exist with the rate for non-Hispanic Whites (14.9), Hispanics (25.5), African Americans (83) and Native Americans (23.7). According to the Centers for Disease Control and Prevention (CDC), the leading cause of pregnancy-related death in the United States is cardiovascular disease, followed by sepsis and hemorrhage. The number of women with severe maternal morbidity (SMM) has increased significantly across the country.

Dr. Geller explained the regionalized perinatal system established by Illinois consisting of 10 perinatal centers. Surveillance for maternal mortality in Illinois began in 1892 and was defined as "a death caused by direct or indirect complications of pregnancy occurring during the prenatal period or within 90 days after delivery or termination of the pregnancy". In 1989, Illinois added a pregnancy checkbox to death certificates to better monitor data, and perinatal centers began reviewing deaths in 1992. In 2002, the Illinois legislature revisited the maternal death review code and extended the period of surveillance to one year post-pregnancy. Hospitals are required to report any maternal deaths within 24 hours. The Illinois Department of Health collects records from the hospital, coroner, medical examiner, law enforcement and other health care providers. Dr. Geller described the abstract of medical records for these cases and the assessment of whether the death was preventable, as well as the role of Illinois' Statewide Maternal Mortality Review Committee (MMRC). The purpose of these internal and external review processes are to discover whether the death could have been avoided and to identify what medical staff could do differently in the future. The MMRC meets four times per year to review cases in which the patient, provider and hospital are all de-identified; the process is protected, so there is no assignment of blame. Since the beginning of surveillance, the MMRC has determined that 35% to 40% of pregnancy-related deaths in Illinois were potentially preventable. Dr. Geller noted that the MMRC found more cases to be potentially preventable than the perinatal center reviews, highlighting the importance of unbiased review.

In addition, a second review committee, the MMRC-V, was formed to look at maternal deaths due to violence; the MMRC-V examined maternal deaths due to homicide, suicide and substance abuse. While there was not necessarily a connection between these deaths and pregnancy, the MMRC-V wanted to identify missed opportunities for intervention and collect data on social determinants of health. Clinicians have begun screening for intimate partner violence and postpartum depression. Dr. Geller also discussed Illinois' Obstetric Hemorrhage Project and Maternal Hypertension Initiative and implementation of a severe maternal morbidity review that is a facility-level review of cases in which there was an intensive care unit admission or transfusion of four or more units of blood. With proper education and skills training, hospital readiness and patient care can be improved. Several states have active maternal mortality reviews, and others are in the process of establishing review committees. The key steps to establish review of deaths and morbidities are: legislation mandating reporting and protecting the review process and participants from discovery in litigation; infrastructure for collection of medical records and data abstraction; and the creation of an external multidisciplinary team to explore system and community factors.

Sharon Phelan, M.D., Department of Obstetrics and Gynecology, University of New Mexico (UNM) School of Medicine, reported on the status of maternal mortality review in New Mexico. According to Dr. Phelan, the usefulness of data from 2008 to 2014 is limited because it is dependent upon the accuracy of coding and data entry on death certificates or linked death and birth certificates. Based upon those data, New Mexico averages about 20 maternal deaths per year, and for every woman that dies, 50 others have SMM. About 41% of maternal deaths are "accidental", but there is no additional information about the nature of the "accident" that could be used to prevent the deaths. Dr. Phelan discussed several factors complicating New Mexico's current approach to maternal mortality review: the small number of cases and small population affected; the complexity of the health care system that involves many providers and stakeholders; limited access to patient data; and the lack of required reporting of remedial measures or improvements achieved. It is important for the state to develop methods of helping smaller hospitals interface with larger hospitals to provide for timely and smooth transfer of acute cases. Dr. Phelan is seeking legislation that would require the Department of Health (DOH) to create and maintain the maternal mortality and morbidity review process, and she explained what proposed legislation would include. Since those conducting the review would be volunteers, the cost would be minimal for DOH staff activities. There needs to be confidentiality and protections for providers to encourage reporting and ensure patient privacy. Membership of the review committee would be diverse and interdisciplinary. New Mexico has unique challenges in providing health care to its residents due to distances, economics, legal status and cultures. These challenges cannot be ignored. Legislation will provide the statutory authority to enable a comprehensive maternal mortality review.

Eirian Coronado, program manager, Maternal and Child Health Epidemiology, DOH, shared some additional data and statistics with the committee relating to maternal mortality. Ms. Coronado stated that access to data and records is key and that the level of data the state currently collects is inadequate for this purpose. Two major health issues for women in the state are

diabetes and mental health. About 11% of women self-reported diabetes during pregnancy. Several years ago, the CDC found that New Mexico ranked high in the incidence of postpartum depression, approximately 13% of women at the time. In 2009, that number jumped to 20%, which is double the national average. Nearly 56% of New Mexico women of reproductive age are obese. The rate of neonatal abstinence syndrome (newborns needing to go through medically supervised withdrawal as a result of maternal exposure to illicit drugs during pregnancy) has also increased over the last several years. Ms. Coronado stressed the need for more information to get a clearer picture of what is going on in the state.

Kenneth Winfrey, health outreach coordinator, Office on African American Affairs, agreed that a review process would be helpful, adding that this legislation coincides with his organization's goals. He expressed concern that New Mexico's small African American population has some of the highest rates of maternal mortality in the state.

Senator Ortiz y Pino reminded the panelists that the LHHS will be considering legislation for endorsement during its November meeting and invited them to bring a draft of the legislation at that time. In response to committee members' questions, the following points were discussed by the panel:

- the difference between "pregnancy-related" and "pregnancy-associated" conditions;
- details about the MMRC process in Illinois;
- funding for the Illinois project during the current financial crisis;
- usage of the Illinois model by other states;
- the need to protect review materials from discovery and concerns about patient privacy;
- the need for developing trust that the process is not punitive;
- ongoing revisions of language for proposed legislation;
- the existence of a bill on this topic that was introduced in the house of representatives during the 2015 regular session;
- collaboration between the DOH and other stakeholders;
- the need for more comprehensive data on Native Americans and for partnership with the Indian Health Service;
- limitations of the current mortality review process;
- the potential to use videoconferencing, such as Project ECHO, to decrease costs of the review committee;
- the need to address maternal morbidity and increase access to care for pregnant women;
- the prevalence of postpartum depression;
- the use of mandates to require training and reporting;
- the impact of socioeconomic conditions on pregnancy outcomes; and
- concern over the state budget and additional pending budget cuts.

Update on Family Planning Initiatives

Erin Armstrong, reproductive rights attorney, American Civil Liberties Union of New Mexico (ACLU-NM), provided an overview of the key requirements related to family planning. Thanks to advances in evidence-based policy, there is a patchwork of strong requirements that ensure that most women are entitled to comprehensive family planning coverage. Under the federal Patient Protection and Affordable Care Act (ACA), all private insurance plans must include United States Food and Drug Administration (FDA)-approved contraceptives and the related services without any cost-sharing. Ms. Armstrong explained that a plan can choose the brand carried on its formulary as long as there is an exceptions process that is easily accessible. Plans cannot refuse to cover a specific method of contraception or require a patient to use a less expensive method. Medicaid has a long-standing requirement that covers family planning and supplies as part of the full benefits package. There is a category of eligibility for these services, even if the person does not qualify for other Medicaid benefits. Medicaid managed care organizations (MCOs) may not impose cost-sharing, and there are enhanced protections for freedom of choice in family planning, including the right to see the qualified provider of the member's choosing. The federal match for Medicaid family planning is 90%.

New Mexico was one of the first states to require family planning by insurance companies. Now that the ACA is in place, the New Mexico statutes are somewhat outdated and could be revisited to align with federal requirements. One potential change is mandating plans to allow for a one-year supply of contraceptives; many states have passed laws to ensure this, and it would benefit a rural state such as New Mexico. Ms. Armstrong noted that coverage is only one critical piece of family planning. There needs to be a strong safety net to provide access for family planning activities. Steps that can be taken include: 1) training providers on the full range of methods; 2) community education; 3) simplification of coding and billing; 4) administrative and financial assistance for clinics to keep contraceptive products in stock; and 5) prompt payment and reimbursement policies.

Jody Camp, section manager, Family Planning Unit, Colorado Department of Public Health and Environment (CDPHE), shared the successes and lessons learned from the Colorado Family Planning Initiative (CFPI) with the committee (please see handout). The CFPI successfully increased access to long-acting reversible contraception (LARC) while making a tremendous impact on all health indicators for women. The initiative began in 2008 with the primary goal of providing access to all FDA-approved contraceptives, with an emphasis on LARC for women who choose it. LARC is a completely reversible method, lasts between three and 10 years and costs between \$400 and \$800. Ms. Camp explained how Colorado uses a sliding scale of patient charges and assesses patient needs through patient-centered counseling. After eight years, Colorado saw a significant increase in the usage of LARC across various age groups. Both birth rates and abortion rates of teens decreased by 48%. Additionally, a teen is more likely than women in any other age group to give birth to a second child within two years. This rate decreased by 58%. Ms. Camp highlighted some of the costs avoided following the implementation of the CFPI. These estimated avoided costs impacted both entitlement and non-entitlement programs such as the Supplemental Nutrition Assistance Program (SNAP), Medicaid

and the Colorado Child Care Assistance Program. Total costs avoided from 2010 to 2014 were estimated at between \$66 million and \$70 million. The CDPHE plans to continue its efforts by training providers outside the Title X network, including those at school-based health centers (SBHCs) and pediatricians. Ms. Camp added that the department will also be conducting an analysis of sexually transmitted infections (STIs) as they relate to LARC usage.

Janis Gonzales, M.D., chief, Family Health Bureau, DOH, updated the committee regarding the DOH's family planning initiatives and partnerships. The DOH has applied for federal funding to purchase LARC products but has so far been unsuccessful. There are 68 Title X providers in 30 counties and 47 public health offices around the state. Of Title X clients, 13% preferred LARC as a contraceptive method. The DOH is working to build its educational programming within the state through age-appropriate websites and programs for both teens and parents. Dr. Gonzales mentioned a largely successful social media campaign and the BrdsNBz text-back service for teens to have their questions about reproductive health answered. The DOH plans to continue social media campaigns on a quarterly basis. New Mexico teens are increasingly interested in learning about LARC. The DOH is currently working with Project ECHO to roll out Reproductive Health ECHO in January 2017. The unbundling of LARC by Medicaid for federally qualified health centers (FQHCs) was completed in September. FQHCs, including many SBHCs, will now be reimbursed for LARC devices separately from the reimbursements they receive for associated office visits.

Megan Pfeffer, chief, Quality Bureau, Medical Assistance Division (MAD), Human Services Department (HSD), shared the HSD's initiatives to expand family planning services in the state. Effective September 1, 2016, the MAD unbundled LARC drugs and devices from FQHC rates, allowing providers at clinics to bill separately for LARC. The HSD does not require prior authorization for LARC. MCOs do not require prior authorization from a physician; however, if the provider does not have the device in stock, it can send the request to a pharmacy. The HSD is revising Medicaid MCO contracts to add a new tracking measure requiring the MCOs to measure the use of LARC among members ages 15 through 19. Ms. Pfeffer added that the HSD continues to be actively engaged with the statewide LARC work group facilitated by Young Women United and the Association of State and Territorial Health Officials LARC learning community.

Nathan Eckberg, program evaluator, Legislative Finance Committee (LFC), presented the progress report and update from the 2015 *Effective Practices to Reduce Teen Pregnancy, Including the Use of SBHC* report. The report assessed New Mexico's teen birth rate as it is consistently one of the highest in the nation. The report found that teen births are concentrated in certain areas of risk, and as a result, evidence-based interventions targeted to these teens and geographic regions could produce significant population-level improvements. In the long term, children from teen pregnancies will cost taxpayers an estimated \$84 million due to Medicaid costs associated with their births, increased reliance on public assistance and poor educational outcomes. As a state, New Mexico has seen significant progress in the reduction of teen births but still has many challenges to overcome (please see progress report). Mr. Eckberg recognized

that the DOH and HSD have made significant progress in implementing LFC recommendations, including the unbundling of reimbursement for LARC devices. The LFC progress report highlights efforts by counties to develop comprehensive community plans.

Elaine Sena, executive director, MyPower, Inc., discussed the organization's mentoring program for girls and a road map to prevent unwanted teen pregnancy in Lea County. MyPower, Inc., is a nonprofit organization founded in 2009 that works with girls in fifth through ninth grades through group mentoring programs and a summer life skills camp. Ms. Sena provided details about the organization and shared Lea County's plan, which was developed by concerned citizens to reduce teen pregnancy. In 2008, research showed that Lea County had the highest rate of teen pregnancy in the state — three times the overall state rate. Through the work of various programs and policy changes, that number dropped by 33% in 2014. Ms. Sena emphasized the role of parents and community-based approaches in combating teen pregnancy and STI rates. The "Road Map for Success" developed by the community has five key strategies for Lea County:

1. make evidence-based, comprehensive sex education accessible to all young women and men;
2. identify and promote multiple places where teens can access information and resources about sexual health and contraceptive care;
3. encourage and assist adults to have safe and open conversations with youth about sexual health and healthy relationships;
4. develop programs that expand teens' educational and career goals; and
5. create a countywide coalition that will manage this comprehensive plan and track progress in achieving the goal of reducing the Lea County teen birth rate among 15- to 17-year-olds by 30% to a rate of 29 births per 1,000 by 2018-2019.

MyPower, Inc., requests funding for the DOH offices in Hobbs and Lovington to hire a full-time health care practitioner who focuses on reproductive health. Over the last several years, the local DOH office has gone from having a full-time provider to having a practitioner present only two days a month in Hobbs and one day a month in Lovington. Reinstatement of funding for comprehensive SBHCs is also requested.

Abigail Reese, program director, New Mexico Perinatal Collaborative, shared some of the ongoing programs for the collaborative. The collaborative has shared values of improving access to reproductive health, specifically contraception, for women and all people in New Mexico and leveraging resources to effectively expand access to LARC in appropriate and impactful ways. Ms. Reese noted the importance of provider education and training on non-coercive counseling and insertion and removal techniques in addition to administrative components related to billing, stocking and scheduling. The collaborative has had the ability to provide feedback about what is challenging for clinicians and providers in trying to provide LARC services. Ms. Reese recognized the important collaboration between the many members of the work group and state partners, such as the DOH. The collaborative is led by community,

policy and professional (clinical) expertise. Ms. Reese also acknowledged the participation of Young Women United.

Nancy Rodriguez, executive director, New Mexico Alliance for School-Based Health Care, shared a few facts about SBHCs. There are currently 70 SBHCs across the state, and the DOH contracts with and funds about 50 of those. School boards have the authority to make decisions on what is provided by SBHCs. Ms. Rodriguez stated that access to family planning will not exist if funding to SBHCs is cut and clinics are closed. SBHCs need General Fund money to operate. These clinics serve uninsured and undocumented children who do not qualify for Medicaid and insured youth who do not want their parents' health insurance billed for family planning services. Ms. Rodriguez told the committee that one SBHC in the southern part of the state had to absorb \$10,000 in one month for those who were either uninsured or did not want their parents' insurance to be billed. By closing these clinics and reducing funding, teen pregnancy rates are likely to increase.

Following the presentations from the panel, the committee had several comments and questions regarding:

- the lack of obstetricians and other women's health providers in parts of the state, particularly Lea County;
- a specific request that the DOH make a full-time provider of family planning services available in Lea County;
- prior authorization requirements under private insurance and Medicaid;
- the inability for SBHCs to bill insurance while protecting medical confidentiality;
- the need to address confidentiality and patient privacy in a broader context;
- cultural sensitivity and fears relating to usage of LARC;
- the lack of contraceptive options for males;
- ACA coverage for female contraceptives only;
- the need to ensure education for STI prevention as part of LARC efforts;
- ongoing studies to determine whether there is an association between LARC and the incidence of STIs;
- neonatal abstinence syndrome;
- a request that the LFC analyze potential cost savings associated with LARC and teen birth reduction;
- the process for a community to establish a Title X clinic;
- the need to encourage local school boards to approve providing family planning services in SBHCs; and
- the need for easy, teen-friendly access to contraceptive and reproductive health information.

Children, Youth and Families Department (CYFD) Update

Monique Jacobson, secretary, CYFD, addressed the committee with an update on CYFD programs and efforts to increase employee retention within the department. The CYFD is

working to improve the quality of life for all New Mexico children. The department is working hard to change the culture at the agency by creating attainable goals and helping to address employee safety. The notion of "be kind, respectful and responsive" is critical, along with accountability, in all aspects. Secretary Jacobson discussed the CYFD's four major divisions and current initiatives to increase retention of workers, increase quality of services and produce better outcomes for children (please see handout).

Protective Services Division. Secretary Jacobson stated that the nature of the job is very exhausting and emotionally draining on staff. The CYFD added 25% more field workers through nine "rapid hire" events, without decreasing quality of staff or hiring methods. The turnover rate for workers was decreased from 33% in fiscal year (FY) 2014 to 25.3% in FY 2016. Several safety measures were developed to ensure staff and field workers' safety. Secretary Jacobson detailed initiatives to reduce burnout for workers, improve outcomes, improve conditions for foster parents and improve placement stability and timely adoptions. The Protective Services Division is determined to reduce the amount of secondary trauma experienced by children as they come into the system. The CYFD is looking at areas where there are good outcomes and trying to replicate those practices in other areas. The Protective Services Division continues to bring in multiple providers and partners as part of expanding child advocacy centers.

Juvenile Justice Division. Since 2008, the CYFD has transformed New Mexico's juvenile justice system into one based on rehabilitation rather than punishment through its Cambiar initiative in secure facilities and a range of community-based programs. The CYFD continues to improve recruitment and retention efforts for the Juvenile Justice Division. The department has collaborated with the New Mexico Corrections Department Training Academy, modifying the curriculum to focus on foundational skills to ensure workers' success and improve safety with verbal de-escalation training. The CYFD found that many of its day-to-day operations policies and procedures were out of date; it is currently working to address this. Secretary Jacobson shared details about initiatives, such as life skills, to enhance programming for clients in facilities, as well as programming for clients in the field by enhancing transition services.

Early Childhood Services Division. Secretary Jacobson believes that child care is one of the single greatest tools available to prevent child abuse. Educational facilities are safe places for children, providing them an opportunity to get out of the house. Early childhood services also allows for parents to receive education, which helps to address some of the intergenerational problems the state faces. Home visiting is also a powerful prevention tool, providing access and information about services. It is critical to continue to balance quality and access in early childhood services. In response to complaints about additional costs to providers, the CYFD is working to increase incentives for quality services.

Behavioral Health Services Division. Initiatives within the Behavioral Health Services Division include efforts to improve the array of services, the quality of services and services to youth. Several statewide surveys were conducted to determine where service gaps exist. The CYFD is dedicated to treating children as more than just "a file"; employees are getting to know

them and are making them feel heard. Learning how to talk to children and giving them a seat at the table are critical. The department is not just saying it needs more services but, instead, taking note of what services are working well and expanding those.

Pull Together Campaign. Secretary Jacobson stressed that the Pull Together Campaign is not by any means a marketing campaign. The program seeks to address the fragmentation of the system by forcing groups that should be working together to start the conversation on how they can work together. Communities are driving these conversations, placing an emphasis on localization. The state agencies alone cannot be the answer to solving the issues facing New Mexico children; neighbors and communities need to be reminded of their responsibility for the well-being of children. Referring to the backpack program, Secretary Jacobson challenged legislators to promote the collection of backpacks in their districts. The backpack program, which entails filling backpacks with toys, snacks and supplies that are given to children entering protective custody, is meant to help children feel love and support as they enter into protective custody. She stressed the importance of making New Mexicans aware of the programs and resources available by simplifying how people are accessing resources.

Secretary Jacobson shared the legislative priorities for the CYFD during the upcoming legislative session. The list is similar to the objectives from the previous two legislative sessions. A top priority for the department is increasing the penalty for assaulting or battering a CYFD worker. Overall, Secretary Jacobson believes it is about holding people accountable.

Brian Hoffmeister, program evaluator, LFC, shared the LFC program evaluation for the effectiveness of juvenile justice facilities and community-based services in the state (please see handout). The CYFD's Juvenile Justice Division has three secure facilities, three reintegration centers, 14 juvenile probation districts and a total FY 2017 budget of \$73 million. Mr. Hoffmeister discussed the positive outcomes the Cambiar initiative has had, highlighting that juvenile recidivism rates have fallen. As the population in juvenile justice facilities decreases, the costs of juvenile commitment are rising. Facilities are operating with excess capacity, resulting in a higher cost per client. LFC staff identified up to \$1.2 million in potential unrealized savings from closing Lincoln Pines Youth Center. New Mexico juvenile facilities are showing improvement relative to national averages. Safety and incident tracking is still a concern in facilities; there are growing rates of incidents despite lower populations. Mr. Hoffmeister noted significant issues with data reliability that make community-based program effectiveness difficult. Only 46% of clients were discharged from juvenile community corrections successfully between FY 2013 and FY 2015.

Maria Griego, program evaluator, LFC, described the use of multisystemic therapy (MST) in the state. MST is an evidence-based treatment, funded through Medicaid, with a proven track record in reducing juvenile recidivism. The focus of MST is geared toward juveniles on probation. Provider availability issues have resulted in fewer clients receiving services. Ms. Griego shared a map that illustrated service gaps in areas around the state, noting that those are the areas that may benefit most from MST. It is important to understand drivers of juvenile

justice involvement, and the CYFD catalogues data from the juveniles with whom it works. An emerging topic is the concept of "crossover youth", who are children involved in the child welfare system at higher risk of entering the juvenile justice system. According to the CYFD, 46% of youth who recidivate within 12 months had a history of substantiated involvement with the Protective Services Division.

The LFC recommends that the legislature consider reducing the juvenile justice services budget by \$1.2 million to reflect declining facility populations. Cambiar works, Ms. Griego said, but as the population in detention decreases, there is opportunity to use more community-based programs. The LFC has several key recommendations for the CYFD, including: continuation of cohort-specific recidivism analysis with reporting to the legislature; evaluating the juvenile justice services budget and identifying opportunities to achieve efficiencies and cost reductions by reallocating resources and optimizing unused space; working with the HSD to identify MST providers and build teams in high-risk areas; and formalizing policy coordination between the Protective Services Division and Juvenile Justice Division for crossover youth.

Following the presentation, members of the committee discussed several aspects of the presentation. Some key points addressed were:

- the recommendation of identifying top probation violations for juveniles;
- questions regarding the percentage of youth successfully discharged;
- success rates of MST;
- the possibility of housing children's specialized and respite care under the CYFD;
- the percentage of children with special needs in foster care;
- the need for continuation of coordination with MCOs and expansion of wraparound services;
- funding needs for CYFD programs and spending existing funds on efficient programs;
- the use of provider report cards;
- overall vacancy and retention rates at the CYFD;
- the need for early intervention in schools;
- greater recognition and support for the role of foster families;
- inquiries about kinship guardians;
- the CYFD's role in pre-K efforts;
- the LFC recommendation to decrease juvenile justice services funding;
- an update on the CYFD's previous presentation (2015) seeking an emergency placement facility;
- a pilot project on protective services child care;
- the benefits of separating behavioral health into its own division;
- questions regarding the state contract with OptumHealth; and
- a request for a gap analysis.

Approval of Minutes

Upon review and a proper motion by the committee, the minutes from the July 25-29, 2016 meeting of the LHHS were approved unanimously.

Children's Court Improvement Commission Recommendation

The Honorable Petra Jimenez-Maes, senior justice, New Mexico Supreme Court, provided some background on the Children's Court in New Mexico. In 1995, the federal government became concerned with the increase in abuse and neglect cases in New Mexico. At the time, it was taking a long time for youth to get into foster care and released for adoption. The probation office was under the jurisdiction of the courts, and Children's Court cases were typically assigned to the newest judge. The assessment phase of the New Mexico Court Improvement Project (CIP) yielded data that informed the setting of the overall mission of the CIP as well as its initial strategies. The CIP's mission was achieving permanence, in a more timely, efficient and cost-effective manner, for children who have come into the care and custody of the state. Seven implementation strategies were initially adopted by the CIP, and a handout was provided detailing efforts and accomplishments to date. In 2009, the New Mexico Supreme Court ordered a commission of 20 court-appointed members to improve capacity and expand the scope of the CIP. The CIP was subsequently renamed as the New Mexico Children's Court Improvement Commission (CCIC).

With help from a federal grant, the New Mexico Children's Law Institute was founded. The institute is administered through a contract with New Mexico State University. This three-day program provides training for social workers and attorneys, who are able to earn credit in their respective fields. Currently, there is no specific training track offered for judges; however, the Annie E. Casey Foundation sponsors a lunch during the program that provides an opportunity for judges and foster children to interact. The youth are asked to share some of their experiences, and they are given a chance to discuss some of the changes they would like to see in the process. Because Children's Court cases are becoming increasingly complex, this initiative has been very helpful in providing additional training and support.

Justice Jimenez-Maes shared information about the new case management system implemented by the courts. The system, known as Odyssey, has helped to address some of the data entry issues. There are still some problems ensuring that accurate data are being entered. With use of grant funds, efforts are being made to work with information technology personnel to properly train clerks on the new system. Unfortunately, the grant funding will not be continued for training and maintenance of the new data system. The federal government wants New Mexico to achieve permanency for children within 15 months. The CCIC will be reporting back to the federal government about case disposition time lines at the end of October.

Ezra Spitzer, executive director, New Mexico Child Advocacy Networks, is a co-chair on the CCIC. The co-chairs have been looking at the structure of the commission, and their findings will be released within the next week. The CCIC has formed both juvenile justice and behavioral health subcommittees. Systems transitions in health care and schools were identified as

priorities. Mr. Spitzer noted that another issue was the implementation of the Child Welfare Act. Juvenile justice and protective services youth tend to have poor educational experiences. The CCIC is looking at how to get these children the stability they need to succeed in the future. Additionally, the CCIC is looking at the issue of crossover youth, opportunities for intervention and outcomes for children based on race and ethnicity.

Justice Jimenez-Maes added that she assigns specific judges to handle children's cases; these judges want to be involved with these cases. There are about 24 Children's Court judges who participate in various trainings. One recommendation from the CIP was to understand the needs of tribal members. A group of seven state court judges and seven tribal judges works together as part of a tribal consortium for Native American youth. The state needs to ensure that there is funding to cover costs for children and parent attorneys, including the cost of travel for clients in rural areas. Allowing attorneys to see children in their environments is a key component for making better determinations about their needs. Justice Jimenez-Maes stated that the courts and these support services are typically underfunded.

Paid Family Leave

Representative Armstrong presented on behalf of Representative Chasey, who will be sponsoring legislation creating the Caregiver Leave Act. Under this act, employees would be eligible to take paid family leave to care for themselves or a family member in the event of a serious health condition or to bond with a newborn. The act does not create any new benefits and would allow for a broad interpretation of leave policies beyond personal illness.

Pamelya P. Herndon, executive director, Southwest Women's Law Center, provided the recommendations of the Family-Friendly Workplace Task Force. House Memorial (HM) 2 was passed during the 2015 regular session to create a task force to study the benefits of bringing paid family leave to the state (please see handout). The task force met five times with a variety of different stakeholders. The cost of administering this employee contribution program would only be administrative and would likely become part of the Workforce Solutions Department.

Sarah Coffey, staff attorney, Southwest Women's Law Center, noted that the act would essentially bring what is allowed at the federal level to the state level. Currently, the federal Family and Medical Leave Act (FMLA) only applies to employers with 50 or more employees, and employees must meet various criteria to be eligible. Employees who do not qualify for FMLA job protection have no job protection during these circumstances. New Mexico has a rate higher than the national average for aging residents and special needs. Nearly one-half of all working adults, particularly women, in the state have provided care for a family member within the last five years. Additionally, 46% of women and 40% of men are also providing care to minor children while caring for a relative. Almost one-half of these caregivers have experienced some sort of work-life conflict, and 48% of caregivers reported losing income. Many other states are looking at creating paid family leave laws. New Mexico does not have any laws that protect an individual's job following childbirth or while the individual is caring for family.

Ms. Coffey explained the details of the proposal. Under this act, all private and government employers would be required to offer paid family leave regardless of the number of employees. All employees would be paying into the fund, and all employees would be eligible for paid family leave once they contribute a predetermined amount or a predetermined number of contributions to the fund. Employees would be reimbursed 67% of their average salary with a floor and cap. An employee's employment and health benefits would be protected while on paid family leave — this would be the only cost to the employer. The panelists highlighted some of the additional benefits of paid family leave. A program like this could help address New Mexico's ranking as forty-ninth in child well-being. Paid family leave reduces the likelihood for new parents to use public assistance. New Mexico families have limited access to child care for young infants; this is an additional strain for those who do not have other family to rely on for help during the first few months.

Members of the committee inquired about the following aspects of the presentation:

- consideration for employers with generous existing leave policies;
- opt-out potential for individuals who would not use the benefits of the program;
- similarities to disability insurance;
- the potential need for addressing an age requirement of six weeks for admission to a child care facility; and
- requests for more information about costs and logistics for implementation of the act.

TriCore Reference Laboratories (TRL)

John Anderson stated that TRL was founded in 1998 and currently employs 1,300 New Mexicans. TRL would like to host the committee at its facility during the 2017 interim. TRL has been a big success story for the state, according to Mr. Anderson. He mentioned that two of the presenters on the agenda are currently in Washington, D.C., discussing some of TRL's accomplishments with the federal Centers for Medicare and Medicaid Services (CMS).

Michael Crossey, M.D., chief medical officer, TRL, informed the committee that TRL does 98% of its testing in New Mexico. TRL is the largest laboratory in the state with the capacity to perform more than 2,000 different tests. Dr. Crossey stated that TRL has developed its information technology infrastructure to include 15 full-time employees who work to move information to the people who need it in a timely fashion. To him, it is frustrating to see information stuck in silos. Some of these issues relating to the sharing of medical information are regulatory, and legislation will be considered to address those impediments for the upcoming session. Dr. Crossey noted that there is a lot of information that currently exists that could be utilized for addressing some of the issues the state has with health care.

In response to some questions from the committee, Dr. Crossey stated that approximately 75% of TRL's data is interfaced with the New Mexico Health Information Exchange (NMHIE). There are some issues with the need for prior authorization for testing. TRL has a different model with high value that Dr. Crossey believes the health plans will be interested in purchasing.

A member asked about usage of electronic records. In response, Dr. Crossey stated that TRL is interfaced with 250 electronic medical records sources, making it a paperless entity. As part of the private sector, TRL is prohibited from using patient social security numbers for identifying patients. Patients have unique identification numbers, and all of their information is associated and stored as part of the electronic master patient index. The system can triangulate information to identify the correct patient, making it easier to access patient records. While no electronic system is foolproof, it is important to find a balance between total security and total lockdown of information. Paid consultants are typically hired to hack systems to identify vulnerabilities. Patients and medical professionals have very fast and efficient access to records. The committee was invited to take a tour of the facilities during the next interim.

Recess

The first day of the LHHS meeting recessed at 5:31 p.m.

Wednesday, October 26

Welcome and Introductions

Representative John L. Zimmerman, co-chair, Tobacco Settlement Revenue Oversight Committee (TSROC), welcomed everyone to the joint meeting of the LHHS and TSROC and asked members and staff to introduce themselves.

Tobacco Settlement Revenue Expenditures in New Mexico and in Other States

Ari Biernoff, assistant attorney general, provided a brief overview of the Master Settlement Agreement (MSA) signed in 1998 by New Mexico and 46 other states to resolve litigation with five major U.S. tobacco companies over the costs to states resulting from the use of tobacco products. The tobacco companies are referred to in the MSA as "participating manufacturers", or PMs. Pursuant to the MSA, annual payments to the states by the PMs are made in April of each year. The calculation of the annual amount payable to each state, which is made by an independent auditor, has several elements but is generally based on each state's share of national cigarette sales; the New Mexico market is around 0.6% of the national market.

At the time the MSA was executed, the PMs were the largest tobacco companies in the country. There are smaller tobacco companies that did not participate in the settlement, and these companies are referred to as "nonparticipating manufacturers", or NPMs. Upon signing the MSA, the PMs raised concerns that, because of the payments they had to make to the settling states, the NPMs would gain an unfair advantage in sales. This unfair advantage, the PMs argued, would lead to an increased market share for the NPMs and therefore a loss of market share to the PMs as an unintended result of the settlement. To address this concern, the MSA provided that the PMs' annual payments to the states could be reduced if it could be shown that the PMs had lost market share to the NPMs as a result of the settlement. These reductions are called "NPM adjustments". States could avoid the NPM adjustment by passing and "diligently" enforcing escrow statutes that would require NPMs operating in the state to either join the MSA and comply with its terms or to establish an escrow account and make regular payments into that

account to make up the difference between the NPMs' nonparticipation and the MSA payment burdens on PMs. While the principal is in escrow, NPMs collect the interest on the principal deposits and will recover 100% of the principal after 25 years.

The MSA allows the states and the PMs to challenge the calculations or determinations made by the independent auditor of the NPM adjustment. Most states' courts have decided that a dispute over a state's "diligent enforcement" is subject to arbitration. Challenges are initially resolved by arbitration, and the arbitration decisions may be appealed to state court, but the standard of review is very deferential to the arbitrators.

The PMs challenged New Mexico's diligent enforcement of the escrow statute for calendar year 2003. In 2013, an arbitration panel consisting of three retired judges decided that New Mexico had not diligently enforced the escrow requirements in 2003. As a result, the subsequent April payment was reduced significantly (around \$21 million versus the prior year amount of around \$39 million). The panel's decision also imposed additional liability on the state by including factors that reduced the payment beyond the formula established by the MSA. New Mexico immediately appealed the arbitrators' decision to the district court in Santa Fe, raising two issues: diligent enforcement; and the additional liability. The district court judge issued a decision in September 2016 that left intact the arbitrators' decision that the state had not diligently enforced the escrow requirements in 2003; the judge also vacated the arbitrators' imposition of additional liability because the court found that arbitrators had exceeded their authority by doing so. The court reversed the arbitrators' decision to apply extra penalties that will result in an additional payment to New Mexico of approximately \$9 million to \$12 million. The Attorney General's Office (AGO) has asked the independent auditor to recalculate the penalty in the 2003 decision and is confident that the next April payment will be adjusted upward. The payment is due to be received in April 2017 at the same time as the regular annual payment; the total payment is expected to be approximately \$48 million or more.

Mr. Biernoff explained that the role of the AGO in this case is to protect the payments due to New Mexico from the PMs. That money is initially deposited into the Tobacco Settlement Permanent Fund (TSPF). The AGO does not formally have a role in determining how the settlement money is to be expended. However, Mr. Biernoff commented that the animating goal of the tobacco lawsuit and the MSA is to compensate states for higher health care costs due to misleading claims by tobacco companies regarding the health effects of smoking. To that end, New Mexico law provides that tobacco settlement money be used for health and education programs.

A member asked which companies are not part of the MSA. Mr. Biernoff replied that they are companies that emerged after the MSA was entered into, and most of them are not household names. The only one based in New Mexico is Sandia Tobacco Manufacturers, Inc.; it is currently in bankruptcy. It is one of a dozen companies that emerged and had sales in New Mexico after the MSA was entered into. A member asked if American Spirit cigarettes is one of those companies' products. Mr. Biernoff replied that American Spirit is a product of Santa Fe

Natural Tobacco Company, which used to be based in Santa Fe but is now based in North Carolina and is now part of R.J. Reynolds, one of the largest cigarette manufacturers.

A member asked if New Mexico was indeed lax in enforcing the escrow provision. Mr. Biernoff explained that many of the companies in violation of the escrow provisions were "fly-by-night" companies based overseas, and their home countries often did not recognize U.S. jurisdiction. As a result, enforcing the escrow requirement was problematic. Escrow enforcement has improved considerably today as most NPMs are based in the U.S. and are generally compliant with their escrow obligations.

A member asked if it is believed that New Mexico is complying today, and Mr. Biernoff replied that New Mexico now has a better record of effective enforcement of the escrow provisions. Nonetheless, he expects the PMs to challenge the NPM adjustments every year because their potential for savings is worth the litigation expense for them.

A member asked how long the MSA payments are due to New Mexico, and Mr. Biernoff replied that the payments are in perpetuity.

A member asked if the MSA includes e-cigarettes, and Mr. Biernoff replied that it does not and that it also does not include cigars and most other tobacco products (except for RYO, roll-your-own tobacco, which is included). A member commented that the MSA provisions that reduced or eliminated marketing of cigarettes, especially to youth, were the most beneficial initiatives in the agreement, but they only apply to domestic sales. The MSA did not change the activities of tobacco companies in foreign countries.

Concerning the revenue distribution, a member asked if it was correct that 50% of the revenues received were distributed to health and education programs and 50% of revenues were deposited into the TSPF; Mr. Biernoff responded in the affirmative. Regarding the 2016 special legislative session, a member asked if the funds swept for solvency were from the TSPF and not program funds, and Mr. Biernoff responded in the affirmative.

A member commented that the purpose of the creation of the TSPF was to provide a "wealth fund" that would distribute earnings in a manner that the distributions would continue in perpetuity.

A member discussed the fiscal status of the TSPF and its role as part of the state operating reserve. A member commented that the pressure to use MSA payments to shore up the state operating reserve will have a negative impact on the UNM Health Sciences Center, which is a major recipient of tobacco funds.

In response to a member's question, Mr. Biernoff said that the precipitating event of the 2003 dispute between New Mexico and the tobacco companies concerned an estimated escrow

shortfall of approximately \$100,000, and this resulted in a loss of millions of dollars as a result of the 2003 NPM adjustment.

A member asked if the AGO had considered how the new arbitration proposals and possible bills in the U.S. Senate might affect challenges to payments. Mr. Biernoff said that the AGO is aware of the proposals in the U.S. Senate but that the MSA has its own arbitration provision that is unlikely to be affected by legislative changes. In 2003, New Mexico argued that the decision of the 2003 panel should have been heard in court. The MSA provides that the distribution calculation and disputes about the calculation must go to arbitration. New Mexico argued that the state's dispute was not over the computation or issues related to the calculation; rather, it was over what constitutes diligence in enforcement of the escrow requirements of the NPMs. New Mexico and most other states did not prevail in that argument, although Montana did.

A member asked how the Sandia Tobacco Manufacturers, Inc., bankruptcy impacts New Mexico's MSA payments. Mr. Biernoff replied that the bankruptcy does not directly affect New Mexico's MSA payments because Sandia is an NPM. However, the AGO has entered the bankruptcy proceeding to protect New Mexico's interests. A member asked how much money Sandia owes the state, and Mr. Biernoff replied that it was an amount in the thousands, not hundreds of thousands, of dollars.

A member asked what the expected payment is for New Mexico next year. Mr. Biernoff replied that it is estimated to be \$38 million to \$39 million for the regular annual payment, plus \$9 million to \$12 million for funds previously withheld since 2003 and ordered released to New Mexico as a result of the district court's ruling. A member asked if the tobacco companies will appeal the district court's decision, and Mr. Biernoff replied that he expects they will.

Winnable Battles: Tobacco Use Prevention and Control (TUPAC) Program and Other DOH Programs Funded from Tobacco Settlement Revenues

Benjamin Jacquez, TUPAC program manager, DOH, worked through his handout at Item (2), TUPAC Presentation 10.26.16. He highlighted Slide 19, which shows a 62% decline in youth smoking from 2003 to 2015; Slide 22, which shows a 19% decline in adult smoking from 2011 to 2015; and Slide 27, which shows a 42% decline in youth secondhand smoke exposure. Referring to Slide 28, Mr. Jacquez illustrated how TUPAC works with tribes around the state. Slide 32 shows that future health cost savings from the TUPAC program are estimated to be \$1.3 billion. Mr. Jacquez also provided other handouts that are posted on the website and included in the meeting file but that, in the interest of time, he did not address in the meeting.

A member asked what the target age is of the high school initiatives, and Mr. Jacquez replied that it is directed at all age groups. A member asked what was the effect of raising the legal age of smoking, and Mr. Jacquez replied that it reduces the prevalence of smoking. A member asked if anyone has looked at making e-cigarette use restricted to adults and asked if the TUPAC program would support that. Mr. Jacquez replied that the TUPAC program cannot

recommend the use of e-cigarette products since it is not known what is in them. A member asked if the DOH recommended to the governor to raise cigarette taxes. Mr. Jacquez replied no; however, it is recognized by the CDC as a best practice for reducing the incidence of smoking. Raising cigarette taxes is not a policy recommendation of the DOH. A member asked if the CDC has a recommendation on the price point for cigarette prices, and Mr. Jacquez responded that it does not. A member commented that smokeless tobacco also has an effect on health. Mr. Jacquez responded that the DOH is also focusing on smokeless tobacco and promoting tobacco-free rodeos.

Daniel Burke, chief, Infectious Disease Bureau, DOH, explained his handout to the committees. Regarding Item (2), NMDOH Harm Reduction 10.26.16, Mr. Burke described the DOH's HIV, sexually transmitted disease and hepatitis program activities that are funded with tobacco settlement funds. Mr. Burke reported that New Mexico has the highest incidence of liver disease deaths in the United States, at 400 cases per 100,000. Most of these deaths are attributable to hepatitis C infection, he explained. New Mexico also has the largest needle exchange program in the United States, which aims to reduce transmission of infectious diseases through the avoidance of needle-sharing. Mr. Burke emphasized that funding from the tobacco settlement revenues is essential to the Harm Reduction Program and Hepatitis Program because neither program has any federal funding for contractual services.

Beth Pinkerton, manager, Breast and Cervical Cancer Early Detection Program (BCC), DOH, addressed the items in her handout. Item (2), NMDOH BCC Presentation 10.26.16, described the BCC. The program was established in 1991 and uses a statewide network of contract providers. Approximately 81,000 women in New Mexico are eligible for free BCC screening. In FY 2016, the program received \$128,600 and screened 876 women, but the program's fund is sufficient to serve only 15% to 20% of the eligible population. Ms. Pinkerton reported that 100% of tobacco settlement revenue funds appropriated for the BCC are used for direct client services and contribute to making the required funding match for a federal grant.

Judith Gabriele, manager, Diabetes Prevention and Control Program (DPCP), DOH, working through her handout at Item (2), Final DPCP TSROC Committee Presentation 10.26.16, described the program. Ms. Gabriele noted that only one out of four adults in New Mexico with pre-diabetes knows it, and four out of five adults with diabetes know it. In 2012, the estimated cost for adults with diabetes and pre-diabetes was \$2.1 billion. Ms. Gabriele noted the positive correlation between smoking and diabetes. The DPCP is funded with a combination of federal, state general and tobacco settlement funds; the tobacco settlement funds comprised 45% of the budget at \$748,000 in FY 2016.

A member noted that the Harm Reduction Program and Hepatitis Program tobacco settlement revenue funding request for FY 2018 is \$150,000 more than it received in FY 2017 and asked if this request will be coming to the LFC as part of the FY 2018 budget request. Cathy Roche, deputy director, Public Health Division, DOH, replied that she would confer with Secretary-Designate of Health Lynn Gallagher and follow up with an answer for the committees.

A member asked if the DOH is working with the Corrections Department (NMCD) on treatment of hepatitis C. Mr. Burke replied that the DOH is working independently with the UNM School of Medicine's Extension for Community Healthcare Outcomes or "Project ECHO". Per his understanding, the NMCD is also working with Project ECHO. He commented that the numbers of inmates with hepatitis C and costs for treating them are staggeringly high.

A member asked if the recent tuberculosis (TB) cases in Santa Fe County are under control. Mr. Burke replied that TB is an old enemy to humankind and is the largest killer in the world. There are only 50 cases per year in New Mexico. He said that the DOH has a great TB program, but more nurses are needed. Currently, there are four active TB cases in the Santa Fe area, but there are no public health nurses in Santa Fe, so the department has assigned public health nurses from Espanola to care for the TB patients in Santa Fe. A member asked if the nursing positions have gone away, and Mr. Burke replied in the negative and said that it is partly a budget issue, but mostly it is a staffing availability issue. A member asked if higher pay could attract the skilled people needed. Ms. Rocke replied that the department advertises the position in Santa Fe and receives only one or two applications, and when the discussion turns to salary, the applicant often withdraws because the medical industry is very competitive and the salary the state is able to offer is not comparable to the private sector.

A member asked how the DOH provides data on infectious diseases, and Mr. Burke replied that the Indicator Based Information System for Public Health Data Resource, or "IBIS", is an online database available to the public on the DOH's website. The public can also call and information will be provided.

Regarding the data on Slide 5 of the BCC presentation, a member noted that the numbers have not changed much and asked why. Ms. Pinkerton replied that there is very low variability in the costs and the type of screening. A member asked, if the budget is increased, can more women be served, and the member commented that current research is showing false positives in mammogram screenings and inquired if the DOH is also experiencing this. Ms. Pinkerton replied that the department is following the false positive studies carefully. She replied that the DOH follows national guidelines and educates patients on the benefits of screening.

A member commented that the BCC screening programs need more funding. A member asked if many people are falling through the cracks on BCC screening, and Ms. Pinkerton replied that there is still a need for screening services. Areas in need of improvement are serving the underinsured and uninsured; persons who have high co-pays and deductibles often are not getting follow-up exams if there is something unusual detected in the initial exam.

A member asked whether gene testing is part of the BCC screening, and Ms. Pinkerton replied that it is not at this time.

A member asked if the DOH has any data that link tobacco use to breast and cervical cancer. Ms. Pinkerton replied that in 2014, the U.S. surgeon general issued a report confirming

the link between tobacco use and breast and cervical cancer; the DOH can provide more information to the committees in the future. A member asked the panel to identify specific areas that do not have web access to implement the DCPC.

Regarding diabetes, a member asked whether a sugar consumption relationship to diabetes exists and whether the DPCP includes education on sugar consumption. Ms. Gabriele replied that the primary risk factor is obesity. She said that whether sugar causes diabetes is a complicated issue. She continued that weight, physical activity and caloric consumption are the three factors that are typically studied in determining a person's risk for having or getting diabetes. A member commented that program participation seems low and asked what the agency or legislature can do to increase participation. Ms. Gabriele replied that there are challenges in building up the program infrastructure statewide. The first delivery site in the country was in Chaves County, and the program may be dropped because of the difficulties in operating the program there. Ms. Gabriele expects that when the federal Medicare program begins to pay for diabetes programs in January 2018, participation is expected to go up significantly. She reported that Medicaid and Molina Healthcare of New Mexico already pay for participation in the program. Ms. Gabriele said that at the end of the fiscal year, the DOH will engage all of the stakeholders to work to increase participation in the program.

A member commented that it is frustrating to committee members that the presenters cannot ask the committees for funding though they come before the committees with a funding need. Another member commented that the current hearing is about the use of appropriations from the tobacco settlement funds, not about the operating budget needs.

Centennial Care Tobacco Prevention and Cessation Services

Ms. Pfeffer, working through her handout at Item (3), reported that in FY 2016, Medicaid received \$30,019,700 from the Tobacco Settlement Program Fund, and in FY 2017, \$27,319,300 was appropriated for Medicaid from the Tobacco Settlement Program Fund. The funds are expended for breast and cervical cancer treatment and for other Medicaid programs, including smoking cessation programs. The smoking cessation services are provided under contracts with four MCOs.

A member asked whether the Medicaid MCOs are incentivized to implement smoking cessation programs, given that they make more money if someone gets sick. Ms. Pfeffer said the MCOs have been cooperative in developing and providing prevention and cessation programs.

A member asked whether, if a patient was not enrolled in Medicaid at the time the patient received BCC screening and breast cancer was detected, would the patient be eligible for Medicaid and have cancer treatments paid for by Medicaid. Ms. Pfeffer replied that the treatments would be paid for under the breast and cervical cancer category only if the patient were screened by the DOH if that patient were otherwise eligible for Medicaid under more generous income eligibility guidelines. Otherwise, the patient may qualify under the normal

Medicaid expansion or family Medicaid. If the patient's income were too high for Medicaid, the patient might be covered under a quality health plan through the exchange.

A member asked whether the HSD had smoking cessation screening requirements in the contracts between the HSD and the MCOs. Ms. Pfeffer replied that the HSD does not at this time, but these requirements are being considered in discussions with the providers. A member asked if there are data on the success of the smoking cessation programs, and Ms. Pfeffer replied that the performance tracking initiative with the MCOs will begin to provide data on effectiveness.

Tobacco Prevention, Cessation and Regulation Legislation

Representative Armstrong presented two draft bills for discussion and said that she was not seeking endorsement at this time. The first bill proposed raising the age limit to legally access tobacco products to 21. The second bill raises the cigarette tax by 10%.

In support of the proposal to raise the age limit for legal access to tobacco products, Representative Armstrong said that the use of flavored tobacco products is rising, particularly among young people. Some states have restricted the sales of flavored tobacco products, she explained. An across-the-board raise of the legal age to purchase tobacco products would address the sale of flavored as well as other tobacco products. She noted that 90% of adult smokers started smoking before age 19.

In response to questions by a member, Representative Armstrong said that one state, Hawaii, set the legal age for purchasing tobacco products at 21 in January 2016; Alabama, Alaska, New Jersey and Utah set the age at 19; and the remaining states either have set the age at 18 or have no age limits.

Members discussed the penalties for underage smoking and enforcement.

In support of the proposal to raise the cigarette tax, Representative Armstrong said that 10% is the lowest cigarette tax raise that should be considered, but studies show that the higher the tax, the less the use, and she would prefer to see the tax increased 35% to 45%.

Members discussed the effects of increases in taxes on cigarettes on smoking reduction and cessation and possible uses for increased revenue from the cigarette tax.

Members generally expressed support for both measures.

New Mexico Allied Council on Tobacco (ACT) — Tobacco Prevention Coalition

Janna Vallo, commercial tobacco control and prevention coordinator, Albuquerque Area Southwest Tribal Epidemiology Center (AASTECC), introduced herself and Laurel McCloskey, executive director, Chronic Disease Prevention Council, and Lacey Daniell, New Mexico grassroots manager, American Cancer Society Cancer Action Network.

Ms. McCloskey, Ms. Daniell and Ms. Vallo, working through the handout at Item (5), related that the Chronic Disease Prevention Council was established in 1997 and partnered with the AASTEC and other community members, health organizations and business professionals to create the ACT, a coalition that advocates for proven tobacco use prevention strategies through statewide partnerships. Ms. Daniell highlighted that tobacco use costs \$1.44 billion annually in New Mexico, which translates to a per-household state and federal tax burden from smoking-caused expenditures of \$945 per year. The members of the ACT work together to support proven measures to reduce tobacco-related disease and death and associated costs, including regular, significant increases in the price of tobacco, smoke-free workplaces and public places and comprehensive tobacco prevention and cessation programs.

In response to a member's question, Ms. Daniell was very complimentary of the TUPAC program's efforts, calling the program the "experts" in youth tobacco use prevention and cessation.

A member asked what the ACT thinks of the proposed legislation to raise the cigarette tax. Ms. Daniell replied that the CDC recommends raising the price per pack by at least \$1.00 in order to impact the incidence level of smoking, noting that tobacco companies often issue discount coupons to users to neutralize the costs of increased taxes.

Update on Tobacco Cessation Programs Funded Through the Indian Affairs Department (IAD)

Suzette Shije, deputy secretary, IAD, explained that in July 2008, the IAD received its first allocation from the tobacco settlement funds, allowing the establishment in early 2009 of a competitive grant system to fund tribal commercial tobacco prevention and cessation programs, with special emphasis on Native American youth, while recognizing the traditional ceremonial role of tobacco use. Deputy Secretary Shije noted other tribal efforts to encourage prevention and cessation of commercial tobacco use, particularly that the Navajo Housing Authority, the largest tribal housing authority with more than 10,000 units, is currently considering making all housing units smoke-free.

Deputy Secretary Shije introduced Allie Moore, project manager, IAD, who described the development of the grant program and summarized the various tribal tobacco prevention and cessation programs, referring to the handouts at Item (6). Ms. Moore reported that outcomes of the program funding and programs include: funding 10 programs in 10 pueblos, tribes and nations; creating six part-time jobs; generating \$70,000 of in-kind contributions from grantees; reaching 43% of tribal communities; and engaging more than 8,275 Native American youth and adults. Ms. Moore added that the New Mexico Behavioral Risk Factor Surveillance System estimates a 20% decline in the smoking rate between 2011 and 2015. Between 2003 and 2015, the New Mexico Youth Risk and Resiliency Survey estimates that smoking among American Indian high school youth in New Mexico has declined 63%.

Deputy Secretary Shije testified that the Mescalero Apache Tribe is the first tribe in the country to submit to FDA compliance inspections for growing tobacco. She introduced Willymae Smith-McNeal, program coordinator, Mescalero Apache tribal tobacco cessation and prevention program. Ms. Smith-McNeal, referring to her handout at Item (6), explained the Mescalero recognition of traditional ceremonial uses of tobacco as distinct from commercial personal uses, and she described the parallel development of the commercial tobacco prevention and cessation program and introduction of growing tobacco for ceremonial purposes. She showed members a number of visual aids and games she uses in the tobacco prevention and cessation program; her handout includes a number of examples of student-made posters.

Approval of TSROC Minutes

The TSROC approved the minutes of its September 26, 2016 meeting with no amendments.

Public Comment

Cynthia Serna, former director of New Mexicans Concerned about Tobacco and current grassroots organizer of the American Cancer Society Cancer Action Network, noted that when funding for tobacco prevention and cessation programs is cut, tobacco use increases almost immediately. She urged the legislature to support continuation of funding for programs.

Nat Dean, traumatic brain injury survivor, provided the committees with a brochure from the Disability Advisory Group About Tobacco (DAGAT) New Mexico. Ms. Dean requested that funding for the DAGAT remain intact. She also addressed the importance of the legal availability of medical marijuana and stated that, as a medical cannabis patient for seven years, she has been able to reduce her number of medications from 27 to six.

Lisa Rossignol spoke as a health policy advocate for getting children with autism into Centennial Care coverage. She noted that Centennial Care has cut services, particularly respite care services, to families with children with special health care needs, and she urged legislators to reinstate and protect that funding.

Mary Beresford, DAGAT director, reported that disabled people have a very high rate of smoking, so access to cessation programs is vital to their overall health.

Long-Term Leveraging Medicaid Subcommittee (LTLMS) Recommendations

Angela Medrano, deputy director, MAD, HSD, introduced Carol Luna-Anderson, executive director, the Life Link, and chair, LTLMS, and Nick Estes, member, LTLMS, and member, board of directors, Health Action New Mexico (HANM).

Ms. Luna-Anderson, referring to her handout at Item (8), summarized the LTLMS' eight formal recommendations. Included among the recommendations is a recommendation that the state assess a provider fee or tax that would be used for enhancing Medicaid provider reimbursements through application of a larger federal medical assistance percentage (FMAP).

Mr. Estes told the committees that provider taxation is regulated by federal law and advised proceeding with expert help. With two exceptions (New Mexico and Alaska), every state and the District of Columbia use provider taxes. Alaska is considering provider fees as well. Under these states' laws, a certain "class" of health care providers that receive Medicaid reimbursement is charged a fee, and they generally recover the amount paid through enhanced Medicaid reimbursement. Yet "you cannot guarantee that they will be held harmless", Mr. Estes warned. He stated that the LFC is aware of this concept, as are other agencies in the state.

A member asked whether HANM's handout provides merely an example of the sort of provider fee that could be imposed. Mr. Estes answered that indeed it does, and that the fee would be charged on those services that would garner increased FMAP.

When asked what Secretary of Human Services Brent Earnest's and the governor's reactions were to the LTLMS' recommendations, Ms. Medrano told the committees that Secretary Earnest was reviewing the recommendations and that she did not know of a response from the governor.

A member discussed the role of the New Mexico Medical Insurance Pool, and how it protects the state's private insurance risk pool from incurring extensive losses that would result in greater premium increases for the private health insurance market.

A member asked the panel which of the LTLMS' recommendations were made by unanimous vote of the LTLMS members. Ms. Luna-Anderson answered that the provider tax recommendation was made unanimously. At the member's request, she went on to review other recommendations as follows.

- Recommendation number two on the LTLMS' recommendations listed in the handout was also unanimous, pursuant to which the HSD would work to leverage federal funds through waivers, intergovernmental transfers and Medicare pilot projects. Mr. Estes mentioned that Rio Arriba County Department of Health and Human Services Director Lauren Reichelt was eager to access more funds through such matching funds.
- Recommendation number four related to value-based purchasing by MCOs. Deputy Secretary Medrano said that the HSD is implementing new reimbursement methodologies. One FQHC had a contract pursuant to which the center bears the risk for caring for specific populations. MCOs have been directed to use 16% of their capitated rates for value-based purchasing, according to Deputy Secretary Medrano.
- Recommendation number seven related to home visiting funded through the state's Medicaid program in order to enhance funding through the Medicaid FMAP. Deputy Secretary Medrano stated that the CYFD model of home visiting is not a medical model, and hence, not likely eligible for Medicaid reimbursement. In response, a member stated that 81% of babies statewide are born to mothers enrolled in Medicaid. The member proposed that the HSD seek a waiver of the "medical services"

requirement as home visiting services are for prevention of future medical and social costs.

- A member stated that the member wants recommendation number seven to be "seriously considered".
- A member inquired whether there are any Medicaid co-payments designed to change behaviors and promote more responsibility for health. Deputy Secretary Medrano stated that no formal recommendations came from the LTLMS in this regard. The General Appropriation Act of 2016, however, does require that some cost-sharing be imposed. The CMS would have to approve such an arrangement. Some states have successfully imposed co-payments. Another member stated a belief that the administrative burden and cost of collecting the co-payments become a burden on providers. Also, it may result in Medicaid recipients avoiding care that could prove more costly in terms of their health and their burden to the Medicaid budget. Some insurers, the member noted, have removed co-payments where prevention will save on later costs. Another member noted a discussion of this in the latest LFC newsletter at page 1.

Recess

The meeting recessed at 4:41 p.m.

Thursday, October 27

Welcome and Introductions

Legislators from the LHHS and Courts, Corrections and Justice Committee and staff introduced themselves.

Corrections Health Care: Report of the Corrections Health Care Task Force; Federal Prison Rape Elimination Act of 2013 (PREA)

Maria Martinez Sanchez, staff attorney, ACLU-NM, told the committees that the ACLU-NM receives 70 complaints from New Mexico prisoners each month and that 10% to 20% of those complaints are regarding failures of the prison health system. Ms. Martinez Sanchez said the complaints include neglect in diabetes, cancer and hepatitis C care; untreated broken bones, hernias and kidney stones; dental neglect; and psychiatric medications not being provided.

Ms. Martinez Sanchez stated that she sees a pattern of neglect that violates the Eighth Amendment to the United States Constitution's prohibition on cruel and unusual punishment. She said that the State of New Mexico jails a lot of people but then fails to care for them. In addition, Ms. Martinez Sanchez said that preventative care would save the state money and that the state is opening itself up to liability in its substandard medical care of inmates.

To close, Ms. Martinez Sanchez said that the ACLU-NM wants to be included in the task force created pursuant to Senate Memorial 132 (2015). Without a prisoner health advocate, she said, the task force would be incomplete.

Jody Neal-Post, attorney at law, discussed the difficulties some of her clients faced in receiving health care while incarcerated. There were challenges with missed appointments, shackling on limbs despite a medical prohibition and failure to finalize recommended medical parole by the Parole Board. Ms. Neal-Post highlighted the fact that despite attempts by the NMCD to secure an inmate's medical parole, the Parole Board would not grant it. She urged the committees and the task force to change the statutory guidelines for parole boards to ameliorate the problem. Ms. Neal-Post said that the state faces unnecessary exposure to liability based on a failure to provide adequate health care to inmates. She said that when inmate health care is more compassionate and humane, it is also cheaper. She said that she wants to see the task force continue and to have inmates participate on the task force, as everyone wants to be part of their own health care.

Matthew Coyte, Coyte Law, P.C., said that he gets about 20 inmate requests for help per week. He said that from a legal standpoint, these are difficult cases to win because there is a required showing of deliberate indifference of the prison as a health care provider. As long as the prison doctor gives the inmate Ibuprofen or Tylenol, the prison is immunized from lawsuits. Of course, cases can still be filed alleging negligence and malpractice against the doctor, but those cases are almost never filed. He said that he understands that the prisons are in a difficult situation, too. A lack of funding has led to understaffing, which only aggravates the situation.

Mr. Coyte said that the new contract for inmate health care prioritizes fiscal responsibility over medical care, as evidenced by there being limited medical oversight over the contract, but significant financial oversight.

Wendy Price, Psy.D., chief, Behavioral Health Bureau, NMCD, told the committees that she led the task force created pursuant to Senate Memorial 132 and went over the various issues discussed by the task force. The top maladies faced by inmates are hepatitis C, HIV and psychological disorders. She said that there are challenges to care, but that inmates are educated as to how they can request treatment.

Jillian Shane, PREA coordinator, NMCD, stated that 11 adult prisons and two community jails in the state all passed the PREA audit.

Steve Jenison, M.D., said that he oversaw HIV treatment in all New Mexico prisons, which meant visiting each facility at least every three months and having a state public health nurse involved to ensure continuity of care for each patient.

Questions from members of the committees and the ensuing discussion focused on hepatitis C treatment, including Section 340B of the federal Public Health Service Act discounted drug pricing eligibility; medical oversight at the NMCD; the task force; and the new contract between the NMCD and Centurion.

Members and presenters agreed that hepatitis C treatment under UNM's Project ECHO program has been very effective. In the last year, there were 65 to 70 inmates treated for hepatitis C, which represents a big jump. While this may seem like a low number, with 58% of the state's inmates having hepatitis C, most states only treat about 1% of their inmates with hepatitis C. The biggest hurdle to treatment is the high cost, which is \$90,000 to deliver a 12-week course of hepatitis C treatment to one person. Under the deeply discounted pharmaceutical pricing available pursuant to Section 340B, the cost would be half that.

Alex Sanchez, deputy secretary, NMCD, said that 340B eligibility has a number of requirements, and the state fails to qualify, but it is written into the contract with Centurion that vendors will still seek it. A member mentioned a federally funded health provider in Albuquerque that would qualify for 340B pricing and said that the NMCD should partner with the provider. According to information received by another legislator, 340B pricing was actually discontinued at the recommendation of an NMCD medical director who no longer works for the state. That medical director sought pharmaceutical savings through the NMCD's contract with Corizon Correctional Healthcare.

A legislator asked how the NMCD decides who are among the 1% of inmates who are treated for hepatitis C. Deputy Secretary Sanchez said that the NMCD has a process for assessing whether an inmate would compromise treatment with intravenous needle usage or if the inmate has another condition that would have an impact on the viability of the treatment. When selecting an inmate for treatment, the NMCD contacts Project ECHO. Deputy Secretary Sanchez said that, though not all patients receive this expensive course of medicine, all patients receive, at a minimum, the care that an indigent patient would receive on the outside. A legislator said that Project ECHO is a "game changer", but the state cannot expect the same level of delivery if it is underfunded.

Regarding medical oversight of those incarcerated at NMCD facilities, Deputy Secretary Sanchez said that there is a medical director, Dr. Boynton, and Health Services Director Angela Martinez, who is in charge of the auditing and medical care. Upon questioning, Deputy Secretary Sanchez stated that Dr. Boynton is not employed by the NMCD but is in fact the Centurion medical director. There is no medical director employed by the NMCD. Some legislators expressed concern that the health services director for the NMCD is not a medical professional as has occurred in the past.

Discussing the Corrections Health Care Task Force, members asked if the right people were on the task force and if there were an opportunity for members and nonmembers to be heard. Legislators voiced concerns when Dr. Price explained that, though it was being finalized for awhile, a draft report of the task force's findings was only sent out the day before for members of the task force to review. A legislator said that it is difficult to assess the task force's work when information is provided at the last minute.

Ms. Martinez Sanchez said that the ACLU-NM got a late invitation to join the task force, and after being assured that the director of the ACLU-NM could call in to participate in the meeting, the videoconferencing technology was a consistent obstacle to his ability to join in. Deputy Secretary Sanchez alleged that the director of the ACLU-NM attended four out of the five task force meetings.

In response to a question, Deputy Secretary Sanchez said that among the task force's recommendations, there is no recommendation that the task force continue. Legislators requested copies of those recommendations, that the task force continue its work and that it include more advocacy groups. Members said that a reason for the task force to continue is that it provides ongoing progress reports to the legislature.

Regarding the contract with Centurion, which went into effect on June 1, 2016, Deputy Secretary Sanchez said that there are actually two contracts, one for \$41 million for health care and one not to exceed \$11 million for pharmaceuticals. She said that the company does recruit within the state for staff and that, for the most part, the staff will remain the same. The improvement, she said, will happen in the required performance measures. A live dashboard is the centerpiece of that and is the key to real-time assessment.

Deputy Secretary Sanchez said that the dashboard will provide, on request, a real-time update on inmate information. Deputy Secretary Sanchez said that officers do not enter information into the dashboard; it is the vendor's responsibility. Members of the committees expressed concern that requested care by the inmates is not being provided and asked that the dashboard reflect that in an effort to improve care.

To close, a legislator suggested that the NMCD seek offset funding from the Indian Health Service to the extent that the NMCD provides health care to Native American inmates.

Corrections Medicaid Enrollment and Suspension

Kari Armijo, deputy director, MAD, HSD, discussed how the HSD is rolling out its program to ensure that Medicaid-eligible inmates have timely access to post-release health care (see handout). Deputy Director Armijo highlighted the impact of information technology and regulatory changes, the counties and agencies currently participating and the pilot program between the Bernalillo County Metropolitan Detention Center (MDC) and Molina Healthcare.

Deputy Director Armijo said that the HSD is working with more counties than are identified in the handout, but those not mentioned are still a work in progress. She said that there are still some delays with the daily sharing of information, but the process is automated. Another benefit is that over one-half of the inmates are actively engaged in their post-release health care coordination, and this drives down recidivism.

Jerry Roark, director, Adult Prison Division, NMCD, said that the NMCD has started signing up inmates for Medicaid 60 days before their release and have reached a 90% sign-up rate.

Gabriel Nims, special projects coordinator, MDC, said that the MDC accounts for the lion's share of the county budget, some \$75 million to \$80 million a year, and it is realized how important it is to be fiscally responsible and good custodians of that money.

Mr. Nims said that the MDC used to have a passive enrollment system, according to which the MDC waited until a Medicaid-eligible inmate requested it and even then it would hold the inmate's application for Medicaid until that person's release date. Now, MDC staff is approaching those inmates who qualify, helping them to fill out the application and then sending the applications for processing earlier. In response to a question, Mr. Nims said that inmates can still refuse to enroll, but that is rare. Mr. Nims said that the first 72 hours after release is the most important for recidivism, so any delay in continuity of health care can have an impact.

Currently, the Medicaid enrollment pilot project is ongoing only with Molina Healthcare, one of the four Medicaid MCOs, but other MCOs are watching closely. In fact, the MDC/Molina Project is generating interest by Seattle-King County officials in the State of Washington.

Mr. Nims closed by discussing a proposed reentry resource center, which would include a rest area if an inmate is released at night. The center would be staffed with case managers to connect newly released inmates to available social services. He said that these efforts improve the system and have a positive financial impact.

Solitary Confinement and Custodial Segregation

Mr. Coyte said that whatever one calls it — administrative segregation, administrative housing, protective custody, solitary confinement — these are a lot of names to explain a deprivation of meaningful human contact, where a person is kept in a room for 23 hours a day on weekdays and 24 hours on weekends. Mr. Coyte said that while solitary confinement is banned in many states and New Mexico has paid out million-dollar judgments to people wrongly held in solitary, the state has not passed laws to stop solitary confinement.

Mr. Coyte highlighted the fact that inmates with a mental health diagnosis are not officially allowed to be in solitary confinement, but they should be in an alternative placement area. Despite that, he said, in New Mexico, those inmates are still being put in solitary confinement.

Stuart Grassian, M.D., appearing via videoconferencing, told members that restricted environmental stimulation is toxic to anyone and that inadequate exposure to stimulation, internal or external, results in stupor. Dr. Grassian discussed the history of solitary confinement, from an innovative criminal justice incarceration technique to significant limitation of its use because it was long ago found not to foster reform and to seriously and detrimentally impact

prisoners' mental well-being. In fact, he said, the toxic effect has been known for so long, it is absurd that it is still in use.

Dr. Grassian said the arguments in support of solitary confinement are based on prisoners making rational decisions about how to act to avoid solitary confinement, but this situation rarely plays out where the decisions made by the inmate that resulted in solitary confinement are rationally made. This is especially pernicious in light of the fact that 75% of prison beds are occupied by people whose initial offense can be tied to mental illness. A member agreed and said that inmates with traumatic brain injury often have diminished impulse control, which could cause the exact behavior that lands a person in solitary confinement.

Dr. Grassian said that inmates with impaired cognitive ability do terribly in solitary confinement. He said that the worst thing for people with posttraumatic stress disorder is to put them in a situation that they cannot control, and that is what solitary confinement is all about.

A legislator asked if inmates in solitary confinement can receive visitors and why the 23 hours of confinement is de rigueur. Mr. Coyte said that visitation rights depend on the facility and on the level of the prisoner. The 23-hour rule, according to Mr. Coyte, comes from a dictum in a legal case where the judge wrote, "Well, at least they should get an hour a day outside". Now, for whatever reason, that has been incorporated into the solitary confinement practice of many prisons and jails.

To illustrate the deleterious effects of solitary confinement, he cited the example of a once-healthy young man who was picked up for traffic tickets, placed in solitary confinement and came out with a severe mental illness. While held in solitary confinement, the young man was kept naked and forced to defecate in a hole in the floor.

A 54-year-old woman had severe postpartum depression in her twenties, according to Mr. Coyte. She later became severely mentally ill after being held by Valencia County in solitary confinement, where she had to sleep near a hole in a damp floor. For posttraumatic stress disorder and other complaints, she was awarded a \$1.6 million settlement with Valencia County.

Mr. Coyte described the case of a man who was held in Carlsbad in a tiny cell, naked, where he had to endure lights left on 24 hours a day and sleep by a drain into which he was forced to push his feces, which would later bubble up through the drain. He was kept in cold temperatures, with no water with which to wash. He was never released for exercise. "Why do we do this?", Mr. Coyte asked. There needs to be a law that bans these practices, he stated. In 1998, West Virginia banned solitary confinement for juveniles. Mr. Coyte stated that he is currently suing Curry County for use of solitary confinement on juveniles there.

In response to a question about tests that show the different effects of solitary confinement and additional punishment, i.e., leaving the lights on for 24 hours or removing all furniture or the inmate's clothes from the room or the inmate's clothes, Steve Allen, director of

public policy, ACLU-NM, said that most prisons and jails do not collect good data on whom they put in solitary, so no such tests exist. The little data that are collected, Mr. Allen said, are not useful for comparison because each facility collects different information. In the past, house and senate bills were introduced in New Mexico that would have required prisons and jails to collect information on solitary confinement in a uniform way. Those bills did not pass. Colorado, he explained, took a data-driven approach and requires uniform data collection. This has resulted in a drastic decrease in the use of solitary confinement. During their 2017 legislative sessions, Idaho, Maine and Texas are going to consider laws using a data-driven approach to solitary confinement.

Mr. Allen said that other research has shown that there is no good reason for the use of solitary confinement on minors, the mentally ill or anyone for more than 15 days. He said that Colorado is the national leader in improving techniques for the use of solitary confinement.

Grace Philips, general counsel, New Mexico Association of Counties, said that there are correctional facilities in 27 of the 33 counties in the state and far fewer facilities for juvenile inmates, which means that juvenile offenders are often incarcerated farther from home. She stated that New Mexico has a much higher incarceration rate than do other states. One-third of those incarcerated in county jails are in for failure to comply reasons, including probation violations, parole violations and warrants. Housing of probation violators alone cost counties \$35.8 million in FY 2016. County jails also hold many people who live with mental illness. On average, 2,557 inmates a day in New Mexico county jails have a diagnosed serious mental illness.

Ms. Philips said that when the legislature seeks harsher criminal penalties, especially in times of financial hardship, longer sentences mean a bigger cost to the taxpayer. She also said that jails and prisons are de facto mental health hospitals and posited that there are more people in jail taking psychotropic medicine than there are in mental health facilities and more county detention staff than clinicians treating the mentally ill.

To close, Ms. Philips said that in her experience, families do not typically bond out the mentally ill, as those families often use the jail as a safe way to remove a person from the home.

Pablo Sedillo, director, Public Safety Department, Santa Fe County, highlighted the county's efforts to handle the mentally ill. All of the county's public safety officers and first responders have crisis management training and know crisis-intervention techniques. Also, Santa Fe County has two reentry specialists and is looking for a third.

Mr. Sedillo reiterated what Ms. Philips said regarding the families of the mentally ill. He said that the families of those with mental illness are often happy when the mentally ill person is held in a detention center. Mr. Sedillo explained that, nevertheless, jails are not hospitals. While they do their best to care for mentally ill inmates, it is not the same as a hospital setting. County jails do not have trauma areas, for example, as a hospital would.

Michael Ferstl, assistant director of operations, Bernalillo County Youth Services Center, said that he is the former head of the United States Marshals Service for New Mexico, and as such, he is very familiar with the state's correctional facilities. He said that New Mexico has well-run jails and that the solitary confinement lawsuits stem from staff failures and not department policy. He said that as a corrections professional, he sees through a lens of prisoner days. He warned against taking these lawsuits out of context and said that five lawsuits arising out of 47 million prisoner days is not a high number at all.

Mr. Ferstl said that the Bernalillo County Youth Services Center does not utilize solitary confinement, as that term is defined. In fact, he thinks that the segregation policy his facility uses is worthy of being a national model. Mr. Ferstl said that he is wary of any blanket legislation regarding solitary confinement because he fears that it will hamper the efforts of corrections officers.

When asked about how long juveniles are kept in isolation at the Bernalillo County Youth Services Center, Darren James, case manager, Bernalillo County Youth Services Center, discussed some case studies and said that when inmates relapse, they might be in isolation more than a few weeks.

Mr. Roark said that New Mexico's adult facilities use the American Correctional Association's definition of restrictive housing, which includes 22 hours of cell time a day. He said that despite all efforts to curb it, there will always be illegal activity in prisons, be it trafficking, gambling or something else. That activity will spur outbursts of violence, which will, in turn, require the separation of inmates. A legislator said that perhaps that is the case, but that there is a difference between segregation and segregation with additional punishment.

A large number of beds are going unused at the DOH's New Mexico Behavioral Health Institute at Las Vegas (BHI), according to one legislator. Why, the legislator asked, is the DOH turning people away from treatment at the BHI? The legislator requested that the LHHS follow up with testimony from the DOH on the BHI's accessibility for seriously mentally ill New Mexicans.

A legislator said that there will be a bill introduced next session and that it is important that legislators learn from the NMCD and county corrections officials about jail management so that the language in the bill reflects the legislative intent. The legislator wants New Mexico to comply with international standards.

Finally, a legislator said that oversight of probation and parole needs to be taken from the NMCD and given to the judiciary, which is better prepared to provide objective administration.

Public Comment

Diana Crowson discussed her son, who spent almost two years in solitary confinement in Las Cruces. She said that she is aware of an inmate, not her son, who received only an Ibuprofen after suffering a stroke.

Ruth Hoffman, director, Lutheran Advocacy Ministry-New Mexico, read the following statement.

Mr. Chairman and Members of the Committee,
Our denomination, the Evangelical Lutheran Church in America, adopts social statements which are the underpinnings of our advocacy work. The following is a quote from our newest social statement on criminal justice: 'As people of reason, we accept differences in correctional philosophies, but as people of faith we reject dehumanization of the incarcerated through brutalizing means whether legal, psychological, sexual, emotional, racial, cultural, or spiritual.' With this underpinning, we oppose the use of solitary confinement for juveniles and the seriously mentally ill. We also urge that it be restricted for use with the general population of those incarcerated and that the use of solitary confinement be closely monitored and tracked.

Ms. Hoffman said that Mississippi has virtually eliminated solitary confinement, not because of a moral distaste for its use, but because it saves the state a lot of money.

Reverend Holly Beaumont stated that 80% of the job is just "showing up", and she was present to represent 300 faith leaders in support of limiting solitary confinement. (Please see letter provided in the handouts, Item (18), for the week's hearings.)

Leona Stuckey-Abbott spoke against the use of solitary confinement.

Recess

There being no further business before the committees, the meeting recessed at 5:25 p.m.

Friday, October 28

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:59 a.m. and the members and staff of both committees introduced themselves. He also mentioned that legislators and staff were invited by Robin Otten to tour supportive housing facilities at Lomas and Second in Albuquerque at 8:00 a.m. on Veterans Day, November 11.

Adverse Childhood Experiences in Juvenile Offenders in New Mexico and What We Can Do About It

Amir Chapel, research scientist, New Mexico Sentencing Commission, discussed a newly released report about adverse childhood experiences (ACEs). The report features results from a behavioral health risk factor survey, which randomly sampled 26,000 adults nationwide. The field of ACEs is growing quickly. It started with health outcomes, is now being used with juvenile justice issues and will likely be used to assess a number of things in the near future.

The New Mexico Sentencing Commission looked at a number of factors that it considers to be ACEs. Those factors are emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, parental divorce or separation, family violence or domestic abuse, household substance abuse and household member incarceration. One hundred percent of female inmates and 93% of male inmates in New Mexico facilities surveyed were found to have experienced physical neglect, and 81% of inmates had experienced a diagnosable substance abuse or dependence issue. These were the most common correlates for probation violations.

George Davis, M.D., director of psychiatry, CYFD, stated that the ACE study was "one of the greatest behavioral health studies ever done". He said that ACEs have long-term effects on people's physical, mental and emotional lives, but not every ACE has the same deleterious effect. In fact, ACEs work in concert with one another, and typically, four different ACEs is the number where studies show that they have an impact. Studies show that a person who has experienced four or more ACEs will live 20 years less than if the person had not had any ACEs.

Dr. Davis said that juvenile delinquents are created, not born, but intervention needs to happen early, long before the person commits a crime. ACE intervention has to rewire these children's brains. Dr. Davis said that while not all neglected children end up in trouble, 90% of those in the juvenile justice system in New Mexico experienced ACEs. Early childhood trauma is an attachment disturbance, which is an emotional disruption causing an inability to be calmed by adults. Sports, t'ai chi and any large-muscle activities that are multisensory; vocational skill-building; showing respect; animal therapies, such as equine and dog therapy; and using discharge planning in facilities are all methods that the CYFD employs at its facilities that can be helpful in counteracting the effects of ACEs.

A legislator said that prevention is the first step, and one of the challenges is getting home-visiting services to the right homes. The legislator said that experience shows that the people who sign up for home visiting are rarely the people who need it. There are good results with home visiting, but it is obvious that those who accept it are in families where the parents are more informed and more likely to accept and incorporate constructive criticism.

Dr. Davis said that the difficulty is not identifying those most in need of home visiting but to coerce those families into accepting the visits. This is especially the case where there is a need for ongoing visits. Solutions posed were tying cash assistance or Medicaid to home visits.

A legislator asked whether marijuana legalization might contribute to ACEs. Dr. Davis stated that this would be part of a larger picture. Where there is substance abuse in the home, there may be ACEs.

The discussion focused on lifestyle tips for improving the home life of children in New Mexico. Topics discussed include helping young mothers, providing books and toys to help with parenting, de-incentivizing divorce, providing cash assistance to single parents and treating substance abuse.

A member said that one way to break the familial incarceration cycle is to prevent recidivism by prohibiting a lack of criminal history to be used as a condition of employment. Another legal solution posed was to tie home visiting to early childhood development efforts so that it can be considered a medical home visit and be covered by Medicaid.

In response to a question about what types of probation violations are leading to incarceration, Mr. Chapel cited a report from a few years ago on what probation violations land people in jail. However, he said, a lack of uniformity in the data collection continues to be an obstacle. There are some uniform rules that are being implemented now that should help in the future.

A member mentioned Uniform Probation Code provisions that are being used in New Mexico and the need to teach parenting skills.

In closing, a legislator warned that, based on ACEs, there will be more women in the criminal justice system as more and more girls are being traumatized.

Sharpening Prescribing Practices for Pain Management

Michael Landen, M.D., state epidemiologist, DOH, told the committees that the prescription monitoring program is critical to sharpening the prescribing of pain medication to more effectively combat pain and not over-prescribe. (Please see handout under Item (20) for details and, on page 8, recommendations.) Dr. Landen cited a study that shows that the mortality rate among middle-aged White Americans is on the rise, in stark contradiction to comparable countries where the rate is going down. He attributed the difference to pain and pain medications. He said that more than one-half of the people who die of a prescription overdose have a prescription for the drug that caused it, but just under one-half do not. More than two-thirds of people who die of opioid overdose are on chronic opioid therapy.

Dr. Landen said that oversight, like that provided by the New Mexico Prescription Monitoring Program (PMP), if used effectively, can prevent overlapping prescriptions. However, there are still 3,000 to 6,000 patients in the state with overlapping prescriptions.

Discussing specific drugs, Dr. Landen said that hydrocodone was rescheduled in 2014, after which overdose deaths dropped precipitously. He also said that New Mexico is a leader in the use of Naloxone, an overdose medication.

Dr. Landen closed by saying that what is being done is not working, but work continues on the problem. For example, the chronic pain survey findings by the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council will be implemented in 2017.

Joanna Katzman, M.D., M.S.P.H., director, UNM Pain Center; and director, UNM Project ECHO Chronic Pain and Headache Program, said that the UNM Pain Center saw 8,000 patients last year suffering from an array of maladies. She said that most heroin addicts started with prescribed opioids given to them by a friend or relative. An important way to address this and other issues is to train everyone that can prescribe how to and how not to prescribe opioids. Dr. Katzman said the need is to train everyone, not just doctors and osteopaths, but nurse practitioners, physician assistants, etc. Currently, a five-hour training is now required for doctors at all federal clinics.

Demetrius Chapman, M.P.H., M.S.N.; R.N., executive director, Board of Nursing, provided a primer of advanced practice registered nursing. There are four types of advanced practice registered nurses (APRNs), three of which are regulated by the Board of Nursing: C.N.P., C.R.N.A. and C.N.S. Certified nurse-midwives are regulated by the DOH. APRNs in New Mexico have prescriptive authority that does not require physician oversight, while neighboring states have more limits to the prescriptive authority of APRNs. All APRNs are registered nurses with a bachelor's degree in nursing and either a master's degree or doctorate in advanced nursing.

APRNs include:

1. C.N.P.— (certified nurse practitioner), who provides primary care in community and acute-care settings, of whom New Mexico has 1,794;
2. C.R.N.A. — (certified registered nurse anesthetist), who provides anesthesia care or pain management, of whom New Mexico has 425; and
3. C.N.S.— (clinical nurse specialist), who has different training than a C.N.P. in that the C.N.S. is more specialized in one population, disease process or anatomical system, such as the cardiovascular system, of whom New Mexico has 130.

Mr. Chapman provided an overview of recent federal law impacting the nurses' prescriptive authority and related training and said that the CDC guidelines for the prescribing of opioids for chronic pain are a nice synthesis of the current science that is available regarding the prescribing of opioids.

He said that the PMP has been a valuable tool for APRNs in determining treatment for patients with opioid prescriptions. Mr. Chapman discussed Suboxone and said that limited access and high need have resulted in a market on the street for the self-treatment of addiction.

He said the limited number of patients that a certified Suboxone prescriber can treat also creates a barrier to care because there are not enough providers to meet the needs of opioid-addicted patients. The limit was 30 and is now 100, but that will still not be enough.

Ben Kesner, executive director, Board of Pharmacy (BOP), introduced Shelley Bagwell, director, PMP, BOP, and Sarah Trujillo, licensing manager, BOP. Ms. Bagwell went through the steps of the PMP. She said the program has been responsible for lowering the number of doctor shoppers. To increase use of the program, doctors and providers are required to have a PMP file. To better gauge their own work, providers will now be able to stay informed on where they rank in the state and among similar specialists regarding prescribing medications.

Ms. Trujillo told the committees that there are 13 types of prescribing licenses that the BOP issues. She stated in response to a staff request that there are currently 950 custodial drug permits issued to boarding homes statewide.

Ralph McClish, executive director, New Mexico Osteopathic Medical Association, told the committees that the Board of Osteopathic Medicine is currently changing its rules partly to address opioid prescribing. He stated that opioids are physically and mentally addictive and that the public needs to know that. He stressed that patient education is a critical aspect of this discussion that is often ignored. He expressed his support for the use of abuse-deterrent opioids. "We had a small dip in opioid deaths" when there was more public messaging about the dangers of opioid use, he asserted. With less outreach and education, the numbers have again worsened.

Sondra Frank, J.D., executive director, New Mexico Medical Board, told the committees that until now, there has been a structural problem linking the PMP to the appropriate doctor. When someone enters data into the PMP but does not reference the right doctor, the doctor does not receive credit, and then it looks in the system as if the doctor was noncompliant or as if the doctor was not using the system enough or at all. When that happens, the doctor can end up on the high-risk prescriber list. Last year, there were 56 complaints filed about providers. Some of the confusion, Ms. Frank said, is that for some reason, cancer and hospice physicians thought they were exempt from the PMP, but they are not. Anyone with dispensing power, except veterinarians, must use the PMP. If a doctor needs retraining in pain medication prescribing, the New Mexico Medical Board sends the doctor to the Center for Personalized Education for Physicians in Denver. Ms. Frank said that New Mexico Medical Board investigations can be triggered by PMP irregularities.

In response to a question about why oxycodone use is so prevalent, Dr. Landen said that, often, oxycodone is the most appropriate thing to prescribe for pain. Dr. Landen said that among those people who die from opioids, 85% are dealing with chronic, not acute, pain.

When asked if there is a danger of overdose if the drugs are used as prescribed, Dr. Katzman said that in her opinion and in her experience, for the people who are taking their opioids responsibly, the risk of death is low.

A member forwarded the idea of using medical marijuana as an alternative to opioids. Mr. McClish said that there is a lack of cannabis training for doctors. He said that doctors want to prescribe cannabis, but they do not know how to go about it.

In response to the question of whether there is a problem mixing opioids and cannabis, several presenters explained that it is hard to know how to parse out what drug is having what effect and that there are many issues with cannabis, including the various legal issues. While the evidence for the benefits of cannabis for chronic pain is strong anecdotally, the evidence-based research is sparse because it is banned. In fact, a legislator said, cannabis research is a big reason to legalize. The possibilities for application seem very broad, and it can be paid for by diverting regulatory fees for cannabis to medical research.

A legislator expressed disappointment with the fact that there is little funding for training while providers attempt to treat pain appropriately. The legislator said that there is an unfunded mandate to train clinicians to treat pain adequately while not getting patients addicted.

Non-Pharmaceutical Treatment for Chronic Non-Cancer Pain

Michael Pridham, D.C.-A.P.C., N.R.C.M.E., member, executive board, New Mexico Chiropractic Association, explained the role of chiropractic treatment in the attempt to deal with the opioid epidemic. He said that a big challenge to these efforts is that in New Mexico, Medicaid does not reimburse providers for chiropractic treatment for opioid addiction, but there are 27 states that do. Dr. Pridham said that a patient's pharmaceutical costs are 85% lower when the patient seeks chiropractic treatment first.

Juliette Mulgrew, N.D., M.S.A.Y., vice president, New Mexico Association of Naturopathic Physicians, said that pain is a personalized experience. People with the same malady will experience different levels of pain and require differentiated treatment. Ms. Mulgrew said that pain is a symptom, not a diagnosis. In fact, many people who come to seek naturopathic pain treatment are already using opioids. She said that there is a six-month wait to get into a pain clinic, so other therapies are important and need recognition and support.

In response to a question, Dr. Pridham told the committees that the veterans' hospital in Albuquerque covers chiropractic treatment if the patient gets a referral from the patient's primary care physician to a qualifying chiropractor.

When asked what the legislature can do to help, Dr. Pridham said that chiropractors are legally prohibited from telling patients to stop using opioids and that it would be helpful to be able to do so if appropriate. He told the committees that some chiropractors would be seeking to change their scope of practice to permit this.

Medication-Assisted Treatment

Lindsay LaSalle, senior staff attorney, Drug Policy Alliance, said that New Mexico has been innovative and is credited with a lot of firsts in drug treatment and drug policy.

Eugenia Oviedo-Joekes, associate professor, School of Population and Public Health, University of British Columbia (UBC), discussed a study with Dilaudid that she published in *Psychology Today*. She said that by providing clean drugs, clean needles and a safe place to inject and having a person around in case of an overdose, deaths and the spread of disease went down. The study included more than 200,000 injections, and there were only 27 overdoses that required Narcan. Also notable in her work, she said, were better familial relationships for the addicts and significant savings in emergency room treatment costs and criminal justice costs because of an 80% retention rate in treatment.

Miriam Suzanne Komaromy, M.D., associate director, ECHO Institute; and associate professor of medicine, UNM, said that using technology allows front-line providers to access information via telemedicine. Dr. Komaromy said that the case-based treatment supported by the web-based database allows providers the ability to share best practices and to reduce disparities in the provision of health care. She said that opioid addiction is the most common disorder seen and that three-fourths of the physicians changed their treatment after working with the ECHO program. Dr. Komaromy said that the institute just got a grant from the United States Department of Health and Human Services' Health Resources and Services Administration to launch six opioid use disorder programs.

Andrew Hsi, M.D., principal investigator, FOCUS Programs at the Center for Developmental and Disability, UNM Health Sciences Center; principal investigator, Reflejos Familiares Project; professor of family and community medicine, discussed neonatal opioid withdrawal syndrome (NOWS) and said that since data started being collected, New Mexico is high on the list of NOWS per capita. He said that long-term outcomes of those who suffer NOWS are hard to predict. Dr. Hsi said that UNM pediatric clinics have become a significant provider, with about 120 families with young children receiving treatment, including a growing number of fathers. "We care for a very challenged population", he stated in response to a question about whether the adolescent wing at Turquoise Lodge is needed to provide detox services to adolescents. He spoke of administrative barriers that make it harder to serve people who desperately need assistance. He urged that health care administration be informed by medical expertise and not by "administrative fiat".

Dr. Komaromy stated that Turquoise Lodge is very important for reaching "highly at-risk" people. She also informed the committees that UNM was starting a post-detention clinic on an outpatient basis for children released from juvenile facilities. She stated that UNM would send case managers to homes to ensure compliance, and if there were issues at home, UNM would send a caregiver to help.

Responding to a legislator's question, Professor Oviedo-Joekes said that the use of opioid-assisted treatment is patient by patient and that treatment is meant to reach patients as they are and to go from there. Professor Oviedo-Joekes said that just starting this treatment is not a magic elixir that will put the patient back into the workforce right away. The treatment discussed in her

study is for the very poor, very addicted and not socially competent people who must come to the clinic three times a day.

Professor Oviedo-Joekes said that treatment varies country by country. In some places, clinics will allow the patient to take home a maintenance dose, which is rare, but that in her clinic, if anything is sent home with the patient, it would be methadone, which is much less popular than heroin. In fact, for the addict, Professor Oviedo-Joekes explained, opioids go from being a street drug to being a medication, and this provides the person with a great sense of pride. While the patients go to the clinic in Vancouver, British Columbia, for the medication, the staff is there to care for them as patients and provide them with an entire suite of social services. Another benefit to these clinics, Professor Oviedo-Joekes said, is that when heroin is offered for free at the clinic, the black market for heroin is undercut.

When asked about treatment for alcohol abuse and dependence, Professor Oviedo-Joekes stated that UBC has a small pilot project group in Vancouver that makes its own alcohol for consumption as a community. The project is showing that alcohol consumption is diminishing through the community work.

A legislator expressed frustration at the fact that the state is closing juvenile detoxification facilities, and the medical director of one facility does not believe in medical detoxification. Dr. Hsi said that the decision of whether or not to provide inpatient detoxification should be a medical one for the particular patient and not done by administrative fiat. Ms. LaSalle said that most people do not require inpatient detoxification, but facilities should prioritize treatment for the sickest rather than exclude those very patients.

Economic Burden of Prescription Opioid Abuse

Alan White, Ph.D. in economics, UBC; M. Litt. in economics and mathematics, and B.A. in economics and mathematics, University of Dublin, Trinity College; managing principal, Analysis Group, Inc., provided the members with a map of the United States showing the prevalence of prescription opioid abuse by zip code that indicates that large swathes of New Mexico are in the top 10%. He said that the medical cost associated with an opioid abuser is \$20,000 above the average person. The total burden on the United States is \$50 billion a year, he stated. That figure includes only diagnosed prescription opioid use, Dr. White explained, so it is likely a very low estimate. There are also associated costs that this estimate ignores, such as missed days of work, for example.

Dr. White mentioned two initiatives that may reduce opioid abuse and curb its costs. First is the use of tamper-resistant pills so that users cannot alter them to smoke or snort the drug. Second is interpreting claims data to identify patients at risk for abuse before treatment begins.

A legislator questioned the figure previously cited as a cost to the criminal justice system and said it is much more costly.

In response to a question by a member, Dr. White said that an opioid will typically be 20% of the cost of its equivalent abuse-deterrent opioid.

Public Comment

Nat Dean, disability advocate, said that at Express Scripts, the difference in price between an opioid and its equivalent abuse-deterrent opioid is \$15.00 versus \$90.00.

There being no further business before the committees, the meeting adjourned.

Revised: November 7, 2016

**TENTATIVE AGENDA
for the
SEVENTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**November 14-15, 2016
Room 321, State Capitol
Santa Fe**

Monday, November 14

- 8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Nora Espinoza, Vice Chair, LHHS
- 8:40 a.m. (1) **Pharmaceutical Costs**
—Jenny Felmley, Ph.D., Program Evaluator, Legislative Finance
Committee
—Mark Tyndall, Executive Director, Retiree Health Care Authority
—Nancy Smith-Leslie, Director, Medical Assistance Division, Human Services Department
- Pharmaceutical Manufacturers**
—Saumil Pandya, Senior Director of Policy and Research, Pharmaceutical Research and Manufacturers of America
- Pharmaceutical Benefits Managers**
—Mark Wermes, Vice President, Public Sector Clients, Express Scripts
- Pharmacists**
—R. Dale Tinker, F.F.S.M.B., Executive Director, New Mexico Pharmacists Association
—Danny Cross, R.Ph., Owner, Southwest Pharmacy
—Minda McGonagle, Government Relations, New Mexico Pharmacy Business Council
- Health Insurers**
—Louanne Cunico, Pharmacy Director, Presbyterian Healthcare Services
—Frank B. Koronkiewicz, Director of Pharmacy, Molina Healthcare of New Mexico
—Martin Hickey, M.D., Executive Director, New Mexico Health Connections
- 12:00 noon **Lunch**

1:30 p.m. (2) [Consumers and Providers on Pharmaceutical Costs](#)
—Colin Baillio, Director of Policy and Communications, Health Action
New Mexico
—Betty Chang, M.D., Member, American College of Physicians
—Betsy Imholz, Special Projects Director, Consumers Union
(via videoconferencing)

3:30 p.m. (3) [Pharmacy Benefits Management Regulation](#)
—Andy Romero, Director, Consumer Assistance Bureau, Office of
Superintendent of Insurance

4:30 p.m. (4) [Public Comment](#)

5:00 p.m. **Recess**

Tuesday, November 15

8:30 a.m. **Welcome and Introductions**
—Senator Gerald Ortiz y Pino, Chair, LHHS
—Representative Nora Espinoza, Vice Chair, LHHS

8:40 a.m. (5) [2016 New Mexico Health Care Workforce Committee \(NMHCWFC\)
Report](#)
—Richard Larson, M.D., Chair, NMHCWFC; Executive Vice Chancellor,
University of New Mexico Health Sciences Center

10:00 a.m. (6) [Kinship Guardianship Report](#)
—Liz McGrath, Esq., Executive Director, Pegasus Legal Services for
Children

11:00 a.m. (7) [Preliminary Findings on Sexual Assault Evidence Processing Audit](#)
—Timothy Keller, State Auditor, Office of the State Auditor (OSA)
—Sarita Nair, Esq., Chief Government Accountability Officer and General
Counsel, OSA

12:00 noon **Lunch**

1:30 p.m. (8) [Burrell College of Osteopathic Medicine \(BCOM\): Primary Care in
Rural and Tribal New Mexico](#)
—John Hummer, President, BCOM

2:00 p.m. (9) [Public Comment](#)

2:30 p.m. (10) [Review of Proposed Legislation for the 2017 Regular Session](#)
—Michael Hely, Staff Attorney, Legislative Council Service (LCS)
—Shawn Mathis, Staff Attorney, LCS

5:00 p.m. **Adjourn**

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

November 14-15, 2016
Room 321, State Capitol
Santa Fe

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on November 14, 2016 by Senator Gerald Ortiz y Pino, chair, at 9:00 a.m. in Room 321 of the State Capitol in Santa Fe.

Present

Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Sen. Mark Moores
Sen. Mimi Stewart

Absent

Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis

Advisory Members

Sen. Craig W. Brandt
Sen. Jacob R. Candelaria (11/15)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Howie C. Morales (11/14)
Sen. Bill B. O'Neill
Sen. Mary Kay Papen (11/14)
Sen. Nancy Rodriguez (11/15)
Sen. William P. Soules
Rep. Christine Trujillo
Sen. James P. White (11/14)

Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
Rep. Don L. Tripp

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

Staff

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

Minutes Approval

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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Monday, November 14

Welcome and Introductions

Senator Ortiz y Pino welcomed everyone to the seventh and final meeting of the LHHS for the 2016 interim. Members of the committee and staff introduced themselves. The morning agenda was set to provide different perspectives on the pharmaceutical industry with input from manufacturers, pharmacists and health insurers.

Pharmaceutical Costs

Jenny Felmley, Ph.D., program evaluator, Legislative Finance Committee (LFC), shared the LFC's "Health Notes" on pharmaceutical costs with the committee, specifically looking at state agency prescription drug spending (please see report for full information). In the years between 2000 and 2012, the country saw a steady but relatively gradual increase in spending on prescription drugs; at the same time, the growth rate of spending from year to year actually declined. The decline was due to a combination of the "patent cliff", which is the expiration of many drug patents at approximately the same time, and lower costs for the generic versions of these drugs. By 2014, spending on drugs increased by more than 11 percent due to few patent expirations, raising prices for both generic and brand-name drugs and expanding use of new high-cost specialty drugs. These specialty drugs can be enormously beneficial and may ultimately reduce medical cost by treating and curing conditions before they become chronic or require costly medical interventions. They include drugs for cancer, hepatitis C and multiple sclerosis. While these advances in prescription drugs are important, they have been very costly for state budgets and have increased the out-of-pocket expenses for insured patients. In fiscal year (FY) 2016, the 10 state agencies that purchased prescription drugs spent a combined total of over \$680 million, an almost 54 percent increase from FY 2014.

New Mexico agencies that spend money on prescription drugs have varying structures and serve different populations. However, all of the state agencies reviewed by the LFC report are experiencing each of the prescription drug cost trends, adding to the statewide spending increase. The Human Services Department (HSD) is by far the biggest spender, with over \$423 million in FY 2016 spent on prescription drugs for more than 800,000 New Mexicans in the Medicaid program. The Medicaid drug spending from FY 2014 through FY 2016 has risen by 83

percent, with a 212 percent increase in spending on specialty drugs, particularly for hepatitis C. Dr. Felmley noted that the HSD's prescription drug spending patterns are similar to other state Medicaid programs, particularly those that expanded their programs under the federal Patient Protection and Affordable Care Act (ACA). Because the HSD sets payment rates annually based on data from previous years and assumptions about the future, the HSD often ends up paying more than necessary up front and then recovers its overpayments later. There are two ways the HSD balances out overpayments: (1) rebates available through the Medicaid Drug Rebate Program; and (2) recovering overpaid funds from the managed care organizations (MCOs) through risk corridors.

Dr. Felmley highlighted several aspects detailed in the LFC report, focusing on the expansion of the hepatitis C risk corridor. In FY 2015, 451 patients received treatment for hepatitis C, with the average cost of treatment per patient at \$81,000. While hepatitis C is at the top of the list of Medicaid's most costly conditions, medical conditions like diabetes, cancer and inflammatory conditions account for large portions of state agency prescription drug spending and are also indicative of the health issues prevalent in the state. The four member agencies — the Risk Management Division of the General Services Department, the Albuquerque Public School District, the Public School Insurance Authority and the Retiree Health Care Authority (RHCA) — together spent approximately \$220 million on drug coverage in FY 2016 for about 175,000 school employees, state government employees, state retirees and their eligible dependents. The Interagency Benefits Advisory Committee (IBAC) estimates that it saves approximately \$25 million per year through joint purchasing, about \$10 million of which is associated with pharmacy spending. Dr. Felmley discussed some the key efforts for cost containment by state agencies. Each of the agencies are pursuing cost-containment options that focus primarily on increasing cost-sharing with their members through some degree of expanded copayments, coinsurance and out-of-pocket maximums. Dr. Felmley cautioned that if drugs become so expensive that health plans and state agencies can only contain their costs by shifting more of the burden to consumers, they do so at the risk of leading their members to cut their own out-of-pocket costs by refusing to fill prescriptions to begin with or by extending drugs by methods, such as skipping doses. If patients are noncompliant with necessary medications due to costs, then the original promise of improved outcomes and cost savings disappears. In general, it appears that solutions to the rising prices of prescriptions drugs through any sort of restructuring of market incentives, patent protections or other means would need to be made at the national level.

Mark Tyndall, executive director, RHCA, talked about the members of the IBAC, of which the RHCA is a member. The IBAC represents around 175,000 members throughout the state with an estimated \$220 million in prescription costs. Mr. Tyndall acknowledged the report prepared by the LFC and Dr. Felmley, noting that the report is well-researched and factually correct. IBAC members are self-funded purchasers that use market leverage and utilization management. The IBAC has a partnership with Express Scripts, the largest pharmacy benefit manager (PBM) in the country, with a reputation as a ruthless negotiator with the pharmaceutical industry. Express Scripts has between 85 million and 90 million members. While New Mexico

does not have many members, the state is able to join in some of the same benefits as other large Express Scripts PBM populations, providing a better opportunity for price negotiation. IBAC benefits from Express Scripts' huge mail-order operation and help with prescription rebates from manufacturers and sale of generic drugs.

Mr. Tyndall discussed Express Scripts' utilization management and other benefits offered through the company. Express Scripts processes claims in real time and works on prior authorizations, while offering immediate medication management review for contraindicated prescribed medications and drug interactions. Express Scripts uses step therapy, which requires members to try the lowest-cost alternative before moving on to medications that are more expensive. Mr. Tyndall explained the exclusionary formulary, which began in 2014 and initially placed downward pressure on prescription prices. This tactic was not popular with prescribers and pharmacists. That price trend has since halted, and it is time to begin looking at other possible options. The contract with the Express Scripts ends this year, and the IBAC will be looking to see if any other companies can better meet the needs of the state. Mr. Tyndall added that part of the reason the cost for prescriptions is so high is due to the sheer number of prescriptions individuals are taking; on average, a person has five or more prescriptions. The state needs to begin discussions about the prevalence of larger health problems.

Senator Ortiz y Pino shared a statement by Alex Sanchez, deputy secretary of administration, Corrections Department (NMCD), regarding information incorporated in the LFC report. Over one-half of New Mexico's prison population, or approximately 7,700 inmates, has hepatitis C. The NMCD has spent over \$6.5 million on hepatitis C treatments alone, and if it were to treat all individuals with the disease, the cost to the state would be about \$250 million.

Nancy Smith-Leslie, director, Medical Assistance Division, HSD, thanked Dr. Felmley for the informative report. Ms. Smith-Leslie noted that 10.4 percent of the total budget for Centennial Care is spent on pharmaceuticals. This is a 14 percent increase on a per-capita basis. The Medicaid dispensing rate in New Mexico is higher than the national average; however, 87 percent of the dispensing rate is for generics. A consulting firm hired by the Texas Association of Health Plans reported that New Mexico was ranked fourth best in net cost for prescriptions. Ms. Smith-Leslie recommended greater flexibility for MCOs to manage pharmaceutical benefits. Each New Mexico MCO has a PBM and a formulary. MCOs have flexibility to negotiate exclusivity provisions for specialty drugs. Around 14,000 Medicaid members have hepatitis C; the state cannot afford to treat this entire population, but it has a strategy to treat 1,750 each year. The previous year, more than 400 people were treated at a total cost of \$32.6 million. With rebates, the cost of the new hepatitis C drug has decreased from \$70,000 to \$50,000 per patient; the cost of the medication is also decreasing. Everyone except those with the mildest forms of hepatitis C is being treated by Medicaid. The HSD is trying to be conservative, but it is also mindful of cost avoidance. Additionally, the HSD is working to avoid any potential class actions lawsuits, which can be extremely costly for the state.

Following the presentation about pharmaceutical costs, the committee discussed the following points:

- medical care provided by other states to their prison populations;
- the potential for 340B pricing for treatment of HIV/AIDS, and the use of the Minnesota purchasing collaborative;
- the importance of correct usage of medication for health and cost containment;
- rebates in Medicaid;
- the impact of eliminating the retirement fund for state employees in light of the current state budget crisis;
- prioritizing treatment for patients with hepatitis C and ongoing research of the disease;
- the cost of drug treatments outside the United States;
- the approval process for generic drugs through the U.S. Food and Drug Administration (FDA) process;
- the negotiation process for MCOs; and
- the need for incentives for cost containment by MCOs.

Pharmaceutical Manufacturers

Saumil Pandya, senior director of policy and research, Pharmaceutical Research and Manufacturers of America, responded to some of the statements made by the previous panel. Mr. Pandya noted that there is a difference between the net price and the list price, and when rebates are taken into account, the actual cost increases are not as high as they appear. Mr. Pandya explained how manufacturers set a list price and that is the starting point for negotiation, similar to the sticker price on a car. Cost-sharing is based on the list price of the drug, and the consumer pays the full list price as part of the deductible. The rebate is given to the insurance company, so the patient is not getting the benefit of the negotiated rates. Consumers are seeing the growth in the list price, but that is not the real cost. What has changed, however, is more awareness by consumers of the list price.

Prescription drug costs account for about 10 percent of the total health care expenditures in the United States. Physician- or hospital-administered drugs add an additional four percent. Spending on prescription drugs is increasing, but so are the rest of health care costs. As a share of total health care spending, spending on prescription drugs is staying constant. Mr. Pandya informed the committee that the consolidation of practices in hospitals was intended to institute practice guidelines and dictate structure; but in reality, hospitals have the highest cost for care. Medicaid has a price increase cap: a statutory rebate of about 23.1 percent for name-brand products and 13 percent for generics. Medicaid also gets the best price in the market; the net overall rebate in Medicaid is 60 percent off the list price. Fee for service is a very small part of Medicaid.

In regard to who funds research, Mr. Pandya said that the federal government conducts the research of pharmaceuticals through the National Institutes of Health (NIH). The NIH's

entire budget for 2013 was \$30.8 billion, a large portion of which is not research. In 2015, pharmaceutical companies spent \$58.8 billion on research alone. The industry is extremely high-risk, with only 30 percent of products making it to drug trials and only 12 percent of those products actually making it to market. It can take up to 10 years for a product to get through the FDA process. Competition exists not only with the release of generics but also among brands. Currently, there is no market to develop drugs for rare diseases and conditions. Mr. Pandya emphasized the overall impact of hepatitis C on not only medical expenses and resources, but also the number of lives lost to the disease. There are significant cost savings in reducing the number of individuals needing liver transplants, and great work is being done in the industry to expand treatment options.

PBMs

Mark Wermes, vice president, Public Sector Clients, Express Scripts, provided the committee with some background on the pharmaceutical benefits industry. Express Scripts has about 35 different state health plans and is the largest PBM in the country, serving more than 85 million members. Mr. Wermes stated that Express Scripts takes a lot of actions to reduce costs. The company was the first PBM to get hepatitis C drug prices reduced by rebates. Prices in the United States for this drug are better than those in the United Kingdom. Express Scripts develops a formulary and works with pharmacy networks. All independent pharmacies are allowed in its network, which has helped these pharmacies stay in business. Partnerships with independent pharmacies are transparent, and Express Scripts works to pass 100 percent of discounts and rebates on to the clients. Express Scripts has a fixed administrative fee, with only one source of margin on generics in the mail-order pharmacy.

Pharmacists

Minda McGonagle, government relations, New Mexico Pharmacy Business Council (NMPBC), shared with the committee how independent pharmacies fit into the overall industry. The NMPBC is an advocacy arm of Texas-based American Pharmacies, an independent pharmacy cooperative with more than 600 stores in Arizona, New Mexico, Oklahoma, Louisiana and Texas. The mission of the NMPBC is to advance and defend the business model of New Mexico independent pharmacies by making lawmakers and policymakers aware of the critical health care and economic contributions that independent pharmacies make to communities and the growing challenges of that role. Pharmacists are often the only health care available to rural New Mexicans, who have limited access to physician care. Independent, or community, pharmacists typically spend more time with patients than do their chain counterparts; they counsel patients on medications and chronic health conditions, give immunizations and offer referrals to physicians for treatment, when necessary. Ms. McGonagle provided the LHHS with a handout detailing some of the issues and challenges that members of the NMPBC are facing and how they hope to evolve with the industry as it changes. The NMPBC has no current legislation requests but will be looking at legislative proposals to address some of the issues facing independent pharmacies in the future. Ms. McGonagle added that the goal of the presentation is to provide an overview of what independent pharmacists have done historically, what they currently do and where they would like to go in the future. Community pharmacists help lower

the overall costs of health care by going beyond filling medications. Prescription drugs are a tool to help patients stay healthy, but another value of the service is working with and engaging patients to improve outcomes.

Danny Cross, owner, Southwest Pharmacy, stressed the important role community pharmacies play by ensuring that individuals are using prescriptions properly. Community pharmacists are the front line for checking for adverse drug interactions, identifying problems and working with patients to solve any issues. Mr. Cross noted that the effectiveness of medications relies heavily on individuals taking them appropriately; community pharmacies can and do play a major role in that. Approximately 30 percent of prescriptions around the country are filled by independent pharmacies. Southwest Pharmacy in Carlsbad employs about 40 people in Eddy and Lea counties and is very involved in the community. Mr. Cross stated that the pressures he sees from PBMs make it more difficult to do business as an independent pharmacy. Independent pharmacies are excluded from contracts, and pricing is set by PBMs. Independent pharmacies do receive a dispensing fee, but that is the only compensation they receive. There is a set fee for prescriptions, regardless of what it costs the pharmacists to purchase. As a small business owner, Mr. Cross finds it difficult to sustain operations because networks are constantly restricting patients' use of independent pharmacies, resulting in a loss of business. Mr. Cross added that there are also new quality initiatives from PBMs to reward and penalize pharmacists. These are retroactive adjustments that can go back for up to 30 days.

R. Dale Tinker, executive director, New Mexico Pharmacists Association, acknowledged that New Mexico's good ranking for cost containment is due in large part to the efforts of community pharmacies. New Mexico's Medicaid data illustrate that the overall pharmacy generic substitution rate is 85 percent. With the exception of 2007, New Mexico has had the lowest cost for prescriptions for the past 12 years. The state has been a leader in pharmacists providing clinical care since 1993, with the passage of the advance practice pharmacist law. Pharmacists' prescribing protocols were added statutorily in 2001, and there are currently five approved protocols: immunization; tobacco cessation; emergency contraception; tuberculosis testing; and naloxone (an opioid antagonist). There is an opportunity for the legislature to recognize the significant contributions to patient health and to cost containment that pharmacists provide to health care in New Mexico through the support of proposed legislation for pharmacist clinical services reimbursement. The proposed legislation was included for the committee, and Representative Armstrong agreed to carry the bill in the 2017 regular session.

In response to the presentation, the committee addressed the following topics with the panel of pharmacists:

- price-setting of prescription drugs at independent pharmacies;
- limitations by health plans on using independent pharmacies;
- inquiries about the proposed legislation;
- the status and implementation of previously passed medication synchronization legislation;

- successes of independent pharmacies in providing patient care;
- mail order versus retail sales of pharmaceuticals;
- the increasing mandated use of mail-order delivery;
- concern over waste of medication following hospice care;
- a description of how medication adherence is measured;
- the importance of supporting independent pharmacies, particularly in rural areas;
- a network adequacy evaluation to include pharmacies;
- price comparisons; and
- potential future legislation and regulation to address some of the other issues facing independent pharmacies.

Health Insurers

Louanne Cunico, pharmacy director, Presbyterian Healthcare Services (PMS), discussed the escalating costs of pharmaceuticals and what tools insurance companies have to manage those cost increases. Since 1998, Medicaid has had closed formularies. PMS uses traditional care and pharmaceuticals that are clinically effective, while approving prior authorizations and conducting network negotiations. The insurance company can no longer cut reimbursement rates to pharmacies. Ms. Cunico believes that the only alternative to cutting costs is to look at health conditions that are the biggest spenders for pharmaceuticals: diabetes; rheumatoid arthritis; and multiple sclerosis. Giving the example of diabetes, Ms. Cunico stated that even a 25 percent rebate does not justify retail drug cost increases. The solution is finding other methods of managing these patients by working with providers and practitioners. Most health plans have difficulties managing patients with hepatitis C. Companies want to ensure that patients are taken care of, but they also need to be sure that treatment is being approached in a cost-effective manner. Less than one percent of the total number of written prescriptions are for specialty drugs, yet they account for the largest share of the costs to health plans. Health plans have done all they can to reduce costs from their side. The next step in addressing cost is knowing how much pharmaceutical companies are spending on marketing products.

Frank B. Koronkiewicz, pharmacy director, Molina Healthcare of New Mexico, is a third-generation pharmacist who now works for Molina. Molina serves around 232,000 members of the Medicaid population in New Mexico. Molina is located in 11 other states, and in comparison, Mr. Koronkiewicz noted, Centennial Care and the HSD do a good job of administering the program. The HSD allows Molina to do its job without being overly prescriptive or mandating rules and requirements like in other states. Molina has the ability to create its own preferred drug lists and maintain its own provider network. Rebates are only available for brand-name pharmaceuticals, and over 89 percent of prescriptions filled in New Mexico are generic; therefore, concentrating on rebates will not get the lowest net cost. Mr. Koronkiewicz explained supplemental rebates, clarifying that in order to receive a rebate, manufacturers want a greater market share. For that reason, Molina often forgoes the supplemental rebate. Approximately 50 percent of supplemental rebates through Molina are on test strips for blood glucose, not pharmaceuticals. By federal law, rebates are collected by the HSD.

Mr. Koronkiewicz addressed hepatitis C treatment and what Molina is currently doing in cooperation with the HSD. While Molina is attempting to treat as many cases as possible, the approach has been to treat the worst cases first, based on the level of fibrosis. Cost is not the only barrier to treatment; there is also a lack of providers to treat these patients. There are not enough prescribers in the state. Molina does support community pharmacies and uses mail-order services sparingly. Due to the tendency for the Medicaid population to move around and the large number of homeless members, Molina does not believe that mail order is an appropriate service. Beginning in 2017, Molina will be instituting the filling of 90-day supplies of medications at community pharmacies. This practice helps ensure medication adherence, which is an important component of disease management. Molina goes to great lengths in this area, particularly with medications for hepatitis C. Molina contracts with University of New Mexico (UNM) Hospital for medication therapy management.

Martin Hickey, M.D., executive director, New Mexico Health Connections, presented a recent course on the ACA at UNM. Dr. Hickey suggested that to understand why health care is so expensive, one must follow the money. Many concerns have been raised about what the recent presidential election means for health care and the ACA. Prior to the election, there was an inability to fix some parts of the ACA, but cost increases soared due to individuals with advanced conditions receiving coverage for the first time. Over 90 percent of the increases in premiums are a result of specialty drugs. According to Dr. Hickey, the United States is the only country that lacks oversight in the area of drug pricing. Inpatient costs are undoubtedly decreasing, while outpatient costs are on the rise. Nationally, more than 29 million people have diabetes. The treatment cost for this disease is over \$245 billion. This cost is expected to rise 20 percent over the next several years. The average consumer is paying for these increases of specialty drugs in their premiums and in their tax dollars. President-Elect Donald Trump proposed expanding the high-risk pool, which is necessary to reduce the cost of health insurance. There may also be consideration of legislation or regulations to re-import pharmaceuticals back into the United States that have been approved for use. The pricing of drugs in the United States is well beyond what they are sold for in the rest of the world.

Mark Epstein, M.D., chief medical officer, New Mexico Health Connections, acknowledged that games are being played in the pharmaceutical industry. The business model has been built upon monopolistic behavior and then pacification. Dr. Epstein explained that when a patent is about to run out, there are minor changes made to extend the life of the product's patent. Products like EpiPen have a monopoly on the medication, disallowing competition and resulting in pricing that is uninhibited. Dr. Epstein calls for greater transparency for patients, clinicians and physicians. There is a frequent lack of clarity about who is paying for what. He added that coupons are used by drug companies as a method of steering business toward particular products. Health plans have done what they can to reduce costs; the last hurdle is addressing pharmaceutical costs, particularly those of specialty drugs.

On questioning, the health insurer panelists and the committee members discussed the following topics:

- the need for price transparency;
- the estimated impact on New Mexico from the potential dismantling of the ACA;
- the need to fund school-based health centers and the availability of long-acting reversible contraceptives (LARCs);
- the increase in demand for LARCs following the presidential election;
- challenges with electronic records, reporting and data tracking;
- criteria consistency among New Mexico's four MCOs for hepatitis C treatment;
- the cons of using rebates for pharmaceuticals;
- the respective roles of the state and the federal government in addressing issues related to the pharmaceutical industry; and
- the overall need for regulation in the pharmaceutical industry.

Consumers and Providers on Pharmaceutical Costs

Betsy Imholz, special projects director, Consumers Union, gave a presentation to the LHHS via videoconferencing about the consumer perspective on rising prescription drug prices. Consumers Union is the policy and advocacy arm of the nonprofit *Consumer Reports* magazine (see handout for full remarks). The United States still pays the most for health care among high-income countries but has worse outcomes. A *Consumer Reports* survey from March 2016 shows that when people are hit with higher drug costs, they are more likely to take unhealthy steps, such as skipping doctor appointments, tests and procedures; not filling their prescriptions; or not taking prescriptions as directed. Even individuals with insurance are experiencing challenges with high-deductible plans and rising out-of-pocket costs imposed by insurers. Beginning in 2014, there was a spike in spending on prescriptions due to growth in brand-name drug prices, the emergence of new brand medications and moderate growth in generic drug prices. Specialty drugs are the primary driver of recent drug spending; the pricing trend for specialty drugs jumped from 14.1 percent in 2013 to 30.9 percent in 2014. Part of the issue is that policymakers and the public are largely unaware of how drug prices are determined. There is publicly available data on research and development (R&D) costs; however, 38 percent of all basic science research is paid for with tax money through federal and state governments. The share spent on R&D by pharmaceutical companies is not publicly known. It is also important to compare R&D expenditures by private companies to marketing costs for particular drugs. A 2014 report from GlobalData found that nine out of 10 major pharmaceutical companies spent more on marketing than on R&D. The lack of transparency around the real pricing of drugs needs to be addressed.

Ms. Imholz provided several examples of drugs whose costs have been left completely unchecked, leaving consumers without any options but to pay the list price or take riskier measures. One such product is the EpiPen, which has risen in price by nearly 550 percent since 2007. There are two approaches that could be taken to contain drug prices, according to Ms. Imholz. The first is to make the currently dysfunctional marketplace work by creating true competition. This would require transparency around costs and curbing monopoly power in the market. An additional approach would be greater government intervention in pricing through direct government negotiation with drug manufacturers, formulary creation and exercising "march-in rights" for essential medicines, or price setting. The conversation about drug pricing is

beginning to occur at both the state and federal levels. While many approaches to addressing underlying costs require federal action, some things the states can do include: (1) pressing New Mexico's congressional delegation to take action at the federal level; (2) requiring transparency by drug manufacturers regarding how drug prices are set; (3) creating an independent entity to review prescription drug effectiveness and oversee pricing, or joining with other states or purchasers that have one, and empowering the entity to challenge price gouging; and (4) enacting consumer protections, such as capping out-of-pocket monthly expenses and requiring fair formulary designs that do not discriminate against particular conditions and keep medications affordable. Ms. Imholz emphasized that in a wealthy nation, consumers should not have to choose among paying the rent, putting food on the table or getting medications they need to cure or control health conditions.

Betty Chang, M.D., member, American College of Physicians, shared her perspective as a physician on prescription drug pricing. Prescription drug costs have steadily risen since 2012, and the trend will continue. Patients are bearing the cost burden, with approximately 18 percent of patients paying out of pocket. Like a few of the previous presenters, Dr. Chang noted that many patients choose not to take medications or skip doses due to the steep cost. The EpiPen is a prime example of patients avoiding proper dosages due to cost. With a price of over \$600 per dose, patients frequently wait to decide if the reaction is bad enough to justify using the lifesaving medicine. Dr. Chang stated that she is regularly having conversations with patients who have to decide between paying their rent or filling a prescription. The majority of patients do not know how to shop around for prescriptions. A good tool is the download GoodRX, which allows consumers to compare prices of medication through various pharmacies, which can fluctuate. Dr. Chang agreed with the importance of greater transparency in the industry, adding that policies to increase competition could help reduce costs.

Dick Mason, Health Action New Mexico, shared several stories of patients grappling with price increases on lifesaving medications. These stories included an individual unable to afford epilepsy medication and a parent trying to pay for prescriptions for a medically fragile child. Mr. Mason noted that these are frequent struggles for everyday New Mexicans. He stated that New Mexico Health Connections is in good shape and running well. One area of concern is the escalating cost of inpatient care due to the cost of drugs being nearly double when prescribed in the hospital. The number of generic manufacturers has also decreased as companies are being consolidated. Mr. Mason mentioned several pieces of legislation relating to price transparency for pharmaceuticals, including one that will be introduced during the 2017 regular legislative session. A bill passed by the legislature in 2013 authorized the Office of Superintendent of Insurance (OSI) to regulate PBMs. The issue with this bill was the lack of funding, which prevented its implementation. Mr. Mason believes this would have been helpful had the funding component been available. The formation of the New Mexico Coalition for Affordable Pharmaceuticals is currently under way and will hopefully begin addressing some of these issues.

In response to committee members' questions, the following points were discussed by the panel:

- pharmaceutical companies spend more money on advertising than R&D;
- there is a growing movement among physicians against marketing and a recent trend by pharmaceutical companies to gear advertising toward consumers;
- the United States is one of only two countries that allows advertising for pharmaceuticals; the other is New Zealand;
- a decision by UNM to end the practice of giving out drug samples to influence consumer usage habits, especially since samples are frequently the newest and most expensive drugs;
- a need for action to address these issues at the federal level;
- calls for transparency as a nationwide movement;
- the potential for notification of price increases at the state level or by the PBMs;
- examples of other businesses or corporations, such as public utilities, required to share proprietary information;
- the lack of transparency around the real price of drugs, making it difficult to identify the real cost savings;
- the potential for capping out-of-pocket monthly expenses;
- physicians are unable to do the extensive paperwork required for assistance programs due to existing administrative burdens;
- limits by the state on MCOs for changes during a plan year; and
- an inquiry about laws in other states to guarantee the availability of drugs on the formulary.

Minutes Approval

Upon a motion by Senator Stewart, seconded by Representative Armstrong, the committee considered the minutes from the fifth meeting of the LHHS in Farmington. After discussion, a member noted a spelling error in the name of a presenter. Without further objection, the minutes were adopted as amended with the name change.

PBM Regulation

Andy Romero, director, Consumer Assistance Bureau, OSI, believes there are about 180 companies that may be identified as PBMs in the state. The OSI is working to get as many companies licensed as possible, but that is limited by statutory regulation. Lois Petro, staff counsel, OSI, has done some analysis of what other states are doing in regard to licensure of PBMs. Only two states leave oversight of PBMs to their pharmacy boards. Since 2014, 30 companies have been licensed. Out of 100 companies, 15 claim they are not PBMs and, therefore, are not subject to the Pharmacy Benefits Manager Regulation Act. The OSI will continue to research these companies and send out another communication to remind them that they need to be licensed. If they remain out of compliance, they will be referred to the OSI's investigations bureau for further action.

A member of the committee expressed concern that information would not be gathered in time to make legislative adjustments in the upcoming session. Ms. Petro noted that there is no

designated staff for this effort, and regulation is typically complaint-driven. The OSI will be working to establish procedures, particularly those for complaints, to make sure regulation is fair and transparent. Another member requested that this issue be made a top priority to avoid budgetary concerns. Mr. Romero added that he is worried that pharmacies are doing business with unlicensed PBMs, and because the OSI does not regulate pharmacies, it is limited on what action it can take. The OSI was requested to indicate in its budget request what would be needed to ensure proper staffing to address PBM regulation under the act.

Public Comment

Barbara K. Webber, Health Action New Mexico, thanked the committee and the public for their commitment to addressing the issue of pharmaceutical costs and urged committee members to continue to pursue the issue. Addressing this issue is important for consumers and patients, particularly for a state with high poverty rates. Ms. Webber stated that she is approaching the age of 80 and is currently taking very few medications, yet her costs for medications alone are over \$50,000 per year. She views herself as an average consumer. Ms. Webber has a skin condition and is currently taking biologics as part of a clinical trial. She testified that this medication has been a lifesaver for her. Drugs like these are very important to patients, but so many people cannot afford them. The number of life-changing pharmaceuticals that actually make it to market needs to be looked at more closely.

Liz Thomson, a former state representative, noted that consumers do not go into a grocery store without knowing the cost of products, yet the pharmaceutical industry is different. Consumers are frequently forced to go to one place for something they need and, at times, cannot live without, and they pay an unknown price. She believes advertising of pharmaceuticals is misleading and encourages patients to inquire about specific brand-name drugs during doctor visits. Ms. Thomson's son is on Medicaid through the developmental disabilities (DD) waiver. Now that he is 26, he is no longer eligible for his family's private insurance policy. Ms. Thomson added that when private insurance turns down his treatment, so does Medicaid. It is less beneficial for the family to keep him on private insurance, even though it is a savings to the state.

Carol Maestas testified again before the committee, requesting that Rett syndrome be added as a qualifying condition for the DD waiver. Rett syndrome, which primarily affects girls, used to be classified under the autism spectrum but has been removed. The cost to care for individuals with Rett syndrome is astronomical and places a heavy burden on working-class families, even with insurance. Ms. Maestas pursued the DD waiver in the past for her granddaughter and was told that the child was not yet sick enough to qualify. Her goal is to prevent her granddaughter and other children from becoming sick enough by getting them the early intervention and treatment they need before their condition progresses. Senator Michael Padilla, who carried a memorial to that effect in 2016, has requested the drafting of another memorial for the upcoming session asking the Department of Health (DOH) to consider the condition for DD waiver eligibility. A member of the LHHS asked about the fiscal impact of adding Rett syndrome and inquired about a letter to the DOH requesting more information on the

number of individuals this would affect. Ms. Thomson noted that the real issue is the long waiting list for the DD waiver. The wait list is well over 10 years out and currently has more than 6,000 individuals waiting for services. Individuals with Rett syndrome would likely already qualify for the waiver based on their symptoms, but there are no waiver slots available.

Mr. Mason briefly addressed concerns regarding the ACA under the new presidential administration. Mr. Mason plans to request a memorial about the impact the potential repeal of the ACA would have on New Mexico.

Recess

The first day of the LHHS meeting recessed at 4:25 p.m.

Tuesday, November 15

Welcome and Introductions

The LHHS meeting reconvened at 8:58 a.m.

2016 New Mexico Health Care Workforce Committee (NMHCWFC) Report

Richard Larson, M.D., chair, NMHCWFC; and executive vice chancellor, UNM Health Sciences Center (HSC), presented to the LHHS the organization's final report, which includes findings and recommendations (please see handout). The Health Care Work Force Data Collection, Analysis and Policy Act was passed in 2012, requiring licensure boards to develop surveys on practice characteristics. According to Dr. Larson, New Mexico is the only state that tracks health care provider needs within a state. The act was unfunded and to date has not received any funding. Licensure data are directed to UNM HSC for stewardship and storage; confidentiality of data is strictly enforced. Dr. Larson highlighted some of the accomplishments since 2013, primarily the NMHCWFC's role in enhancing funding for various program expansions and workforce positions. The creation and development of New Mexico's telehealth services (Project ECHO) has helped to meet needs around the state. As of December 31, 2015, New Mexico has 9,382 licensed physicians; 1,995 certified nurse practitioners (CNPs) and clinical nurse specialists (CNSs); and 1,293 practices. There has been an increase of 441 practicing medical doctors and 65 CNPs/CNSs since 2014. Dr. Larson explained that not all of the physicians licensed in the state practice here — licensing fees are cheaper in New Mexico than in other states.

Dr. Larson noted that the 2015 survey of medical doctors implemented by the Regulation and Licensing Department (RLD) omitted the item asking for physicians' specialties. It is critically important that the specialties question be reinstated for future years to allow for robust year-to-year comparisons. At Dr. Larson's request for committee assistance with the matter, a member of the committee requested that LCS staff draft a letter to the RLD urging it to reinstate this component of the survey.

A breakdown of the distribution of New Mexico primary care providers was delivered to the committee, and Dr. Larson noted areas of deficiency. Lea County is currently the worst in the state for availability of providers, lacking 21 physicians, 13 CNPs/CNSs and 13 physician assistants (PAs). Since 2013, there has been an overall increase in the number of providers actually practicing in the state. However, the rates are still low — only 65 percent of licensed CNPs are currently practicing. Practitioner shortages are most severe in less-populated counties. Without redistributing the current workforce, New Mexico needs 124 primary care physicians, 36 obstetricians and gynecologists, 18 general surgeons, 109 psychiatrists, 201 CNPs/CNSs, 128 PAs, 67 dentists and 292 pharmacists. One future issue to consider is the fact that New Mexico has the highest percentage of physicians in the nation over the age of 60.

Dr. Larson addressed the status of behavioral health in New Mexico, stating that the behavioral health workforce is in crisis. Limited resources in the state mean limited capacity. There are poor training opportunities surrounding evidence-based therapies and recovery and resiliency. The state is also lacking a targeted workforce recruitment and retention strategy. While New Mexico's rates of behavioral health disorders are similar to the national average, the consequences are frequently more severe. The suicide rate is 59 percent higher than the national rate, and the drug overdose rate in the state is 96 percent higher. The NMHCWFC has several recommendations from its 2016 report that Dr. Larson shared with the committee.

For all health professions:

- A. correct the recent omission by the RLD of the practice specialty item from the physician online license renewal survey platform;
- B. enhance the PA survey with an added practice specialty item. PAs either go into primary care or surgical specialty, and it would be beneficial to track that information;
- C. maintain funding for the loan-for-service and loan-repayment programs at their current levels;
- D. restructure loan-for-service and loan-repayment programs to target the professions most needed in rural areas;
- E. continue funding for expanded primary and secondary care residencies in New Mexico;
- F. support further explorations of Medicaid as an avenue for expanding residencies in New Mexico;
- G. obtain federal matching funds for loan repayment; and
- H. provide funding for the NMHCWFC.

For behavioral health:

- A. expedite professional licensure by endorsement for social workers, counselors and therapists. The state would benefit from stronger reciprocity with other states. Due to the lack of providers in some areas of the state, telehealth can aid in the mentoring needed prior to licensure;
- B. explore opportunities to leverage federal funding for the New Mexico Health Information Exchange and adoption of electronic health records for behavioral health providers;

C. convene a planning group to develop a statewide telehealth infrastructure to deliver behavioral health services via telehealth to rural communities;

D. add social workers and counselors to the professions eligible for New Mexico's rural health care practitioner tax credit. Pharmacists, therapists and social workers are left out of the current program;

E. identify funding for efforts to support and prepare candidates from diverse backgrounds to complete graduate degrees in behavioral health fields; and

F. support Medicaid funding for community-based psychiatry residency programs in federally qualified health centers (FQHCs). Historically, FQHCs have not been involved in behavioral health care due to billing complications.

Following the presentation, members of the committee discussed the findings and recommendations presented by Dr. Larson. Some key points addressed were:

- the current availability of loan-repayment programs in the state and the potential for federal match funding and expansion;
- the need for reciprocity for all health providers, including social workers, therapists and counselors;
- funding and staffing needs for the NMHCWFC — \$250,000 and two full-time employees;
- the potential for more detailed and specific data with additional funding and support;
- the cost of funding resident programs;
- an inquiry about reports of pharmacists graduating but not passing certification;
- the deficiency in the number of providers in parts of the state, particularly the southern region and rural areas;
- challenges with recruitment and retention;
- legislative needs to address some of the recommendations, specifically expediting licensure;
- tracking information for licensed nurse-midwives as a separate data set;
- discrepancies with data reported by MCOs and the need for unbiased reporting for accurately assessing needs in the state;
- creative initiatives by counties to build capacity and encourage professionals to remain in communities following residencies;
- the expansion of FQHCs into behavioral health;
- Senate Memorial 28 (2016) and a recommendation against the program's implementation (see report); and
- a request for draft legislation that includes counselors, social workers and pharmacists in the rural health care practitioner tax credit program.

Kinship Guardianship Report

Liz McGrath, executive director, Pegasus Legal Services for Children, introduced several individuals in the audience representing different organizations of grandparents from Espanola, Rio Rancho and Albuquerque. Pegasus Legal Services for Children provides services to

grandparents raising grandchildren. Ms. McGrath explained that grandparents frequently care for children who would otherwise end up in foster care if it were not for their families. This practice, she explained, is often referred to as "shadow foster care". Unlike the traditional foster care system, grandparents taking in children do not receive any of the help or support that licensed foster parents receive. Resources and assistance for grandparents raising grandchildren are provided through numerous systems, and agency staff are not trained to serve grandparents. These situations affect systems like health care and schools. When grandparents attempt to enroll their grandchildren in school, they are sometimes turned away, even though federal law guarantees these children the right to be enrolled immediately. Children in these circumstances are considered to be "homeless". There are often legal issues and expenses involved in these situations. Children at risk for abuse and neglect sometimes fall into the gap between the requirements of the Kinship Guardianship Act and the Children, Youth and Families Department (CYFD) requirements for taking a child into protective custody. Several states are implementing programs known as "supportive diversion", which avoid the placement of children in foster homes and instead place them with family members.

House Memorial 8 (2015), later extended by Senate Memorial 1 (2016), requested the creation of a task force to study the needs of grandparents raising grandchildren and to make recommendations to the legislature regarding needs for increasing resources and assistance. Ms. McGrath presented the task force's report from the last few years of work (please see handouts), adding that the task force hopes to continue this work. She acknowledged help from the CYFD and the Aging and Long-Term Services Department (ALTSD) in this effort, but she noted that neither agency endorses the recommendations. Ms. McGrath recognized the current state budget situation and requested that further cuts to ALTSD programs that support grandparents be avoided. The following legislation is being proposed to address the needs of grandparents raising grandchildren.

Services and supports for grandparents raising grandchildren. This proposed bill is an appropriation to the ALTSD for \$200,000 to create a statewide network of services and supports for grandparents, including general support services, parent training, support groups, case management, social activities and enrichment activities for children.

Revising Section 40-10B-15 NMSA 1978 — Caregiver's Authorization Affidavit. The proposed bill would add enrollment in early intervention services, daycare, Head Start and preschool programs to the caregiver's authorization affidavit to ensure that these vulnerable children have access to vitally important services.

Revision of NMAC 8.15.2.1 — Requirements for Child Care Assistance Programs for Clients and Child Care Providers. This bill would amend the New Mexico Administrative Code to allow grandparents raising grandchildren to obtain child care assistance benefits without regard to their income and without regard to their status as legal guardian of the child.

Renewal of the Task Force on Grandparents Raising Grandchildren for FY 2018. The members of the task force requested the extension of the task force for an additional year to continue to study and recommend concrete policy changes that could be implemented to expand the availability of resources and assistance to grandparents raising grandchildren.

Public Comment

Delphina Romero of Las Cumbres Community Services shared a story about the lack of support around the state for grandparents assuming the care of their grandchildren. This issue is occurring throughout the state, and she would like to see services available statewide. Support groups for grandparents are growing because the need exists. Some groups have up to 30 grandparents and grandchildren at a time, and the need for legal services and subsidies is very common. Ms. Romero added that grandparents are often caught between the needs of the children and the wishes of the parents.

Lupe Salazar from Espanola has two granddaughters that live with her. Las Cumbres Community Services was the only place that helped her when she began caring for them. Ms. Salazar stated that she never imagined she would be in this situation of raising children all over again. She is unable to get a job because of the children's needs and is also unable to afford daycare so she can get a job because she is currently unemployed. Ms. Salazar recently qualified for Supplemental Nutrition Assistance Program (SNAP) benefits. Because she is not yet 55 years old, she does not qualify for respite services through Las Cumbres Community Services. She stated that she loves her grandchildren, but she needs support taking care of them.

Connie Compton has been raising her grandson, who is now 17, since he was a baby. She found a support group when he was seven years old and it made a tremendous difference. Ms. Compton shared that the child's mother was a substance abuser, and he suffered a lot of trauma. Many of these children experience trauma and have behavioral and mental health issues. A lot of these groups are privately funded. When they run out of funds, they are frequently disbanded. Ms. Compton noted the changes in parenting and how that adds to the challenges. There is a great need for a statewide initiative to address this issue. Information and resources for grandparents exist, but it would be helpful to have a clearinghouse created. One example Ms. Compton relayed was the fact that her grandson was eligible for Medicaid, but she was unaware of the benefit.

Betsy Stilton from Albuquerque stated that it is essential not to cut funding for legal services. Grandparents suddenly become parents again without much warning or preparation for it. Ms. Stilton's daughter died from an overdose, and she assumed care for her grandchildren. Each of the children had different fathers, and legal services were critical. There is a need for a statewide network of available services. When the CYFD or police officers present grandparents with a child, they should also provide them with a folder containing information about how to access services and what resources exist for them. Ms. Stilton noted that Bernalillo County does some of this, but she is concerned about rural areas of the state and the limited resources for those grandparents.

Beth Pacheco of Espanola is caring for three grandchildren between the ages of six and 12. The grandchildren came into her care through the CYFD, which was a long process. Ms. Pacheco received support for the children during the process, but once she formally adopted them, she lost those services. The children no longer qualify for free lunches or Medicaid. In addition, she now has expenses for things like clothing and school supplies. Ms. Pacheco stated that any support the legislature could provide would be appreciated.

Tammy Gray, a caseworker at Methodist Children's Home in Albuquerque, helps provide family outreach. Ms. Gray wants to bring a voice to children who are often in the process of losing parents to incarceration, death or overdose. It is essential for communities to support the grandparents raising the next generation. Ms. Gray stressed the importance of putting and keeping programs in place.

LHHS members thanked the speakers for sharing their experiences. A few members expressed interest in sponsoring legislation proposed by the task force. In response the presentation, the committee discussed the following points with Ms. McGrath relating to kinship guardianship and grandparents raising grandchildren:

- a need for greater efforts by the CYFD to maintain family connections for children;
- a need for better training of employees at the CYFD and ALTSD in handling these situations;
- an awareness of the potential behavioral health issues and the trauma experienced by these children;
- programs and initiatives by other states to offer subsidies and support;
- the ability of the task force to assemble informational packets and determine the contents;
- inquiries about supportive diversion;
- a request to the CYFD for the total number of children placed with grandparents;
- recognition of existing services and the need for a clearinghouse or directory;
- coverage of existing funding for legal services through the ALTSD;
- the difficulty in recruiting contract attorneys in some counties and suggestions for advertising;
- the need for more individuals designated at the Public Education Department to handle homeless children;
- the frequency of children being unable to participate in school activities and athletics due to a lack of guardianship; and
- the need for additional efforts to encourage these children to stay in school.

Disabilities Concerns Subcommittee (DCS) Minutes

There being a quorum of voting members of the DCS, subcommittee members considered the minutes from their fourth meeting, on October 7, 2016. Following a motion for adoption by Representative Garcia, seconded by Senator Lopez, the minutes for the DCS were adopted without any objection.

Preliminary Findings on Sexual Assault Evidence Processing Audit

Timothy Keller, state auditor, provided an update on the processing of sexual assault evidence kits. New Mexico is forty-eighth in the nation when it comes to the frequency of sexual assaults. One in every four women and one in every 10 men may experience an attempted or completed sexual assault. In December 2015, the Department of Public Safety (DPS) organized a task force to look at the issue of untested evidence kits. Throughout the state, there were approximately 4,500 untested kits; the current count is closer to 5,000. The DPS was unable to get responses from some departments around the state. The state crime laboratory has been processing kits with the help of legislative funding and some outside funding. State Auditor Keller informed the committee that the Office of the State Auditor (OSA) audit will be concluded in mid-December 2016, and he shared some initial findings and takeaways.

1. The OSA began picking law enforcement departments, at random, around the state and announced that it was going to conduct on-site audits to confirm counts and check processes. The awareness of the pending audits spurred departments to send everything to the state crime laboratory in Santa Fe, where evidence kits should have been sent in the first place. This happened at every audited location. Now the laboratory has more than double the number of kits than before. The question is why these kits were not being sent in the first place. All it took was an announcement of an inspection to drive action at the local level. State Auditor Keller stated that, many times, local law enforcement hangs on to the kits for various reasons, including waiting to hear back from the victim and lack of evidence to move forward on testing. This is not an issue of resources but rather a department policy issue. The OSA concludes that all kits should be sent for testing.

2. There are two sites for collection of evidence kits that are part of the backlog: the state crime laboratory and Bernalillo County. While almost all evidence goes to the state crime laboratory in Santa Fe, Bernalillo County processes its own kits at the Albuquerque Police Department (APD) Crime Lab. Over one-half of the unprocessed kits are at the Albuquerque facility. The APD Crime Lab is not planning to address the backlog and intends on processing a few hundred per year. There is not a path to getting rid of the backlog at this location.

3. The OSA conducted some confidential surveys with local law enforcement departments regarding the backlog and why the kits were not being tested. From the feedback the OSA received, law enforcement frequently encounters a lack of victim cooperation or credibility. State Auditor Keller emphasized the public safety importance of testing kits regardless of those issues. Attitudes toward sexual assault are driving the backlog and changing the rhetoric matters. In bringing attention to the backlog at local police departments, significant progress was made.

Scott Weaver, secretary-designate, DPS, was present and addressed the committee regarding the backlog. Secretary Weaver stated that law enforcement, including the district attorneys, operate on their skills and training. Often, they are just following standard procedures,

which include not moving forward with cases lacking evidence. Space had to be modified at the state crime laboratory to accommodate the additional evidence from around the state. Secretary Weaver indicated that two full-time employees and three additional employees have been added, funded by outside grants. The money does not address future procedures and policies that need to be established. There are currently eight people working to address the backlog and processing kits. The DPS would like to have 11 by the end of the year.

Members of the committee discussed the following aspects of the OSA's findings:

- the prevalence and reporting of sexual assault on college campuses;
- the difference in how cases are handled based on the entity to which the assault is reported;
- the critical need for protection of witnesses and confidentiality;
- various circumstances that discourage reporting;
- the effect of the backlog on public trust;
- a similar issue of evidence backlogs in other states around the country;
- the importance of testing kits to log evidence into the national registry;
- funding, staffing and equipment needs to address the backlog;
- the need for more accountability among local law enforcement departments and with the district attorneys;
- clarification about the prioritization in testing of evidence kits;
- the distinction between the two laboratories and the lack of authority over the processes in Bernalillo County;
- the difficulty of outsourcing kits for processing;
- challenges with the state budget and the need to prevent reversion of funds;
- the importance of victim advocacy groups in the process;
- the anticipation of completing all testing on kits in the backlog by FY 2019; and
- the potential need for statutory authority to compel local entities to follow procedures for evidence kits.

Burrell College of Osteopathic Medicine (BCOM): Primary Care in Rural and Tribal New Mexico

George Mychaskiw, founding dean, BCOM, shared information about BCOM, which opened August 2, 2016 at New Mexico State University (NMSU). There are currently 162 medical students from New Mexico and elsewhere in the southwest. BCOM is partnered with the University of North Texas Health Science Center and offers a difficult curriculum. Dr. Mychaskiw is very proud of the students and faculty. He shared a story about one student from Espanola and the successes he has had at the school. Residency is very important for students, and BCOM offers programs to offset tuition in exchange for four years of service. BCOM is building partnerships with various hospitals around the state to create opportunities for students. To date, the school has received 4,000 applications — the largest increase in the country at 40 percent. Tuition is equivalent to the UNM School of Medicine. The founding of BCOM has created more than 300 new jobs in the state, with an expected \$120 million annually in economic

impact on Dona Ana County. No taxpayer money has been spent on BCOM. The school hopes to expand to locations like the Four Corners area and Gallup with the establishment of satellite campuses. Dr. Mychaskiw noted the challenges of opioid addiction in New Mexico. He will be speaking at the White House during an upcoming conference about opioids and addiction. Dr. Mychaskiw referenced a previous loan-for-service bill for osteopathic medicine. He encouraged the committee's support of that legislation and its consideration for an appropriation to be added.

Responding to questions from the committee, Dr. Mychaskiw discussed the following points:

- the economic impact of BCOM on southern New Mexico;
- the creation of residencies to address the needs of the behavioral health community;
- the emphasis of residencies on community medicine and primary care;
- BCOM as an example of a successful public-private partnership;
- efforts to build capacity at the school and attract students from around the country;
- funding sources for residencies through the federal Centers for Medicare and Medicaid Services and, potentially, the U.S. Department of Veteran Affairs;
- inquiries about residency programs and how they are established;
- the potential for expanding services in developmental pediatrics and addressing a dire need for autism services;
- clarification about appropriation needs for loan-for-service legislation;
- partnerships with tribal entities to establish Native American programs;
- the large numbers of students from the region and the high percentage of Hispanic students; and
- efforts to increase the health care workforce in New Mexico, particularly in rural parts of the state.

Approval of Minutes

Senator Moores made a motion to adopt the minutes of the October 25-28, 2016 meeting of the LHHS. Senator Stewart seconded the motion, and the minutes of the sixth meeting of the LHHS were adopted without objection.

Public Comment

Nat Dean thanked the committee and the OSA for their enthusiasm and attention to the processing of the rape kits. As a victim, she experiences guilt from not being able to prevent it from happening to someone else. Ms. Dean encouraged legislators not to cut funds to the Disability Advisory Group About Tobacco, an organization that focuses on tobacco use prevention for people with disabilities. Approximately 25.4 percent of individuals with disabilities smoke. That is a higher rate than those without disabilities. Ms. Dean expressed concern about requiring medical cannabis patients to renew their user identification cards every year under the current statute. This is an economic burden for those patients with permanent conditions. Ms. Dean would like to see the elimination of restraints in schools. She believes this has a negative impact on other students and normalizes violent behavior. Ms. Dean is a brain

injury survivor and advocates more funding for the Brain Injury Services Fund. Some past legislation was introduced to add more revenues for the fund. One of the bills required a higher motorcycle registration fee for individuals who choose not to wear helmets and another that allocated \$5.00 from moving violation fines to the fund. Due to the lack of vehicle citations, the fund has been depleted. Ms. Dean stated that there is approximately \$200,000 left in the fund. She requested that other avenues be explored to add more funding.

Ruth Hoffman, Lutheran Advocacy Ministry, acknowledged all of the funding needs around the state and the current budget situation. Ms. Hoffman urged the committee not to "balance the state budget on the backs of the people who need help and services the most".

Ms. Maestas readdressed the committee to answer some questions brought up during her previous testimony and provided the committee with another handout on Rett syndrome. Ms. Maestas emphasized the need for immediate early intervention.

Bill Jordan, New Mexico Voices for Children, echoed the statements made by Ms. Hoffman. The state relies too heavily on the volatile oil and gas industry and has built in a structural deficit by implementing tax cuts. Mr. Jordan stated that the state cannot continue to ask children and families to make up the difference in the budget. He discouraged the notion of taxing food and urged the committee to consider tax increases. Mr. Jordan believes consideration should be given to withdrawing funds from the Land Grant Permanent Funds for K-12, higher education and early childhood development.

Review of Proposed Legislation for the 2017 Regular Session

The following legislation was presented to the committee for endorsement for the 2017 legislative session. Mr. Hely provided a synopsis of each bill, with additional input from stakeholders and advocates who were present at the meeting. Senator Ortiz y Pino noted that support or opposition is reflective only of committee endorsement, not necessarily of the legislation itself.

Carve out behavioral health from Medicaid MCOs (.204335.1). This proposed bill would amend a section of the Public Assistance Act to remove behavioral health services from those services the HSD provides to Medicaid recipients through managed care. This legislation would implement a fee-for-service model and allow the HSD to better track money spent on behavioral health. Pursuant to a motion, the committee voted to endorse this legislation. Two members voted in opposition to endorsement. Senator Ortiz y Pino will carry the bill during the 2017 session.

School nurse in each district (.204382.1). This legislation would amend the Public School Code to require each public school district to employ a minimum of one full-time, licensed registered school nurse. An appropriation for \$1,650,000 is included in the bill. Currently, there are 12 small school districts without a school nurse. An exemption from this requirement would have to be requested by the school district. Members of the committee

discussed various aspects of the proposed legislation. Pursuant to a motion, the committee voted to endorse the legislation. Two members voted in opposition to endorsement. Senator Ortiz y Pino will carry the bill during the 2017 session. Representative Yvette Herrell was identified as the sponsor of this bill.

Health professional disclosures (.204396.1). This bill was withdrawn to be redrafted as a house joint memorial.

Amend the Rural Primary Health Care Act (.204398.2). This bill would provide for funding of eligible clinical programs, eligible workforce development programs and eligible workforce recruitment programs in underserved areas of the state. It would allow for the creation of residency programs and expand health care in rural areas. There is no appropriation component, and the bill is authorizing legislation. Members of the committee inquired about details of how residency programs in rural areas would work. Following debate on the legislation and motion to endorse, the committee voted to endorse this legislation. One member voted in opposition to endorsement. Senator Morales was identified as the sponsor of the bill.

Cardiac calcium scans (.204678.1). This bill would amend several sections of law to require coverage of artery calcification screening for early detection of cardiovascular disease in certain individuals. Upon a motion, the committee unanimously endorsed this bill. Representative Christine Trujillo was identified as the sponsor.

Provider parity (.204692.1). This proposed legislation would enact sections of law to ban discrimination against any health care practitioner working within the scope of that practitioner's license or certification. This bill would mirror the parity provisions of the ACA and would also include pharmacists. Some LHHS members expressed concern that this legislation would undermine the scope-of-practice argument. The committee endorsed the bill pursuant to a motion to endorse, with two members voting in opposition. Senator Ortiz y Pino stated that he would carry the bill.

Indoor Tanning Act (.204790.2). This bill bans the use of tanning devices by individuals under the age of 18 and establishes safety measures for indoor tanning. It was noted that no current licensing or inspections are required for indoor tanning salons. A representative from the American Cancer Society Cancer Action Network voiced the organization's support of the legislation. Pursuant to a motion for endorsement, the committee endorsed the bill, with one member voting in opposition. Representative G. Andrés Romero was identified as the bill's sponsor.

Caregiver leave (.204800.3). This legislation would enact the Caregiver Leave Act to provide employees of private entities who have accrued paid sick leave with the opportunity to use sick leave for family caregiving. This bill does not create a new benefit or mandate sick leave; it just allows sick leave to be used to care for a family member if sick leave is offered by the employer. Some members expressed concern about the impact on small businesses and the

potential negative effect the law would have on teachers in terms of performance evaluations. After discussion, the suggestion was made to add "including adverse performance evaluation" on page five after line 24. Upon a motion to endorse, the committee voted to endorse the legislation as amended. Two members voted in opposition to endorsement. Representative Armstrong stated that she would carry the bill in the 2017 regular session.

Remove severe emotional disturbance/severe mental illness diagnosis requirement (.204864.1). This bill would enact a new section of the Public Assistance Act to direct the HSD to change the basis for reimbursement of preventative and early intervention services for children. Specifically, it would remove the diagnosis requirement of serious emotional disturbance or severe mental illness. This was a recommendation by the J. Paul Taylor Early Childhood Task Force. Upon a motion to endorse, the committee voted to endorse this legislation without any opposition. Senator Ortiz y Pino was identified as the bill's sponsor.

Diabetes Committee (.204944.1). This act would establish the Diabetes Committee to identify goals and benchmarks for state entities to reduce the incidence of diabetes and costs and complications relating to diabetes statewide. Following discussion by the LHHS, representatives from the Public Education Department, the Indian Affairs Department and the ALTSD were suggested as members of the proposed committee. Following a motion to endorse, the committee voted to endorse the legislation as amended. Representative Armstrong was identified as the bill's sponsor.

Chiropractic Physician Practice Act changes (.204981.2). This bill would amend and enact sections of the Chiropractic Physician Practice Act to provide for certification of advanced practice chiropractic physicians. Dr. Steve Perlstein explained the intent of the bill and the benefits for the profession. Under this bill, advanced practice chiropractic physicians will not have prescriptive authority for opioids. Members of the committee discussed the bill, and several concerns were raised. A request for input from the Board of Pharmacy was made. Lacking a motion for endorsement, the LHHS did not endorse this legislation.

Pregnancy accommodation (.205014.1). This legislation would enact the Pregnant Worker Accommodation Act, which would prohibit discrimination in employment on the basis of pregnancy or childbirth or a related condition. Under this act, employers would be required to make reasonable accommodation of an employee's or job applicant's pregnancy or childbirth or a related condition. Employers would be prohibited from retaliation for an employee's or job applicant's assertion of a claim pursuant to the act. Following discussion of the bill and a motion to endorse, the committee endorsed the bill, with two members voting in opposition. Representative Chasey was identified as the bill's sponsor.

Lynn and Erin Compassionate Use Act supply and identification card changes (.205107.1). This act would amend the Lynn and Erin Compassionate Use Act to provide for presumptive eligibility for medical marijuana with three-year certification and to establish new content and possession standards. This legislation is the result of a compromise to address an

issue heard by the LHHS throughout the interim. The three-year certification would be granted to individuals with chronic or terminal conditions. Pursuant to a motion, the committee endorsed the legislation, with one member abstaining. Senator McSorley was identified as the sponsor of the bill for the 2017 regular session.

Senate memorial: financial relief for family caregivers (.204816.1). This memorial recognizes the economic contribution of informal or family caregivers and supporting measures to provide them with meaningful financial relief. The committee voted to endorse this memorial without any opposition. Senator O'Neill agreed to carry the memorial during the 2017 session.

Reimbursement for pharmacy services (.204817.1). This proposed legislation amends several sections of existing law to establish reimbursement parity between pharmacists and certain other licensed health professionals for the same pharmaceutical clinical services. Pursuant to a motion for endorsement, the committee voted to endorse the bill, with two members standing in opposition. Representative Armstrong was identified as the sponsor of the bill.

SNAP limitations (.204989.1). This bill, brought for committee endorsement by Senator Cliff R. Pirtle, would establish guidelines to restrict purchases under SNAP to those foods available under the federal Special Supplemental Nutrition Program for Women, Infants, and Children. Lacking a formal motion, this legislation failed to gain endorsement by the LHHS.

Medical and geriatric parole (.205059.2). This bill would require the director of the Adult Probation and Parole Division of the NMCD to identify and authorize the release of eligible inmates on medical or geriatric parole. Under this legislation, authority would be placed with the NMCD instead of by advisement of the Parole Board. Pursuant to a motion for endorsement, the committee voted to endorse this legislation without any opposition. Senator Ortiz y Pino was identified as the sponsor.

Adjournment

There being no further business before the committee, the seventh and final meeting of the LHHS for the 2016 interim adjourned at 5:21 p.m.

DISABILITIES CONCERNS SUBCOMMITTEE
AGENDAS AND MINUTES

Revised: August 2, 2016

**TENTATIVE AGENDA
for the
FIRST MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**August 4, 2016
Room 307, State Capitol
Santa Fe**

Thursday, August 4

- 9:00 a.m. **Welcome and Introductions**
—Senator Nancy Rodriguez, Vice Chair
- 9:10 a.m. (1) **Fiscal Issues Facing the Department of Health and the Developmental Disabilities Waiver**
—Charles Sallee, Deputy Director for Program Evaluation, Legislative Finance Committee (LFC)
—Eric Chenier, Senior Fiscal Analyst, LFC
- 10:45 a.m. (2) **Public Comment**
- 12:00 noon **Lunch**
- 1:00 p.m. (3) **Report on Developmental Disabilities Supports and Services**
—Cathy Stevenson, Director, Developmental Disabilities Supports Division, Department of Health (DOH)
—Angela Medrano, Deputy Director, Medical Assistance Division (MAD), Human Services Department (HSD)
—Sharilyn Roanhorse, Bureau Chief, Exempt Services and Programs Bureau, MAD, HSD
- 2:00 p.m. (4) **Renewal of New Mexico's Developmental Disabilities Waiver**
—Cathy Stevenson, Director, Developmental Disabilities Supports Division, DOH
—Angela Medrano, Deputy Director, MAD, HSD
—Sharilyn Roanhorse, Bureau Chief, Exempt Services and Programs Bureau, MAD, HSD
—Fritzi Hardy, B.S., M.A., Chair, Association of New Mexico Family Providers

3:00 p.m. (5) **Report on Issuance and Renewal of Registry Identification Cards for Qualified Medical Cannabis Patients**

- Duke Rodriguez, President and Chief Executive Officer, Ultra Health
- Robert Romero, Vice President for Government Affairs, Ultra Health
- Leigh Jenke, President and Chair, Licensed Non-Profit Producers
- Nicole V. Morales, Executive Director, New Mexico E.M.P.A.C.T.
- Anita Briscoe, M.S., A.P.R.N.-B.C.
- Garth Wilson, Patient Representative, New Mexico E.M.P.A.C.T.
- Timothy Keller, State Auditor

4:00 p.m. (6) **Public Comment**

5:00 p.m. **Adjourn**

**MINUTES
for the
FIRST MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**August 4, 2016
Room 307, State Capitol
Santa Fe**

The first meeting of the Disabilities Concerns Subcommittee (DCS) of the Legislative Health and Human Services Committee was called to order by Senator Nancy Rodriguez, vice chair, on August 4, 2016 at 9:22 a.m. in Room 307 at the State Capitol in Santa Fe.

Present

Sen. Nancy Rodriguez, Vice Chair
Sen. Craig W. Brandt
Rep. Miguel P. Garcia
Sen. Linda M. Lopez

Absent

Rep. Tim D. Lewis, Chair

Advisory Members

Rep. Deborah A. Armstrong
Sen. Ted Barela
Sen. Gerald Ortiz y Pino

Rep. Nora Espinoza

Guest Legislators

Sen. Cisco McSorley
Sen. Howie C. Morales

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Rebecca Griego, LCS
Alexandria L. Tapia, Contractor, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=DISC.

Thursday, August 4

Welcome and Introductions

Senator Rodriguez welcomed members to the first meeting of the DCS. Members of the subcommittee and staff were asked to introduce themselves.

Fiscal Issues Facing the Department of Health (DOH) and the Developmental Disabilities (DD) Waiver

Charles Sallee, deputy director for program evaluation, Legislative Finance Committee (LFC), provided the subcommittee with a post-session recap, overall DOH budget update and details about the DD waiver. The state budget for fiscal year (FY) 2017 was built on an estimated \$5.9 billion; however, based upon projections done in May 2016, actual revenues are estimated at \$5.74 billion. Falling revenue projections are forcing the prioritization of departments. Medicaid and public safety remain at the top: Medicaid makes up 15% of the recurring General Fund appropriation. With few options for making up the shortfall, the legislature is looking at drawing funds from the Tobacco Settlement Permanent Fund.

Eric Chenier, senior fiscal analyst, LFC, noted that in terms of the DOH FY 2017 budget, facilities and the DD waiver have been prioritized. DD support makes up \$160.7 million of the DOH's total appropriations. The federal Patient Protection and Affordable Care Act (ACA) and Medicaid expansion improved the financing of rural primary health, public health and facilities. The FY 2017 appropriation included 40 new DD waiver slots and nonreverting language that retains unexpended funds. These new measures are still insufficient to reduce the DD waiver wait list. Mr. Chenier explained the *Waldrop* and *Jackson* lawsuits and their outcomes on the state's financial picture. The subcommittee was provided with an update of ongoing litigation expenses.

Federal regulations require that the cost of community-based services be less than institutional care costs. In 2010, the state's per enrollee costs were on track to equal, and potentially exceed, institutional care costs. At that time, the LFC recommended a needs-based assessment tool; the DOH subsequently implemented the Supports Intensity Scale (SIS). Mr. Chenier informed the subcommittee that the DD waiver application rate has grown at almost twice the number of annually available slots; the wait list is outpacing available slots at about 5% per year. To reduce waiver wait times, New Mexico can look to other states for options in terms of leveraging local funding. Six other states use local funds for the Medicaid match, while 10 states use local funds for other DD programs and services. In FY 2014, New Mexico counties held \$30.4 million in county indigent fund balances. Mr. Chenier suggested that statutory changes could be made to require counties to contribute indigent funds for the needed Medicaid match.

In addition to the DD waiver, the State of New Mexico offers the Mi Via Self-Directed Waiver Program (Mi Via). Mi Via is designed for participants who have disabilities to manage their own services and supports. Individuals can choose the program from which they want to

receive benefits. The average cost per client on Mi Via is \$44,100 a year. In comparison, the average cost per client on the DD waiver is \$70,000 per year; however, Mr. Sallee stressed that these are only averages. In some cases, annual cost per recipient may exceed \$200,000, while other individuals requiring fewer services cost less. Encouraging more people to use Mi Via would help decrease costs and reduce the number of individuals on the DD waiver wait list. The LFC will be working with the DOH to determine what can be done to reduce costs and maximize efficiency.

In response to the LFC's presentation, members of the DCS inquired about the following issues:

- the potential special session and falling revenue projections, including the need for addressing budget expenditures, not just using other funds to cover the budget deficit;
- the wisdom of using the Tobacco Settlement Permanent Fund to address the budget shortfall;
- the need to identify sustainable revenue sources;
- the LFC's updated General Fund financial summary, due out at the end of August;
- the progress of efforts to "disengage" from the *Jackson* lawsuit;
- the status of the *Jackson* and *Waldrop* lawsuits;
- use of county indigent funds to reduce the DD waiver wait list;
- leveraging of local funding and premium taxes;
- tracking of funds from the ACA for the improvement of rural primary health, public health and facilities;
- LFC report cards for state agencies;
- the impact of budget cuts on programs; and
- the lack of additional funding for the DD waiver in FY 2017.

Public Comment

Robert Kegel, advocate and father of a son with severe disabilities, spoke of his four years of research into the state's DD waiver. Mr. Kegel recently met with LFC analysts to present findings that he alleges contradict long-standing claims that New Mexico has the most expensive DD waiver program in the country. According to Mr. Kegel, in 2009, New Mexico was the first state in the nation to replace institutionalization of people with DD with community services. According to Mr. Kegel, if the cost of New Mexico's DD waiver is compared to the spending for community services in other states that institutionalize their severely disabled populations instead of maintaining them in the community, New Mexico's waiver would, of course, be more expensive. Mr. Kegel explained that, in his opinion, a report prepared by a consultant retained years ago to evaluate New Mexico's DD waiver program was misleading because it did not take this into account. Based on research that he has provided to the subcommittee, Mr. Kegel has urged the state, and particularly the LFC, to revisit the consultant's conclusions that the state's DD waiver spending was excessive and thus needed trimming back. Mr. Kegel argued that misplaced reliance on the consultant's report led to the implementation of the SIS. He provided the subcommittee with examples of other states' services and costs, noting how New Mexico is

different. In providing services, the waiver is secondary to schools. Institutional care is done by group homes that provide more services to individuals; the waiver can never exceed the cost of institutionalization.

Texas spends around \$2 billion on 4,000 people, approximately the same number of people on New Mexico's DD waiver. Mr. Kegel explained the funding behind the DD waiver, adding that there is a misconception of what the waiver is actually costing the state. Mr. Kegel noted that New Mexico's DD waiver budget has declined over the last several years. He also criticized the lack of analysis of the state's population of waiver applicants, stating, "We don't know who is on the waiting list, what types of cases are on the list or the extent of services needed for those on the list...yet, we know that the wait list for the waiver is growing faster than our population with an up to 10-year wait.". Other states are using support service waivers, something New Mexico should consider.

Since the state is facing financial difficulties, Mr. Kegel recommended prioritizing Medicaid spending by identifying where money is going and how funds are being used. He noted that Mi Via may have a lower per person cost, but it has an additional Medicaid cost. Mr. Kegel reminded subcommittee members that the *Jackson* lawsuit has saved the state hundreds of millions of dollars because it required the state to close institutions that other states have kept using. Mr. Kegel also expressed concern regarding the billing and lack of cost containment on the part of Medicaid managed care organizations.

Mr. Kegel shared a few examples of DD waiver recipients who had died or had serious medical complications that he claims were due to delays in the approval of individual budgets. He also recommended requiring that anyone conducting audits of waiver programs be a certified public accountant and providing compensation for caregivers who have to stay with DD waiver clients in the event of a client's hospitalization. He also urged adoption of a supports waiver, which would require federal approval but result in an overall cost savings. A supports waiver could provide respite care, case management, nursing for those that need it and potentially a daycare program. If there were a supports waiver, people could be started on services much earlier and they might not end up on the comprehensive DD waiver. Members questioned why some of these services were not being covered under Centennial Care's long-term care services.

Lecie McNeese, DD waiver case manager (CM), spoke to the subcommittee about the vital role of case management in the DD waiver program and provided a handout to members. Case management is the only required service under the waiver program. CMs create individual service plans for program recipients and monitor implementation by service providers through home visits. Ms. McNeese explained that CMs are the conduit for communication among the recipient of services, individual team members, state agencies, families and other community members. In 2007, there was a rate decrease of 10% and that amount was never restored, despite the increases in caseloads, administrative requirements and rising costs in providing services. Ms. McNeese recognized that asking for a rate increase is difficult, given the current financial

climate of the state; however, she did request that CMs be given an opportunity to be included in future discussions related to changes in the DD waiver.

Scott Yuland, CM, addressed an earlier question from a member stating that money spent on the SIS is not necessary. According to Mr. Yuland, an SIS assessment is not required to clinically justify services. The money that is being spent on about 1,000 recipients of the SIS each year, which is not federally matched, could be used for service rate increases or taking people off the wait list, which would be matched with federal Medicaid funds. He suggested that there is money to be "found" within the current system.

Jim Copeland, executive director, Alta Mira Services, informed the subcommittee that his company is one of the few that provides DD waiver, Mi Via, state waiver and early intervention services. He offered a provider's perspective to the subcommittee. Mr. Copeland reminded the subcommittee of a Centers for Medicare and Medicaid Services (CMS) final rule that will restrict the types of programs for persons with disabilities that will be eligible for Medicaid reimbursement. According to Mr. Copeland, the judge presiding over the *Jackson* lawsuit is not satisfied with the consistency of care for the *Jackson* plaintiffs. Providers face many challenges that affect the quality of services, such as large staff turnover rates, mostly due to noncompetitive wages. Providers are often overloaded with requirements from state and federal agencies without corresponding rate increases; most providers are in financial distress. Mr. Copeland would like to see providers included in the decision-making process. He noted that, in 14 years, there have been seven directors in the Developmental Disabilities Supports Division (DDSD) of the DOH and nearly as many secretaries at the DOH.

Lisa Rosenthal, Parents Reaching Out, is an advocate who works to help parents find resources for recently diagnosed children with DD. She shared her personal experience with her daughter who has severe disabilities. She highlighted some of the challenges that families face and what her organization does to help them. She is concerned with systematic dismantling of services and budget cuts to critical programs. Centennial Care has done great work in this area, but it has not been enough for children. Ms. Rosenthal believes that there needs to be a separate waiver exclusively for children. Centennial Care removed community supports and replaced them with care coordination. According to her, care mapping for children with special care needs consists of 35 professional contacts that are involved in a child's care; the system is very complicated and cumbersome. Because Medicaid does not cover it, respite care has been cut down to 100 hours per year. Families are finding ways to reinstitutionalize their children because they are overburdened. She warns that the issue is dire and that it will only get worse.

Report on DD Supports and Services

Sharilyn Roanhorse, bureau chief, Exempt Services and Programs Bureau, Medical Assistance Division (MAD), Human Services Department (HSD), presented with Angela Medrano, deputy director, MAD, HSD, a report on the DD waiver. The current DD waiver expired on June 30, 2016 but received CMS extensions to continue operating through the end of the year, at which time the renewal application will be submitted. Ms. Roanhorse stated that the

waiver renewal time line was significantly impacted by the *Waldrop* litigation and the new CMS rule on home- and community-based services (HCBS) settings. Ms. Roanhorse explained some of the changes to the DD waiver program, including changes required by the CMS to quality measures and reporting and enrollment counts (please see handout for more information).

She explained that every rule and renewal requires stakeholder input. The department began announcements regarding the DD waiver renewal in 2015. She advised that statewide community outreach and informational meetings were held in June 2016 and that the HSD received input from providers, advocacy groups and other interested parties. The DDS has a page on the Access Community Together New Mexico website dedicated to information and submitting comments and ideas to the DDS, which can be found at: <http://actnewmexico.org/ddw-renewal.html>. A complete draft application will be posted on the HSD website in mid-September. Ms. Roanhorse provided information regarding formal public notification, detailing time lines for both tribal notification and general public comment periods. The CMS has a 90-day review period with an opportunity to request additional information, both formal and informal. It is anticipated that the CMS will approve the application by April 2017.

Ms. Roanhorse provided the subcommittee with an update on the CMS rule on HCBS that went into effect on March 17, 2014. The rule is designed to enhance the quality of HCBS, provide additional protections and ensure full access to the benefits of community living. Several changes for HCBS are included in this rule, such as the requirement of comprehensive assessments of all HCBS settings to ensure that services are provided in an integrated setting. The rule applies to all waiver programs and requires formal public input. Approval of a statewide transition plan (STP) is required by the CMS, and all states must be in compliance with the rule by 2019. Ms. Roanhorse shared the status of New Mexico's STP, which encompasses the DD waiver, Mi Via, medically fragile waiver and the Centennial Care waiver. After the period for public and tribal input, the amended STP will be submitted to the CMS by September 30, 2016. Ms. Roanhorse outlined the key components of the STP for the state and the next steps for STP approval. According to her, Tennessee is the only state that has received full approval for its STP; New Mexico is on track for approval.

In response to the presentation, members of the subcommittee inquired about the following issues:

- the definition of "integrated setting", which is the most significant change for the state;
- congregate services that will not be funded under the CMS rule;
- whether the STP is intended to bring all waivers into compliance with the new CMS rule;
- the department's plans to promote provider compliance, rather than termination of providers;
- content changes to the DD waiver and the requirement for third-party clinical review;
- consideration of the supports waiver;

- how *Olmstead* requirements impact the STP;
- the consequences of noncompliance with the CMS rule for providers and the state;
- plans for tribal consultation and public hearings; and
- whether statewide community outreach meetings have been well-attended by consumers and members of the public.

Renewal of New Mexico's DD Waiver

Cathy Stevenson, director, DDS, DOH, noted that there are many other services and supports provided to people in addition to the DD waiver, and she highlighted them briefly (see handout). The DOH has operational oversight of the DD waiver program. Ms. Stevenson drew the subcommittee's attention to the flexible supports program, which provides those on the DD waiver waiting list with \$3,500 per year to purchase services or goods to accommodate their needs related to their disability. This program only has \$500,000 available and is a pilot for what the supports waiver would be; the supports waiver would require a higher level of funding.

Ms. Stevenson also talked about the Family Infant Toddler Program (FIT), which provides individualized early intervention and developmental services to children (birth to age three) who have or are at risk for a developmental delay and their families. New Mexico is one of the few states that funds a program like this. In FY 2016, the FIT served 14,050 children, which was an increase of 762 from the previous year. The number of children served per month is 6,938, with the average cost per child totaling \$3,652 per year. The total amount of federal Medicaid matching funds expended in FY 2016 for the FIT was \$29,194,679; this does not include the state's share, which is in the DOH budget.

The DDS Medicaid waivers provide an array of HCBS to support individuals with DD, of all ages, to live successfully in their homes and in communities of their choice as an alternative to institutional or facility-based care. These waivers include the traditional DD, Mi Via and medically fragile waivers. The FY 2017 operating budget for all of these waivers is over \$105 million. During FY 2016, 4,673 individuals were served by the DD waiver and Mi Via — with 6,402 on the DD waiver wait list. It was noted that the cost numbers in the charts do not include the cost of Medicaid services that persons also receive. Those who qualify for Medicaid get it, regardless of what waiver they have.

Ms. Stevenson explained that the SIS is only for those who are on the DD waiver and is used to help identify service needs for participants. The SIS contract is with the University of New Mexico's Center for Development and Disability. In December 2016, the DD waiver will move from the current three-year assessment cycle to a five-year assessment cycle. In FY 2018, the DOH plans to make the SIS available to a limited number of DD waiver applicants who are next in line for allocation. This will speed up entry into services when funds become available.

The subcommittee was given an overview of the outside review process that ended in June. The outside review process is the additional clinical review as a result of the *Waldrop* case. An initial backlog in clinical reviews required a system-level adjustment to authorize plans on an

interim basis so that providers could bill for services. There have been significant issues on the state side, the case management side and the provider side, but the backlog for annual budgets has been addressed. Plan and budget submissions are often incomplete, and if so, the submissions cannot go on to clinical review without CMs correcting errors or providing supplemental documents. Ms. Stevenson explained how the systems fix was implemented by the state to address issues with the clinical review to ensure that services remain available and providers get paid. She commended the providers and CMs for their work, noting that some agencies have continued to serve people while waiting for their funding. The DOH continues to meet monthly with providers, CMs and the outside reviewer to solve problems.

Following the presentation from Ms. Stevenson, the subcommittee had comments and questions regarding:

- improvement in the approval rate of budgets and the number of budgets returned for additional information;
- qualifying criteria for each waiver program;
- notification of the availability of flexible supports for the DD waiver;
- the fair hearings process since the *Waldrop* settlement agreement;
- concerns about the SIS;
- how the SIS is used to determine a waiver recipient's budget;
- a request for additional information containing a breakout of waiver cost by age group;
- criteria allowing for individuals with critical needs to move from the waiting list to the waiver;
- clarification and details about the medically fragile waiver program; and
- specific constituent cases for DOH follow-up.

Motion 1

After discussion of a potential supports waiver, a motion was made and passed without objection to request a presentation from the LFC on the different support waivers being used throughout the country to be given at an upcoming DCS meeting. The presentation is also to include a report by the LCS on the model being used in Oregon.

Fritzi Hardy, B.S., M.A., chair, Association of New Mexico Family Providers, told the subcommittee about her daughter, who is on the DD waiver. Her daughter is able to attend VSA Arts of New Mexico (VSA), where she gets the help she needs to deal with her seizures. With the new CMS rule, VSA will be eliminated. Under the new rule, individuals cannot be isolated from their peers and are required to be out in the community for 15 hours a week. Ms. Hardy believes that the DD waiver requirement to be out in public interferes with a person's right of association and is unconstitutional. She was in support of the SIS until she started hearing feedback on the system. She wishes the department and programs would listen to input from people dealing with these problems firsthand — the parents, families, caregivers and providers.

Ms. Hardy shared a letter with members from an individual going through the fair hearing process. She added that family living saves the state money, but families need respite.

Ms. Stevenson acknowledged that programs like the VSA model do not fit in with the CMS final rule. The DOH is looking into what can be done for these programs. The CMS is not saying that states cannot have these programs, but the CMS is saying that it will not pay for them. VSA provides services to many clients, but the CMS has stated that reverse integration would not comply with the final rule. Ms. Stevenson added that these issues will be addressed as part of the transition plan.

Report on Issuance and Renewal of Registry Identification Cards for Qualified Medical Cannabis Patients

Senator Rodriguez expressed disappointment as she informed members of the subcommittee and the public that despite an invitation from the subcommittee, representatives from the DOH would not be present to address this issue. Instead, the department sent a letter to the subcommittee with information about the medical cannabis program. Senator Rodriguez stated that a list of questions would be directed to the DOH prior to the Legislative Health and Human Services Committee's upcoming meeting in Taos, which the secretary of health has indicated that she will attend.

Duke Rodriguez, president and chief executive officer, Ultra Health, stated that as a former cabinet secretary for the HSD, he knows the importance of these hearings and meetings to address questions from patients who cannot obtain their medication and manage their chronic illnesses due to problems in renewing their medical cannabis registry cards. According to Mr. Rodriguez, submitting an application on time for renewals should be adequate. Using information from the DOH, he stated that there are 27,980 active patient cards and 6,033 current personal production licenses. Mr. Rodriguez informed the subcommittee that 32% of forms are not processed by the department within the 30-day statutory time limit. In his opinion, in comparison to other states, the 30-day time frame is a generous standard, with New Mexico ranking last among states with medical cannabis programs in getting cards out to patients in a timely manner. He shared information from some neighboring states' programs. In Colorado, there are 106,000 medical cannabis cardholders in the system; as of July, Colorado is running 14 days behind for processing applications. Arizona's program has 98,000 cardholders and is able to issue cards within 10 to 12 calendar days using an online automated system. The fastest-growing program, in Nevada, has processed 20,000 new cards in its first 12 months of creation. On a more global scale, Israel is able to deliver medicine to a patient's door within 24 hours of diagnosis and card request. He suggested working with the Motor Vehicle Division of the Taxation and Revenue Department to get patients a temporary approval for purchase while the DOH processes their cards.

He pointed out that the DOH website fails to mention licensed medical cannabis producers as its partners, despite payments of nearly \$3 million in licensing fees to the department; thus, the patients are paying for 100% of this program. Mr. Rodriguez criticized the

DOH's current limit on the number of plants that can be cultivated, which would only produce one-half of a plant per patient per year, assuming full statewide production. Accordingly, he argued that the department is not meeting its statutory requirement to provide for an adequate supply for New Mexico's medical cannabis patients.

Leigh Jenke, president and chair, Licensed Non-Profit Producers, used to work for Molina Healthcare, where she was charged with serving high-priority members in Medicaid. She sees the same population in the medical cannabis industry. These people are extremely sick, and their registry cards are their lifeline in order to function in the activities of daily living. Patients with cancer want to use cannabis instead of opioids or narcotics because those medications make them sick. Ms. Jenke noted several conditions and diseases that are managed, treated and even halted by medical cannabis. She stated that her organization just went through its renewal process as a producer and had difficulty. The DOH has provided it with a "work around", which she suggested could be done for patients. The medical cannabis industry continues to expand all over the country. Ms. Jenke stressed that patients are the primary concern. The majority of these patients are low-income Medicaid recipients, and they still have to pay out of pocket for medical cannabis because it is not covered under Medicaid.

Nicole V. Morales, executive director, New Mexico E.M.P.A.C.T., thanked the subcommittee for the opportunity to present and weigh in on this issue. The renewal card delay and backlog started in April of this year and is only compounding. So many patients are being affected by this. Ms. Morales raised concern over individuals desperately turning to illegal sources to get the medicine they need to treat their illnesses but who are not getting the quality strains they need for treatment. She was appalled by the suggestions of DOH employees that patients return to opioids and other pharmaceuticals; many have worked hard to get away from these drugs. She thanked the subcommittee for its attention and help in this matter.

Anita Briscoe, psychiatric nurse practitioner, stated that psychiatrists have been referring patients into the program for the last seven years. Ms. Briscoe shared information about the range of conditions of the patients with whom she works, particularly those living with posttraumatic stress disorder (PTSD). Irritability is one hallmark of PTSD and can be manifested in violent outbursts. Ms. Briscoe said it is not a crime to have this condition, but it is a crime to deny access to medicine after doctors and patients have gone through the appropriate measures to get registry cards. She echoed the comments of a previous presenter, reminding subcommittee members that many patients have worked hard to recover from opioid dependence and have been aided by the use of medical cannabis. Ms. Briscoe commented on the risks that patients are taking to get their medicine, which is medicine they have been properly prescribed. She suggested that if New Mexico could pass legislation allowing for the production of massive amounts of cannabidiol, the state could become a major supplier of cannabis oil.

Garth Wilson, personal production license holder, echoed some of the comments from the other presenters. He shared his experience in getting his registry card and producer's license. After waiting 40 days for his card, he called, only to find out that the DOH had mailed the card to

the wrong address. He claims he was "victim-shamed" by the department and blamed for its mistakes. Mr. Wilson told the subcommittee about his care provider being charged \$50.00 for a replacement card after the department mailed it to the wrong address. A veteran and cancer patient had a similar experience. He feels these "mistakes" are criminal negligence on the part of the DOH.

Timothy Keller, state auditor, explained what his office can do to rectify the situation. The Office of the State Auditor (OSA) believes this is a public health emergency, while the DOH is treating it as an administrative challenge. Auditor Keller noted that when this administration thought there was a behavioral health emergency in mid-2013, resources were found immediately to address the problem. The OSA found out about problems in issuing registry cards in mid-June through the fraud hotline and other constituent calls. The OSA gave the DOH 60 days to fix the problem and there are 30 days remaining. The OSA has determined that the DOH is violating the law and needs to address the matter immediately. Auditor Keller does not believe that the department lacks funding to administer the program properly. The program had \$90,000 prior to the most recent payment from the producers. Temporary or emergency personnel could be hired "if this was a priority" for the secretary of health. According to Auditor Keller, the growth of this program was foreseeable and should have been planned for accordingly.

The OSA has looked at the potential of card outsourcing and is concerned that even if registry cards are issued in a timely manner, there may not be sufficient production of medical cannabis to meet the demand, as indicated to Auditor Keller by reports of frequent product shortages. He suggested that caps on production and limits on the amounts that a patient can possess should add up to what constitutes an adequate supply. Nevertheless, the OSA is limited in terms of what it can do. Auditor Keller explained that his office can conduct financial audits but not performance audits. His office is confident that alleged resource constraints do not exist; this program is financially self-sustaining. He noted further that department employees who are recommending that medical cannabis patients "go back to prescription medication" may be breaking other laws.

The OSA has included this issue in its annual audit of the DOH. December will be the earliest the OSA will get those results. If the DOH continues to break the law, it could receive an "at risk" designation from the OSA and subject the state to potential lawsuits. Auditor Keller noted that there have been many options suggested by other members of the panel, and the OSA wants to see an immediate solution.

Several members of the subcommittee stated their displeasure with the DOH for not sending a representative to the meeting. Members discussed the following matters:

- the fee for replacement cards;
- the program's revenues as more than sufficient to pay for the cost of administration;
- various suggestions for addressing the delay in getting medical cannabis to patients, including temporary extensions for cardholders under an emergency rule;

- details about the application process and document requirements;
- whether program requirements are regulatory or statutory;
- the wisdom of annual renewal requirements for chronic conditions;
- the need to treat delays in patient access to medical cannabis as a public health issue;
- the source of "bottlenecks" in the approval and processing of medical cannabis registry cards;
- the likelihood of litigation against the state for violating medical cannabis laws; and
- whether regulations and statutes need to be revisited to guarantee an adequate supply of medical cannabis for patients statewide.

Public Comment

Nat Dean has been a medical cannabis patient for seven years and suffers from chronic pain due to a traumatic brain injury. The usage of medical cannabis allowed her to go from 27 different prescriptions, including narcotics, to about six, thus increasing her ability to be more active. She shared statements from Cathy Smith and Joel White. Ms. Smith is an arthritis patient who has been waiting two months for her registry card and cannot get prescription narcotics for fear of losing her Section 8 housing voucher. Mr. White has multiple sclerosis, a permanent condition. Ms. Dean does not understand why patients have to renew cards every year for conditions that are not going to improve. It is expensive to be required to see a physician for annual reviews. In her opinion, the DOH has sufficient funds from the program alone to address staffing needs.

Mr. Kegel spoke to the subcommittee on behalf of Danny DePalma, who is a DD waiver service provider. Mr. DePalma wanted the members to note that, even if DD waivers were being automatically approved to catch up on the backlog of outside review, in such cases, the client is unable to make any changes. Of the 400 provider budgets, 90 are overdue; two-thirds of the year has gone by, and only one-half of the budgets have been approved. In the meantime, providers have to provide services paid for out of their own pockets. Mr. DePalma has a daughter on the waiver and did not receive any notifications regarding community meetings for DD waiver renewal. Mr. Kegel did not receive any notifications either, and he does not believe that the DOH and HSD are sending out the proper notices.

Richard Talley shared a letter he had sent to the secretary of health and the governor about the difficulty of getting a medical cannabis card. Mr. Talley has been trying to acquire a medical cannabis card for a family member suffering from chronic pain. According to Mr. Talley, it is taking 45 days to 55 days or longer for the DOH to issue medical cannabis registry cards. Because some medical conditions do not change from year to year, he does not understand why a yearly renewal is required. He does not understand how it is easier to obtain prescription opioids than it is to get medical cannabis. He added that Hawaii started its program last year, and it takes 10 business days to issue cards to patients.

James Rivera, tribal member, Pueblo of Pojoaque, raised the issue of tribes being excluded from the medical cannabis industry. If a tribe wants to grow and dispense medical

cannabis, will the DOH be willing to explore this to advance the medical cannabis program in the state? Due to sovereignty status, Mr. Rivera questioned if a tribe would be able to move product after cultivation to a processing plant. He believes the tribes could be a huge asset to the state in terms of the medical cannabis program, as they would not be subject to state law and could produce more efficiently, thus getting patients the medicine they need. Mr. Rivera requests legislation that would allow tribes the ability to move product off tribal land.

Larry Love, patient activist and licensed grower, said the DOH has put the health of patients at risk by delaying renewals and taking too long for initial applications. Mr. Love stated that the last two secretaries of health have not been physicians, and he believes a physician should be involved in the department. According to him, "the governor has done everything to try to kill this program, including hiring the right people to stall it". He added that he has heard a lot of complaints from patients about the rudeness of DOH employees. Mr. Love pleaded with members to ensure that the medical cannabis program survives.

Ms. McNeese stated that level of care is the only requirement for Mi Via. The DD waiver also has this requirement, and she questioned the continued need for the SIS. Both waivers are excellent programs, but Mi Via requires less to qualify. She believes that there is too much red tape and that the system is overburdened. The renewal of the DD waiver is the right time to reduce the burden and streamline the system to make it more sustainable.

Sarah Martinez, CM, talked about resource allocation and explained that both the DD waiver and Mi Via use level-of-care assessments. For non-*Jackson* class members, level of care is used but the money attached to those categories is not the same as for *Jackson* class members — their budgets are tied to SIS categories. If one moves to Mi Via, the budget has nothing to do with disability but is instead based on age. A suggested service may not be offered with the SIS category to which a person is assigned. The use of the SIS is an arbitrary process that is ingrained in the system. Ms. Martinez added that the SIS is never used for planning services; it is wasted money that could be used for something else.

David Valdez, medical cannabis patient, runs a clinic to help patients get enrolled in the program. He said that patients have been dealing with this problem for a long time, and he shared some examples of issues he has experienced with other patients. According to Mr. Valdez, the DOH has a problem with misplacing applications: one out of every five is misplaced. The requirements to resubmit applications cause strain on the patients. He claimed that the DOH will not accept any diagnosis over a year old, even if a physician signs off on it. The DOH is making it difficult for both new applications and renewals. Mr. Valdez has begun hand-delivering applications to ensure that applications are arriving to the DOH. According to Mr. Valdez, DOH employees are rude and have told patients that if they were not answering calls from patients, the employees would have more time to process applications. Mr. Valdez also believes that the caps on tetrahydrocannabinol (THC) levels are ridiculous, and doctors can override that to 100% pure THC if the patient needs it. Some patients are so discouraged that they want to give up, while others are deciding to grow their own for personal use.

Tori Moorman stated that she was not surprised that DOH representatives were not present at the meeting. She told the subcommittee that Families ASAP has been very successful helping families with children suffering from seizures and brain disorders. She wishes that the PTSD diagnosis could be extended to children. She talked about her personal experience with getting a card and the costs associated with it: \$250 for certification by a physician and \$50.00 to replace a registry card that the DOH sent to the wrong address. The THC limit is also a big issue for the department. She was previously on over \$3,500 worth of medication per month paid for by Medicaid. The medical cannabis program is a huge savings to the state. There needs to be accountability on this issue.

Christopher Castillo, patient and licensed producer, told the subcommittee that it took 61 days to get his card renewed. He shared that he had experienced childhood trauma, and as a result, he has trouble sleeping. In the days he was without his card, he was unable to function normally, and he lost his job. He was deeply affected by this delay, and he is only one person out of 30,000 dealing with the same issue.

Adjournment

There being no further business before the subcommittee, the first meeting of the DCS adjourned at 5:48 p.m.

Revised: August 25, 2016

**TENTATIVE AGENDA
for the
SECOND MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**August 25, 2016
Room 322, State Capitol
Santa Fe**

This Meeting Will Be Webcast

Thursday, August 25

- 9:00 a.m. **Welcome and Introductions**
—Senator Nancy Rodriguez, Vice Chair
- 9:10 a.m. (1) **[Update on New Mexico's Developmental Disability Community Providers](#)**
—Kathy Phoenix-Doyle, Executive Director, La Vida Felicidad
—Deborah Battista, President and Chief Executive Officer (CEO), Tresco, Inc.
—Jefferson Kee, Executive Director, Coyote Canyon Rehabilitation Center, Inc.
—Mark Johnson, Past President and CEO, Easter Seals El Mirador
—Richard Weigle, Administrative Coordinator, Association of Developmental Disability Providers
- 10:10 a.m. (2) **[Report from Developmental Disability Case Managers](#)**
—Lecie McNeese, B.S., Director, Visions Case Management, Inc.
—Melinda Broussard, Director, A Step Above Case Management
—Scott Newland, M.A., President, Unidas Case Management, Inc.
—Stacy Scott, M.A., Case Manager, Cariño Case Management, Inc.
- 11:10 a.m. (3) **[Update: Special Needs Planning](#)**
—Nell Graham Sale, Partner, Pregoner, Baysinger, Wideman & Sale, P.C.
- 12:10 p.m. (4) **[Public Comment](#)**
- 12:30 p.m. **Lunch**

- 1:30 p.m. (5) **Autism Flexible Services Program**
—Patricia Osborn, Program Operations Director, University of New Mexico
Center for Development and Disability
—Dauna Howerton, Ph.D., Quality and Compliance Manager, Behavioral
Health Services Division, Human Services Department
—Marc Kolman, Deputy Director, Developmental Disabilities Supports
Division, Department of Health
- 2:00 p.m. (6) **Autism Spectrum Disorder Diagnosis, Assessment and Services**
—Rick Loewenstein, Chief Strategy and Growth Officer, Centria Healthcare
Autism Services
—G. Richmond Mancil, Ph.D., BCBA-D, Executive Director, New Mexico
Autism Learning Partners
—Stacy M. Ertle, M.S., L.P.C.C., Owner and CEO, Bridges, Inc.
—Tammie Teague, M.Ed., BCBA, Executive Director, Guidance Center
of Lea County
—Kathleen Karimi, M.H.A., Co-Founder and CEO, Business Operations,
Behavior Change Institute
—Abel Covarrubias, CEO, Aprendamos Intervention Team
- 4:00 p.m. (7) **Public Comment**
- 4:30 p.m. **Adjourn**

**MINUTES
for the
SECOND MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**August 25, 2016
Room 322, State Capitol
Santa Fe**

The second meeting of the Disabilities Concerns Subcommittee (DCS) of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Nancy Rodriguez, vice chair, on August 25, 2016 at 9:17 a.m. in Room 322 at the State Capitol in Santa Fe.

Present

Sen. Nancy Rodriguez, Vice Chair
Sen. Craig W. Brandt
Rep. Miguel P. Garcia
Sen. Linda M. Lopez

Absent

Rep. Tim D. Lewis, Chair

Advisory Members

Sen. Gerald Ortiz y Pino

Rep. Deborah A. Armstrong
Sen. Ted Barela
Rep. Nora Espinoza

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, LCS
Alexandria L. Tapia, Contractor, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at [https://www.nmlegis.gov/Committee/Interim Committee?CommitteeCode=DISC](https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=DISC).

Thursday, August 25

Welcome and Introductions

Senator Rodriguez welcomed members to the second meeting of the DCS. Members of the subcommittee and staff were asked to introduce themselves.

Update on New Mexico's Developmental Disability Community Providers

Mark Johnson, former president and chief executive officer (CEO), Easter Seals El Mirador, testified before the subcommittee regarding the developmental disabilities (DD) waiver from a provider prospective. Mr. Johnson thanked the subcommittee for its support and its advocacy for individuals with developmental disabilities. Approximately \$331 million goes into the state DD waiver system, including the Mi Via waiver. The system serves approximately 4,400 adults. These services include case management, day support and residential treatment. Mr. Johnson noted that New Mexico is one of a handful of states that operates a totally community-based system and does not have any state institutions of care. Mr. Johnson spoke about some of the cuts that have been made to the system over the last several years. Since 2011, there has been a reduction of almost \$35 million in the DD waiver system. There was a five percent across-the-board rate reduction for providers and an eight percent reduction in the budget for recipients. In 2012, the DD waiver system for adults experienced an additional loss of \$17 million for various programs following a controversial rate study. At the same time, there has been a substantial increase in regulations, as well as mandates from the *Jackson* lawsuit.

The federal Patient Protection and Affordable Care Act has also increased health insurance premiums for more than 300 members of the Association of Developmental Disabilities Community Providers (ADDCP). As a result, several community-based programs have been closed or forced to eliminate supported-employment or supported-living programs. Additionally, some providers are experiencing staff turnover rates of 35 percent to 40 percent.

The difficulty in finding nursing personnel is becoming a real issue for providers. Mr. Johnson noted that the state is now in the twenty-ninth year of the *Jackson* lawsuit, and the state's legal fees to date total \$50 million. There are approximately 288 remaining *Jackson* class members. While the named defendants are the State of New Mexico and the Department of Health (DOH), the state has directed providers to implement the court's orders and requirements in the form of unfunded mandates. Mr. Johnson urged the subcommittee to consider a more comprehensive approach to the waiver system in the pending special session and upcoming regular session. According to Mr. Johnson, provider fees can be leveraged for Medicaid, and the New Mexico Health Care Association is working to resolve revenue enhancements for nursing homes and for intermediate care facilities for individuals with intellectual disabilities to leverage Medicaid funding.

The ADDCP's legislative platform includes: continuing to protect provider services for the most vulnerable population; a Medicaid provider act that would ensure due process for providers to address credible allegations of fraud and limit the use of extrapolation and sampling; *Jackson* lawsuit disengagement, which would require that all stipulations from the *Jackson* litigation be funded with money for compliance purposes; and a consumer and provider protection act that would safeguard providers against frivolous lawsuits.

Kathey Phoenix-Doyle, executive director, La Vida Felicidad, discussed the objectives and impact of the Family Infant Toddler Program (FIT) (please see handout for more

information). FIT serves children from birth to age three who are at risk of, or who have, a developmental disability by providing services in the child's natural setting. The program is designed to work with caregivers and children to overcome delays and maximize the potential of a child to achieve functional outcomes as close to the child's typical developing peer. Since 2009, FIT funding by the DOH for infants and toddlers at risk has been cut from 228 hours of service per year to 24 hours of service per year. That averages out to two hours per month. Currently, there are 10,693 children across the state, both in urban and rural areas, who are actively receiving services. New Mexico is the only state that includes Part C (FIT) programs in its Race to the Top grant. Ms. Phoenix-Doyle explained that this inclusion has actually been cumbersome for any home-based service system, and changes have resulted in additional costs for the providers. A 2003 rate study commissioned by the DOH determined that the rates do not cover the cost of services. For the last 13 years, providers have not been fully reimbursed for early-intervention services for children.

Ms. Phoenix-Doyle expressed concern about the need for higher rates for providers serving frontier areas. Rural areas struggle to attract early interventionists or therapists due to the remoteness of the locations, and those who are willing to travel are not compensated for travel time. In addition, the new Fair Labor Standards Act of 1938 (FLSA) rules raising the salary at which an employee is exempt will have a sweeping impact on providers. The cost of doing business will increase because overtime will now be paid to staff members who were once considered exempt. Ms. Phoenix-Doyle added that with the large amount of paperwork, the time lines and the quality initiatives being introduced, the time spent by early interventionists far exceeds a 40-hour work week. The FLSA rule change will increase the financial burden on providers. She concluded by assuring the subcommittee that all FIT providers are committed to providing high-quality services for children who are at risk of, or who have, a developmental disability. Parents want and deserve access to services for their children to succeed at the highest level possible.

Jefferson Kee, executive director, Coyote Canyon Rehabilitation Center, Inc., is a service provider in the northwest region of the state, including San Juan and McKinley counties. He addressed the subcommittee about how recent rate reductions and implementation of Supports Intensity Scale (SIS) assessments have affected the Indian reservations that his company serves. Mr. Kee explained that there are very few providers on the Navajo Nation, and individuals have no place to go after graduating from school. The staff at the center wants to help individuals with disabilities to live productive lives, but there are few opportunities available for them to remain on the reservation with limited public transportation. Mr. Kee hopes the state would consider the amount of travel some providers have to do and compensate them accordingly. The limited number of physical therapists has also been an issue, along with high turnover rates. In terms of the SIS, proponents of the assessment do not consider the limited access to medical facilities and specialized services for individuals living on the Navajo Nation. Eliminating the SIS would lower costs and allow for the restoration of some funding to direct support services. He requests that the DOH and lawmakers consider the rural areas of the state when conducting rate studies and considering any potential budget cuts.

Richard Weigle, administrative coordinator, ADDCP, agreed that the use of the SIS and the changes in reimbursement rates have affected providers and clients. Mr. Weigle recounted how the state was sued to prevent the use of the SIS in establishing a client's funding level. As a result, the state agreed to an outside review that would determine funding levels. He believes the SIS is redundant and that its elimination would save the state \$500,000 per year. Those funds could be allocated for direct services. In 2014, there were 94 agencies providing residential services. Thirteen have since closed, and several others no longer provide waiver services (please see handout). The loss of those agencies has had an impact on consumer choice, and the loss of funding for agencies has affected the ability to retain and recruit staff. Mr. Weigle echoed support for the legislative agenda outlined by Mr. Johnson, adding that the DOH needs to work closely with the ADDCP and its providers.

In response to subcommittee members' questions, the following points were discussed by the panel:

- the potential structure and channeling of a provider fee to receive matched federal funding;
- what other states are doing with respect to provider fees;
- changes to the rate structure in frontier and rural areas and reimbursement for travel time;
- incentives for individuals to work in these communities and rural areas;
- the simplification and better explanation of rates;
- the difficulty of retaining qualified staff while facing increased regulatory burdens and costs;
- support for another rate study to be conducted;
- the state's ongoing budget issues due to declining revenues;
- wasteful spending on program oversight rather than on direct services;
- various questions about the ADDCP's legislative agenda;
- the impact of the closure of many of the state's behavioral health providers due to unsubstantiated allegations of fraud and the need for provider protections;
- the impact on providers of unfunded mandates from new rules and regulations;
- an early childhood education degree as a potential requirement for the FIT;
- allocations for the DD waiver and the amount received per recipient; and
- the impact of the new federal overtime rule, which becomes effective in December 2016.

Report from Developmental Disability Case Managers

Lecie McNeese, director, Visions Case Management, Inc., provided the subcommittee with a rate sheet that was requested during the earlier presentation.

Stacy Scott, case manager (CM), Cariño Case Management, provided the subcommittee with an overview of the work done by CMs and distributed a handout describing their scope of work. CMs are advocates for the individuals they serve while creating the link to needed

medical, social, educational and other services. CMs facilitate assessments, assist with securing financial and medical eligibility and emphasize and promote the use of natural and generic supports. Ms. Scott explained that CMs are the first point of contact for individuals coming off the wait list and on to the DD waiver. CMs report to the Developmental Disabilities Supports Division (DDSD) of the DOH, but they are independent contractors who do not receive any benefits from the state, such as retirement, sick leave, annual leave or compensation for hours traveled to meet with waiver recipients. Ms. Scott added that CMs are the state's first line of defense against Medicaid fraud as they monitor services and supports to individuals and ensure that they being are administered appropriately.

Scott Newland, president, Unidas Case Management, Inc., stated that the decentralized network is the strength of the DD waiver system. Recipients have a choice of service providers. The decline in the number of service providers has been, in part, due to the relatively constant number of persons on the DD waiver. Since January 2015, there has been a serious backlog in outside reviews for justification of services. This has resulted in budgets not being approved in a timely manner and limiting access to services. Mr. Newland noted that approval of routine changes in a recipient's budget or services that used to take a few days is now taking months. In response to a question from a subcommittee member, Ron Vorhees, director, Medical Division, DDSD, explained the reason for the outside review (OR) by a third party. The DOH has received several complaints about the length of time that the ORs are taking and the lack of communication with CMs; the department is working to address these issues. Mr. Newland believes that the SIS should be eliminated and that funds should be redirected to direct services. He also recommended that the subcommittee stay informed about the status of the OR process.

Melinda Broussard, director, A Step Above Case Management, addressed the subcommittee to advocate for fair compensation for services provided by CMs. The OR process has increased the burden on CMs, yet they have not received any increases in compensation for the additional workload. Ms. Broussard suggested that the SIS be eliminated and that funds be redirected to pay for the additional work being done by CMs. She explained that the extensive amount of documentation being required by the OR for clinical justification of budgets is causing delays. Individual budget packets have gone from 20 pages to upwards of 200 pages. According to Ms. Broussard, changes to the DD waiver program were made without any input from CMs. The DD waiver serves a large range of individuals, and what works for one DD waiver recipient does not necessarily work for all of them. CMs want training on changes to the program prior to their implementation and better professional interactions with the DOH and Qualis, the third-party assessor for DD waiver services. Ms. Broussard provided the subcommittee with an email exchange to illustrate her point that requests for meetings with the DOH and Qualis have been denied.

Ms. McNeese provided an example of the workload increase and new requirements of CMs in terms of paperwork. She explained that most budget rejections and denials of services occur because of technical errors, triggering a request for information (RFI). Ms. McNeese described the RFI process and shared copies of what submissions look like with the additional

paperwork. There are 4,462 DD waiver recipients, and this process has to be done for each individual on an annual basis. Over the last 12 years, the workload for CMs has increased significantly, yet there has not been any increase in reimbursement for at least 10 years. CMs are paid a flat rate for each client and are now spending double or triple the amount of time on each client. In addition, overhead expenses continue to increase, and CMs have to deal with new rules and requirements resulting from any litigation against the state without any corresponding increase in compensation. Ms. McNeese suggested that if a rate increase is not possible, the administrative burden should be reduced. The CMs want to work with the DDS to reduce their administrative burden and eliminate the SIS program. Ms. McNeese added that with the DD waiver currently under revision, now is the time to implement some of these changes to make the system more efficient for providers, CMs and, ultimately, program recipients.

Dr. Vorhees stated that the DOH is looking at how coordination of care can be streamlined. He acknowledged that there are a number of things that can be done to address stressors in the system. Dr. Vorhees said that the DD waiver system is fragile and complex. The department has already been considering suspending the SIS entirely. He told the subcommittee that he would take these concerns back to the DOH and look at the possibility of lengthening the time between budget submissions.

Robert Kegel, a parent and advocate for people with developmental disabilities, believes the new submission requirements are unnecessary. CMs have to submit a new packet every 12 months regardless of whether any changes have been made. Mr. Kegel believes that budget submissions should only be done to justify changes in services. He also believes that the SIS does not work efficiently and should be eliminated.

In the ensuing discussion, subcommittee members discussed the following:

- the need for annual budget submissions without service changes;
- the effectiveness and administration of the SIS;
- details about the third-party assessor, Qualis;
- concern about unnecessary levels of bureaucracy;
- concern about the collapse of the DD waiver system;
- lack of communication from the DOH and the need for addressing phone calls from CMs;
- a request for the DOH to provide the subcommittee with a synopsis of what the OR process is and justification for each level of oversight; and
- a request for the Legislative Finance Committee to provide a report on the Oregon model of supports waivers and the potential for eliminating the SIS.

Update: Special Needs Planning

Nell Graham Sale, partner, Pregenzer, Baysinger, Wideman & Sale, P.C., provided the subcommittee with an update on enabling legislation required by the federal Achieving a Better Life Experience (ABLE) Act of 2014. During the 2016 regular session, the legislature passed the

Accounts for Persons with Disabilities Act (Section 6-8A-1 NMSA 1978, et seq.). The state treasurer is responsible for promulgating rules to implement and administer this act. The act allows for the establishment of support accounts (in accordance with the federal ABLE Act) for eligible individuals with developmental disabilities. Ms. Sale clarified that all DD waiver recipients who became disabled before the age of 19 would be eligible. As provided by the ABLE Act, accounts are tax deferred and are one way to set aside funds for disability-related expenses without affecting the beneficiary's eligibility for means-tested programs like supplemental security income and Medicaid.

Four states have gone into the business of offering ABLE accounts: Florida, Nebraska, Ohio and Tennessee. All but Florida welcome applications from other states, and accounts can be rolled over from one state to another. Ms. Sale emphasized that New Mexico residents do not need to wait for the state treasurer to promulgate regulations for the Accounts for Persons with Disabilities Act to establish support accounts but can do so immediately through other states whose programs are further along. Ohio's program is already up and running, charging \$5.00 a month for nonresident account holders.

Ms. Sale explained how contributions can be made to accounts over time and used for housing and transportation expenses (please see handout regarding ABLE ACT account programs). There is a national ABLE clearing-house website that provides webinars on the different programs available through various states. Ms. Sale urged members to share this information with constituents to let them know this resource is available.

Public Comment

Melissa Coleman addressed the subcommittee as an advocate for parents of children with disabilities. Her son was born prematurely, leading to multiple disabilities, including a diagnosis of autism spectrum disorder (ASD). Her son was able to receive early intervention services from New Vistas; however, when the disruption in the behavioral health system occurred, he lost these support services. Ms. Coleman informed the subcommittee that her son had to be placed in a facility in Utah, and her family has paid nearly \$300,000 out of pocket to get him the services that he needs. She had previously been told that it would take up to 10 years to get on the DD waiver. Her son has been on the DD waiver wait list for seven years. She has seen some improvements in her son's health, but his care is costing about \$11,000 per month. Ms. Coleman stated that the only alternative for families in this situation is the juvenile justice system. Her family is desperate for her son to come home, but with limited resources in the state, it is not possible.

Nat Dean spoke about the Brain Injury Services Fund, which helps with support services for acquired brain injuries. Currently, the fund only has about \$100,000 available. To meet the needs of the approximately 275 people who require services, the fund needs \$1.2 million. Ms. Dean explained how services from the fund are administered. By law, a fee of \$5.00 to be credited to the Brain Injury Services Fund is supposed to be assessed for traffic misdemeanor moving violations. However, since more individuals are being sentenced to community service,

the fund's revenue stream has dwindled. Ms. Dean hopes the legislature will consider supporting the fund in the future.

Liz Thomson, a former state representative, addressed the recently announced five percent across-the-board budgets cuts in response to the state's declining revenues. She is concerned about the rising rates of autism, the availability of services and the impact that budget cuts will have on families of children with ASD. Her son recently had his SIS assessment, and Ms. Thomson described for the subcommittee what his designation of "C class" means in terms of service recommendations. According to the assessment, her son is in need of "mild to above average support", but she stated that her son needs extensive care seven days a week, 16 hours a day. Ms. Thomson believes this is an example of how the SIS is not an accurate assessment tool.

Mr. Kegel provided the subcommittee with a brief presentation and written material on the DD waiver. He discussed the Developmental Disabilities Act (Section 28-16A-1 NMSA 1978, et. seq), which is the enabling act for the DD waiver. According to the statute, "Support and services shall be provided based on individual support and service plans developed by an interdisciplinary team. The team is responsible for collectively evaluating the child's or adult's needs and developing an individual support and service plan to meet the needs." (Section 28-15A-13(B) NMSA 1978). Mr. Kegel pointed out that the statute does not require or provide for outside review, the SIS or any other kind of assessment. The interdisciplinary teams, he noted, are composed of professionals specified by statute that could adequately determine the needs of an individual. He believes that the state needs to be following the law and that 30 percent of funds should not be going to pay for the SIS. Mr. Kegel directed the subcommittee to the statutory requirement for a statewide adult support and services task force charged with quality assurance. Mr. Kegel also addressed the issue of community meetings and what he argues is inadequate public notice of pending changes to the DD and Mi Via waivers. Mr. Kegel said he cannot find one person who received a mail notice for any meeting on proposed changes to the DD waiver. Some case managers and providers may have gotten a notice, but they do not have any obligation to send that information on to parents and caregivers. He asks that the DOH conduct another round of meetings to provide the opportunity for public input. He added that at the meetings he has attended in the past, public comment was limited solely to topics on the agenda. He believes that this allowed the DOH the ability to control the conversation and avoid discussing issues that the department did not want to discuss.

Senator Rodriguez expressed concern about the short notice given for the meetings. She requested an explanation from the DOH for why these notices are being mailed out so late and why the state is not meeting the statutory requirements as mentioned by Mr. Kegel. The Human Services Department (HSD) and DOH representatives at the meeting stated that they would take the concerns of the subcommittee back to their respective cabinet secretaries and the heads of those programs.

Autism Flexible Services Program

Marc Kolman, deputy director, DDS, explained that a variety of autism services are funded by the DOH, including respite supports, and are administered through the University of New Mexico (UNM) Center for Development and Disability (CDD). The program was designed to supply up to \$2,500 a year in support services for individuals who are not Medicaid eligible.

Patricia Osborn, program operations director, UNM CDD, shared a handout with an overview of recent autism initiatives in the New Mexico Legislature. Ms. Osborn discussed some of the background of UNM CDD, noting that it has 35 medical professionals. Two new initiatives of UNM CDD are expanding bilingual services and increasing participation at Camp Rising Sun. Ms. Osborn explained that the camp has been used as a place to train individuals and to increase the awareness of living with a child with autism, providing participants with the opportunity to learn how to meet those needs. UNM CDD has long wait list, and it has seen a 38 percent increase in requests for evaluations. UNM CDD has had to cut services in the last three years due to budget constraints, which has greatly affected the services the center is able to provide. She cautioned that further cuts would jeopardize the system.

Dauna Howerton, quality and compliance manager, Behavioral Health Services Division, HSD, provided a presentation to the subcommittee on applied behavior analysis (ABA) for the last two years. ABA treatments are interventions to change behaviors for members identified with autism spectrum disorder (ASD) and for individuals considered to be at risk. ABA services are available for Centennial Care members ages one to 21. Treatment involves regular assessments for progress and involves the family. Many of the services are done at home. Ms. Howerton described the three stages for ABA and said services include an autism evaluation provider, a behavior analyst and behavioral technicians. These individuals work to develop individualized service plans (ISPs) and set goals for the client. All of the managed care organizations (MCOs) have staff with knowledge of ABA and work with providers to ensure a unified understanding of service. When the program began in May 2015, there were 30 members receiving ABA services; as of March 2016, that number has grown to 118 individuals. The number of ABA providers has also grown from six to 14, expanding each of the three stages. The network of ABA providers continues to grow statewide, making services more accessible to families.

In response to questions from subcommittee members, the panel addressed the following:

- the reclassification of ASD from a developmental disability to a behavioral health issue, so it is now covered by Medicaid;
- the tendency for individuals with autism to have multiple diagnoses and additional needs for services;
- the lack of residential services available for persons with ASD;
- limitations of services through the school system and the inability to extend services beyond school age;
- efforts to create wrap-around services for individuals leaving residential care;

- the criteria for individuals with ASD to be eligible for the DD waiver and the possibility of statutory changes to expand services;
- the increasing number of ASD diagnoses throughout the country and internationally;
- the increasing number of adult ASD diagnoses;
- work by MCOs to return children to their homes from out-of-state institutions;
- the importance of educating members of the legislature and members of the public on health issues like ASD; and
- concern about potential funding cuts for programs due to the state's economic situation.

ASD Diagnosis, Assessment and Services

Rick Loewenstein, chief strategy and growth officer, Centria Healthcare Autism Services, addressed the subcommittee regarding the services his company provides for New Mexicans with ASD. Centria is a leading national provider of ABA, with operations in multiple states. It currently provides in-home and center-based ABA therapy to more than 800 children, including 41 in New Mexico. Mr. Loewenstein explained that Centria came to the state at the request of one of the Centennial Care MCOs due to the shortage of autism providers and board-certified behavior analysts (BCBAs) in the state. Part of Centria's successful growth is due to its community-based approach, which includes learning who the stakeholders are in the community, meeting with them to understand their needs and finding opportunities to work collaboratively in support of children with autism and their families. Centria currently employs 60 people in the state, and it hopes to serve another 30 children in the next few months, which will require the hiring of an additional 50 team members. Mr. Loewenstein applauded the New Mexico Legislature for adopting legislation that has paved the way for thousands of children to access ABA services, and he recognized other state initiatives to expand treatment options.

Mr. Loewenstein also noted a few areas in which the state could improve, primarily in meeting the high demand for services and addressing the lack of human resources. Additionally, there have been several system bottlenecks that have resulted in service delays (see handout). Mr. Loewenstein described some of the problems at each of the three stages of the ABA service program and made recommendations to address them. One difficulty has been the lack of stage 1 providers and that only a licensed psychologist, developmental pediatrician or pediatric neurologist can perform the assessment needed to determine if ABA will be an effective therapy under current state law. This has resulted in hundreds of children waiting to receive an assessment. Mr. Loewenstein suggested that the subcommittee consider allowing limited licensed psychologists to complete stage 1 testing on the condition that evaluations are signed off by a licensed psychologist. In closing, he emphasized the importance of early intervention and reminded the subcommittee that any barrier to services that can be erased will not only benefit a child with autism, it will affect the child's family, friends and community.

G. Richmond Mancil, executive director, New Mexico Autism Learning Partners, also noted the lack of services in the state, particularly in rural areas. Its parent company, Autism Learning Partners, is based out of California and provides services in several states. Mr. Mancil

said that another issue affecting stage 1 is the lack of available ABA services in some areas, even when assessments have been conducted. Frequently, families have to repeat an evaluation. Mr. Mancil urged the support for any funding increases for services around the state. He also recognized the work of Sarah Baca from the New Mexico Autism Society and Shawn P. Quigley, a BCBA from UNM.

Stacy M. Ertle, owner and CEO, Bridges, Inc., discussed some of the barriers to accessing ABA services. Founded in 1997, Bridges, Inc., is the state's oldest provider specializing in autism in both Santa Fe and Albuquerque. Ms. Ertle outlined some of the biggest challenges that need to be addressed, as follows, and requested the support of the subcommittee.

- 1) Autism diagnosis. UNM CDD needs increased funding in order to provide autism diagnoses in a timely manner. Currently, children are placed on a wait list before being seen for a diagnostic evaluation.
- 2) Copayments for ABA. ABA is the most recognized evidence-based treatment for children with autism. While many commercial plans provide ABA as a benefit, a copayment is charged for each date of service. ABA is an intensive service, with multiple sessions per week, resulting in multiple copayments per week. This is very cost-prohibitive for many families. Eliminating date-of-service copayments for ABA, or at least reducing them to a monthly cost-share, would be helpful.
- 3) New Mexico's limited capacity of behavioral health providers. Autism is the fastest-growing developmental disability. Providers in the state cannot meet the growing number of families affected by autism. Drastic cuts in Medicaid reimbursement rates have forced some agencies and companies to greatly reduce or eliminate behavioral health services to Medicaid recipients.

Tammie Teague, executive director, Guidance Center of Lea County, used to be a special education teacher and is a parent of a child with autism. The Guidance Center of Lea County is a nonprofit community mental health organization that added an autism clinic this past April. The clinic provides stage 2 and stage 3 services and offers support to clients in their homes, along with training for parents. Most clients receive 10 to 20 hours of therapy per week; more is available if necessary. The clinic currently has nine children on its wait list. Ms. Teague mentioned that she has contacted each school district in Lea County, and there are an estimated 120 students who have received an autism diagnosis, with the possibility of more who have not been diagnosed. UNM CDD has been a tremendous resource for the guidance center, providing diagnostic evaluations for clients.

Kathleen Karimi, co-founder and CEO, business operations, Behavior Change Institute, offers home- and community-based ABA services to clients in New Mexico. The Behavior Change Institute will be integrating individual and group psychotherapy into its service options. Ms. Karimi explained the use of telemedicine for ABA, which has been an indispensable resource in accessing rural areas. According to the U.S. Census Bureau, there are more than two million people living in New Mexico, and one in 68 will be diagnosed with autism. However,

not everyone should receive ABA treatment. Currently, there are 39 BCBAs in the state who can each oversee about 24 families; this is not enough to meet the need in the state. Ms. Karimi also thanked Dr. Quigley and representatives from the HSD for their work.

Abel Covarrubias, CEO, Aprendamos Intervention Team, shared his story of a family member in Hatch, New Mexico, with a severe seizure disorder. Mr. Covarrubias sees the importance of providing services to children in rural parts of the state. The Aprendamos Intervention Team begins screening children between the ages of 18 months and 24 months, but it is taking UNM CDD eight months to provide a diagnosis. Currently, Aprendamos is servicing 40 children with intensive therapy each week with the help of four BCBAs and one interim supervisor. Mr. Covarrubias hopes to expand to seven BCBAs and to provide services to 20 families on the wait list in Dona Ana County. Challenges that Aprendamos faces include receiving timely reimbursement from Medicaid MCOs, recruiting and retaining BCBAs and the ongoing lack of funding for autism services.

The subcommittee discussed several topics relating to the presentation, including:

- the process for getting credentialed by MCOs;
- various questions about the bottlenecks at the three stages, as outlined by Mr. Loewenstein;
- inquiries about the different certifications of medical professionals and their abilities to perform assessments and create ISPs;
- credentials and oversight of service providers;
- the need to expand the number of medical professionals in stage 1 to get necessary services to clients while maintaining quality;
- extending the authority for masters-level clinicians to do ABA at stage 2;
- current funding for UNM CDD;
- the need for more services in rural areas and expanding the use of telemedicine;
- eliminating per-visit copayments in favor of a monthly cost-share; and
- a request for an annual presentation on autism and treatment infrastructure in the state for the DCS and, possibly, the LHHS.

Motion 1

Upon a motion by Senator Ortiz y Pino, seconded by Representative Garcia, the subcommittee recommended that a letter be drafted and sent to the superintendent of insurance regarding the issue of copayments for ABA services and the financial impact on families. The motion was approved.

Public Comment

Bonnie Hardin, parent, told the subcommittee about her experience with her autistic son. Due to her age, she went to the Mayo Clinic to have a child, who was born with autism and was later diagnosed with attention deficit disorder. Upon her son's release from Texas Neuropsychiatric Institute (TNI), she was given no treatment plan or information about how to

care for her son's needs. According to Ms. Hardin, had her son received early intervention services for the eight months he was at TNI, it would have saved Medicaid a lot of money. Staff needs to be properly trained to help families, and there need to be ABA services for all ages. She believes that funds are being wasted on ineffective treatments, and individuals seeking help for their families are becoming victims of fraud.

Ms. Baca was present at last year's subcommittee hearing on autism. She mentioned that, just last year, there were limited options for ABA, but now the options are being expanded and the wait lists are being reduced. She thanked the subcommittee and the numerous advocates who have supported this issue, noting that there is still work to be done. Ms. Baca has a son with autism, and he is now getting the services that he needs and is doing great.

Zoe Migel, executive director, Bright Futures, has worked in this field for about 20 years. She was also present at last year's hearing and informed the subcommittee that every one of the families she spoke about is now receiving the services they need. Ms. Migel talked to the subcommittee about some of the work that still needs to be done, particularly in providing services to Native Americans and Spanish-speaking immigrant families. She works in rural areas north of Santa Fe; telehealth has been a great asset to these communities. Ms. Migel would like to see the Public Education Department (PED) involved in conversations about autism and to be present at subcommittee meetings. The medical community and the education community need to work collaboratively to truly help a child succeed. She noted that the main issues in the system are at stage 1. The process of becoming a stage 1 provider is arduous; there are people who are qualified to conduct the necessary evaluations, but they are not approved through Medicaid or the MCOs. The reduction in the family psychotherapy billing code has affected her practice dramatically. She added that autism has affects on the entire family as a whole, including siblings. In terms of telehealth, Medicaid recommends reimbursement, but only one of the MCOs will cover it. She believes that a number of companies and providers would expand telehealth services if they were reimbursable.

Ms. Thomson addressed the subcommittee briefly to thank members and the staff for their work and for keeping a light on autism issues. She also suggested that representatives from the PED's Special Education Bureau be routinely invited to subcommittee meetings.

Adjournment

There being no further business before the subcommittee, the second meeting of the DCS adjourned at 4:53 p.m.

Revised: September 15, 2016

**TENTATIVE AGENDA
for the
THIRD MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**September 19, 2016
Adelante Development Center, Inc.
3900 Osuna Road NE
Albuquerque**

Monday, September 19

- 9:00 a.m. **Welcome and Introductions**
—Senator Nancy Rodriguez, Vice Chair
- 9:10 a.m. (1) **Services for Persons with Disabilities: Workforce Innovation and Opportunity Act (WIOA), Vocational Rehabilitation and Independent Living**
—Jessica Hathaway, Policy Associate, Family Opportunity Project, National Conference of State Legislatures (NCSL)
—Kyle Ingram, Policy Specialist, Disability and Employment, NCSL
—Faye Rencher, Senior Program Manager, WIOA, Workforce Solutions Department
—Greg Trapp, J.D., Executive Director, Commission for the Blind
—James L. Salas, Deputy Director for Vocational Rehabilitation Programs, Commission for the Blind
—Joe Cordova, Director, Vocational Rehabilitation Division, Public Education Department
—TBD, New Mexico Statewide Independent Living Council
- 11:30 a.m. (2) **Public Comment**
- 12:00 noon **Lunch**
- 1:00 p.m. (3) **Outside Review of Budgets for Persons on the Developmental Disabilities Waiver**
—Jason Gordon, Litigation Manager, Disability Rights New Mexico
—Ingrid M. Nelson, M.S., Senior Program Manager, Continuum of Care Project, University of New Mexico
—Jennifer Rodriguez, Community Programs Bureau Chief, Developmental Disabilities Supports Division, Department of Health

- 2:00 p.m. (4) **Update: Developmental Disabilities Planning Council**
—John Block, Executive Director, Developmental Disabilities Planning Council
- 3:00 p.m. (5) **Update: Notice of Public Meetings to Solicit Comment on Proposed Changes to Waiver Programs**
—Shari Roanhorse-Aguilar, Bureau Chief, Exempt Services and Programs Bureau, Medical Assistance Division, Human Services Department
- 4:00 p.m. (6) **Public Comment**
- 5:00 p.m. **Adjourn**

**MINUTES
for the
THIRD MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**September 19, 2016
Adelante Development Center, Inc.
3900 Osuna Road NE
Albuquerque**

The third meeting of the Disabilities Concerns Subcommittee (DSC) of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Nancy Rodriguez, vice chair, on September 19, 2016 at 9:17 a.m. at the Adelante Development Center, Inc., in Albuquerque.

Present

Sen. Nancy Rodriguez, Vice Chair
Rep. Miguel P. Garcia
Sen. Linda M. Lopez

Absent

Rep. Tim D. Lewis, Chair
Sen. Craig W. Brandt

Advisory Members

Rep. Deborah A. Armstrong
Sen. Ted Barela

Rep. Nora Espinoza
Sen. Gerald Ortiz y Pino

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Alexandria L. Tapia, Contractor, LCS
Diego Jimenez, Research Assistant, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at [https://www.nmlegis.gov/Committee/Interim Committee?CommitteeCode=DISC](https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=DISC).

Monday, September 19

Welcome and Introductions

Senator Rodriguez welcomed members to the third meeting of the DCS. Members of the subcommittee and staff were asked to introduce themselves.

Services for Persons with Disabilities: Workforce Innovation and Opportunity Act (WIOA), Vocational Rehabilitation and Independent Living

Jessica Hathaway, policy associate, Family Opportunity Project, National Conference of State Legislatures (NCSL), discussed federal workforce funding in New Mexico and the final rules for the WIOA (see handouts for full information). The WIOA, signed into law in July 2014, creates a new vision for how America prepares an educated and skilled workforce and expands opportunity for workers and employers. The WIOA represents the most significant reform to public workforce development in nearly 20 years. Final federal WIOA rules became effective June 30, 2016 and are intended to enable the workforce development system to more efficiently and effectively provide career pathways for all Americans. The final rules include reforms that will affect more than a dozen programs receiving approximately \$10 billion in annual funding and programs that serve approximately 20 million Americans each year. Ms. Hathaway explained the core principles of the act and what they mean for states and local workforce development. There are six core programs of the WIOA, each offering different funds for state workforce development:

- Title I programs for adults;
- Title I programs for dislocated workers;
- Title I programs for youth;
- Title II adult education and family literacy;
- Title III federal Wagner-Peyser Act employment exchange;
- Title IV vocational rehabilitation (VR) (with most funding specifically for people with disabilities falling under Title IV).

The Title I and Title III programs are administered by the U.S. Department of Labor's (DOL's) Employment and Training Administration. Titles II and IV are administered by the U.S. Department of Education. For New Mexico, the total amount of federal WIOA workforce funds for all six core programs in program year (PY) 2016 is \$50,095,722. Ms. Hathaway offered a breakdown for each of the core programs in terms of funding distributions for PY 2016, noting the percentage increases from PY 2015. A time line for WIOA implementation detailing steps required for compliance with the WIOA has been given to all states. To date, most of the milestones have been met, and states are beginning to monitor activities that are part of their state plans.

Kyle Ingram, policy specialist for disability and employment, NCSL, explained the provisions under the WIOA for programs that serve individuals with disabilities. He focused on transition services and the use of a subminimum wage. The WIOA requires that at least 15 percent of public VR funds be reserved for the delivery of pre-employment transition services to students with disabilities. Mr. Ingram explained how states can meet this requirement, clarifying that administrative costs do not count toward the 15 percent. The WIOA's amendments to Section 113 of the federal Rehabilitation Act of 1973 authorizes states to meet the 15 percent requirement through funding; developing and implementing innovative strategies to increase competitive integrated employment; independent living; and post-

secondary education experiences for students participating in pre-employment transition services, so long as the required activities of Section 113 have been provided.

The WIOA places substantial limitations on the use of a subminimum wage, requiring that federal Fair Labor Standards Act Section 14(c) certificate holders ensure and maintain paperwork confirming that new hires and employees have been provided certain career counseling and transition services opportunities before being paid less than the minimum wage. An employer found in violation of the new requirements can be assessed back pay at the full minimum wage for each employee. Mr. Ingram provided an outline of eligibility for subminimum pay for new hires after July 22, 2016. According to the DOL, New Mexico currently has 520 workers, across five community rehabilitation providers, who are being paid a subminimum wage. This is based on self-reporting mechanisms in the Section 14(c) certificate application.

The WIOA is designed to support and encourage competitive, integrated workplaces. The act does not require that employees be in constant contact with individuals without disabilities; this means that self-employment is also viable. Mr. Ingram shared the most recent federal policy trends promoting workforce and community integration. The final report from the DOL's Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities was released in September. One recommendation of the report was for Congress to phase out usage of Section 14(c) certificates, while protecting individuals currently engaged in subminimum wage work from unintended consequences. Another policy change has come in the form of the Centers for Medicare and Medicaid Services (CMS) 2014 final rule for home- and community-based services (HCBS). The final rule set new residential and nonresidential provider requirements for integrated settings and person-centered planning. HCBS settings that do not meet the new requirements have until March 2019 to achieve compliance before becoming ineligible for reimbursement. Mr. Ingram provided a few examples of state efforts to get ahead of this trend, with a greater emphasis placed on increased coordination of services and state-driven efforts to phase out usage of a subminimum wage.

Faye Rencher, senior program manager, WIOA, Workforce Solutions Department (WSD), discussed New Mexico's WIOA combined state plan, which can be found at www.dws.state.nm.us/WIOA-Policy-Plans-Annual-Reports. Under the WIOA, the state plan communicates the state's vision for New Mexico's workforce system and serves as a vehicle for aligning and integrating this system across federal programs. On April 1, 2016, the WSD submitted the WIOA combined state plan to the appropriate federal oversight agencies. The WSD is focused on convening core partners and identifying program-specific sections. The state's two VR entities are the Commission for the Blind and the Vocational Rehabilitation Division (VRD) of the Public Education Department (PED). Ms. Rencher mentioned efforts to increase coordination between employment and training activities; core programs must come together and identify areas where service strategies can be aligned. The WSD is reassessing a one-stop delivery system that will provide universal accessibility while

formalizing contacts for seamless referral and follow-up. The subcommittee was provided with a map indicating the locations of workforce connection centers around the state. The next step for the state is working with local boards on the development and implementation of local WIOA programs. These local boards will play a key role in ensuring effective implementation of the state plan.

Gregg Trapp, executive director, Commission for the Blind, explained that the commission has historically done in the state what the WIOA has implemented on the national level. Before 2008, the Commission for the Blind ranked in the top five on all indicators of primary measures that look at competitive employment numbers. Of their members, 100 percent were placed in competitive jobs with comparable starting wages. Mr. Trapp explained what the pre-employment transition services mean for New Mexico. Some people have questioned the 15 percent requirement. While it creates a new level of services that need to be provided to this population, it takes away funding for other adult services and from administrative services. The Commission for the Blind must spend \$675,000 on transition services, which is more than what has been previously expended. Mr. Trapp believes this affects the commission's ability to continue doing what has already proven to be successful and what the WIOA was intended to do. The changes will force the Commission for the Blind to initiate new data-tracking methodologies and alter the way the commission spends funds on services to avoid federal penalties. Mr. Trapp added that the state's budget crisis will be a big factor, resulting in the potential cutting of services and perhaps the use of a wait list for future members.

James L. Salas, deputy director for VR programs, Commission for the Blind, described some of the pre-employment transition services currently offered for students with disabilities. The Commission for the Blind works with students through age 21 from high school and post-secondary educational institutions offering job exploration counseling, job readiness training and work-based learning experiences. As of now, the Commission for the Blind will continue to serve individuals as young as 14 years old. Mr. Salas explained the Pre-Employment Transition Services step program, which held recent job readiness and job training programs in Alamogordo and Albuquerque. He noted that, unlike other students, blind students typically do not work during the school year or summer breaks. The State Personnel Office (SPO) has reclassified a position resulting in the creation of a statewide job-transition coordinator charged with developing additional training programs, particularly in technology. The use of new technologies offers a lot of opportunities for individuals with disabilities, particularly the blind. The \$675,000 required expenditure cannot be used for purchasing technology or paying tuition.

Joe Cordova, director, VRD, PED, has over 35 years of experience in this field. While the final regulations for the WIOA came out in fall of 2015, Mr. Cordova pointed out that implementation of regulations have had different completion dates. The PED is in the process of sifting through the provisions to see how VR will be affected and is updating policies to comply with the WIOA. The VRD can assist with one-stop systems to implement Title I,

making it more accessible to those with disabilities. The VRD can also call upon the DOL for technical assistance to help clients become more employable. The requirement for pre-employment transition services will be an important component in the future. Mr. Cordova expressed the hope that the state budget situation will remain fairly stable. If five percent cuts are imposed, the PED may have to start a wait list for VR services. The department will be looking at ways to accomplish administrative efficiencies. One potential for cost savings is increasing flexibility in providing group services. Activities such as resume writing and career exploration can be done in group settings. Mr. Cordova added that the PED will continue to look at ways to be more responsive to clients. He believes that the WIOA affords an opportunity to provide more services.

Larry Rodriguez, New Mexico Statewide Independent Living Council (SILC), described the membership of the SILC and the state rehabilitation boards. Mr. Rodriguez hopes that more members will be added to the SILC board in the future. Interested parties can learn more about the SILC's mission on its website.

In response to subcommittee members' questions, the following topics were discussed by the panel:

- what other states are doing in terms of the WIOA;
- minimizing the potential for duplication of efforts while maximizing federal funding and resources;
- coordination with other entities;
- outreach efforts to individuals who have not historically participated in the workforce;
- how the rural nature of New Mexico affects delivery of services;
- the involvement of advocacy groups and stakeholders during development of the state plan;
- the limitations of VR funding;
- outreach to the Developmental Disabilities (DD) Waiver Program;
- the role of Medicaid in the WIOA;
- the potential for budget cuts due to the state's budget crisis and awareness of which programs the state is federally mandated to continue;
- concerns of jeopardizing federal funds and the potential for incurring penalties;
- usage of the subminimum wage rate in New Mexico;
- the potential unintended consequences of the WIOA, specifically the impact on employers of individuals with disabilities;
- the cost benefit of investing in individuals with disabilities to enter into the workforce;
- exclusion of individuals with disabilities from the hiring process solely based on their lack of work experience;
- a request for data on where individuals have been placed for employment at the state, county and local levels; and

- a request for clarification from the WSD on which agency oversees and approves programs.

In response to questions about the subminimum wage, Mike Kivitz, Adelante Development Center, Inc., voiced support and agreement with the tenets of the WIOA. Adelante Development Center is one of the largest supported-employment providers in the DD world. He noted that disabilities range greatly in terms of functional and cognitive abilities and that Section 14(c) is about a prevailing wage. According to Mr. Kivitz, 70 percent of people with disabilities are either not working or are underemployed. He contends that individuals are not being exploited; their housing is good, their insurance is covered and they are provided quality employment. However, without the option for a subminimum wage, individuals with cognitive disabilities will be left out of the workforce unless they can produce at a higher rate. Mr. Cordova added that in the Commission for the Blind's experience, providing competitive wages for blind employees helps make them feel valued, leading to an increase in productivity. However, this is not necessarily possible for all disabilities. Not all disabilities are the same, and they cannot be viewed in such a manner.

Public Comment

Robert Kegel, a parent and advocate for people with DD, believes that there is a tremendous disconnect between the DD waiver and the VRD. Approximately 1.5 percent of the state's population is developmentally or intellectually disabled. That is almost 31,000 New Mexicans. The Developmental Disabilities Supports Division (DDSD) of the Department of Health (DOH) is required to gather input before instituting any regulatory changes. Mr. Kegel stated that the DDSD never consulted with the Commission for the Blind about the implementation of the supports intensity scale (SIS) — a tool that cannot be used on a blind person. To him, these programs are spending money and yielding no real results for individuals. Mr. Kegel questioned why there were not representatives from the SPO present at the meeting. He believes this is because the state is not adequately hiring individuals with disabilities and that the state should consider a 1.5 percent set-aside for employment of persons with disabilities. Mr. Kegel has been researching DD waivers in other states and will be doing a comprehensive presentation for the next DCS meeting.

Lisa Rosenthal, Parents Reaching Out, is an advocate who works to help parents find resources for recently diagnosed children with DD. Ms. Rosenthal is a parent of a child with an intellectual disability. In the past, families like hers could receive between 800 to 1,000 hours of respite care per month. Now they only receive up to 100 hours. Ms. Rosenthal told the subcommittee that she and her husband work four jobs and are unable to use community services for their child due to the level of care she requires. Ms. Rosenthal noted that even a little bit of support funding would be helpful to families like hers.

Claudia Ibaniz applied for the DD waiver for her 12 year-old son with cerebral palsy but was informed of the long wait list for the waiver. Although her family is able to provide some support and care, the family still needs help from outside services. Omar Ibaniz, husband to Ms. Ibaniz, is a native New Mexican and a disabled veteran. He is unable to work and provide the services needed for his son. Mr. Ibaniz is asking for more support for his family and other families in the state in the form of a supports waiver. He noted that Centennial Care only pays for doctor's appointments and that the DD waiver wait list is far too long to wait for help.

Ms. Rosenthal read a statement from Jessica Kingsley, a woman who has recently moved out of state to Colorado. Ms. Kingsley has a son with autism and a seizure disorder. Ms. Kingsley's son was in need of early-intervention services that were not covered by insurance and faced long wait lists for care. The family did not qualify for Medicaid by \$50.00. According to the statement, Albuquerque does not have enough quality providers to support and serve the need in the community. After relocating to Colorado, they are now getting the services they need. The statement encouraged the subcommittee to look at the successful program for early intervention in Colorado and urged lawmakers to consider funding a supports waiver to get children the services they need and the opportunity for early-intervention services. Ms. Rosenthal added that a supports waiver could help families in need stay afloat. A flexible supports waiver would have been specifically geared for people under the age of 18 or for those with autism. In her view, this would help prevent individuals from inappropriately being placed on the DD waiver.

Lisa Miller, assistant director, Behavioral Services of the Rockies (BSR), said it is upsetting to know that there are people who need services and are not getting them. Ms. Miller talked about her organization, which has been applying to expand services into New Mexico. Ms. Miller expressed concern with the process of qualifying as a Medicaid service provider in the state. There are currently two individuals in New Mexico for which BSR has funding — one in Bloomfield and one on the Navajo Nation — but BSR is unable to get approved as a Medicaid provider. Ms. Miller stated that these roadblocks have little to do with providing care and more to do with wording and semantics. Cathy Stevenson, director, DDSD, offered to meet with Ms. Miller and address her concerns.

Jim Jackson, Disability Rights New Mexico (DRNM), admitted that change is always challenging, but he believes that New Mexico needs to get in line with national trends. With the WIOA's employment rules, transition is important to get people meaningful employment while they are young. While the 15 percent-set aside will be difficult, Mr. Jackson said it is easier to find employment for someone just starting out versus an older individual who has not had the opportunity to gain work experience. It will be a matter of making meaningful employment a priority for the state. Mr. Jackson believes that the move away from a subminimum wage is a positive step. One of the key issues in the *Jackson* lawsuit is that the state has failed to meet the employment goals of

the settlement. Mr. Jackson reminded those present that the federal recommendations are the result of input from advocacy organizations and providers in the field. He believes that New Mexico can set the standard for employment by being creative and funding services that help with job placement.

Mr. Kivitz welcomed everyone to Adelante and noted that the community room at Adelante is available for community use. Mr. Kivitz informed the subcommittee that a former advocate of over 30 years, Al Friedman, recently passed away. In response to questions raised during an earlier presentation, Mr. Kivitz stated that there are five nonprofit organizations in the state that use subminimum wage certificates; Adelante is the largest of those employers. Approximately 520 individuals are employed by these organizations, which are mostly DD agencies. Many employers do not want to use the subminimum wage because the required paperwork is burdensome. Mr. Kivitz noted that states that have done away with the use of the Section 14(c) requirement have significantly higher numbers of unemployed individuals with DD. Mr. Kivitz shared some of the programs that are offered through Adelante and invited subcommittee members to tour the "social enterprises" the center operates. Adelante runs a benefit connection center that works with individuals coming out of prison to determine eligibility, and provides assistance with paperwork, for programs. In addition, Adelante also runs a program for recycling donated medical equipment, such as walkers and wheelchairs. Equipment is repaired and cleaned up, then offered to community members in need at no cost. Adelante has partnered with Intel to refurbish computers and distribute them to individuals in the community who need them for job seeking. All of these programs are run by individuals with DD.

The WIOA has placed a large emphasis on settings, which is a big focus for Adelante. The WIOA has eliminated consumer choice when it comes to where people work. Mr. Kivitz believes this to be a civil rights issue. Individuals with DD are being told that they cannot congregate with other persons with DD. In 2011, Adelante generated \$14.5 million in waiver revenues. This year, revenues are projected to be only \$11 million. There have been no increases in staff pay, and Adelante is not permitted to use private funding for pay raises. Mr. Kivitz stressed that restrictions on subminimum wages and settings means individuals with intellectual disabilities will have fewer employment opportunities because individuals with other disabilities are more likely to be hired due to their increased work output. A subminimum wage is not appropriate for every disability. Mr. Kivitz explained the usage of a "prevailing wage", noting that not every job is a minimum-wage job and that pay cannot be calculated as a percentage of productivity.

Outside Review of Budgets for Persons on the DD Waiver

Jason Gordon, litigation manager, DRNM, explained that the outside review (OR) process is a result of the *Waldrop* litigation over the SIS. The suit challenged the use of the SIS in determining the DD waiver budget for individuals. Following an SIS assessment, an individual was categorized into a group that determined the budget for the

individual. The intention behind the OR process is to be more person-centered. The SIS is still utilized as a planning tool, but now the client meets with a case manager to create a service plan that is both clinically justified and medically necessary. The OR is a mechanism to ensure that the services being requested meet those criteria. If there is a problem with the submission, then the outside reviewers can send it back to the case manager to correct errors or request more information. If the budget is approved, then the state is bound by that determination. If the budget is denied, then there must be notice of denial and a right to appeal through a fair hearings process.

Mr. Gordon addressed reports of delays in the OR process. He explained that budget submissions are supposed to be checked for technical issues within 10 days. If the budget is sent back to the case manager, errors must be corrected within 10 days. According to complaints, budget approval is taking weeks or even months. The DRNM has received a lot of calls about delays and has been working with clients and case managers to identify and resolve the issue. These delays do not only affect the budgets, but they prevent service providers from getting paid. There is concern with the impact on providers and the potential for causing closures. Communication between the outside reviewers and case managers could be improved. Mr. Gordon acknowledged reports from case managers who felt they were not adequately trained on the new system's forms or the process for medical justifications. While training for case managers recently took place, there has still been criticism regarding the lack of support for case managers. Mr. Gordon believes that the OR process is a good system, putting the client back in control of the client's own care while ensuring that the state is adhering to the law. The DRNM pledges to continue to facilitate cooperation in the process while addressing the delays. Mr. Gordon urged the continuation of training for providers and case managers, as well as increased communication among all parties.

Ingrid M. Nelson, senior program manager, Continuum of Care Project, University of New Mexico (UNM), explained that the Continuum of Care Project is a quiet partner in the process. The OR process has been in existence for one year. The Continuum of Care Project has been around for 23 years and has the contract for conducting the OR. Ms. Nelson provided some background on the experience of the staff, which ranges from three to 25 years of experience with the DD Waiver Program. The project currently has 27 employees; ideally, it should have 35. The OR process was created from scratch and has improved over the last year by trial and error. Ms. Nelson admitted that the process is not always working well, but now that there is adequate staff, a tickler system has been implemented to ensure that reviews are not sitting unprocessed. A data manager compiles reports and interfaces with state agencies and Qualis Health, a third-party assessor. Ms. Nelson talked about some of the technological and programmatic changes that are being addressed. One of these includes designating an individual to answer calls and emails within 72 hours. She believes that case managers could use more training on the system.

Jennifer Rodriguez, community programs bureau chief, DDS, DOH, noted that since a system change came about as the result of a lawsuit, the department was required to move quickly to get it in place. Now that the OR process has been in place for a year, the DDS has been able to identify areas that are not working efficiently. Ms. Rodriguez provided a handout that illustrated the OR process resulting from the *Waldrop* settlement. The department has noticed two systemic issues as follows.

1. Level of accountability. The system change introduced a new level of accountability for everyone involved. The time frame for case managers and interdisciplinary teams to conduct their work has been shifted, and extra time has to be anticipated. The budget process went from one level of review to two levels.

2. Medical justification. The new set of standards for clinical services did not previously exist. Every budget submission must include a medical justification for services being requested. The provider network will have to get used to this requirement.

Ms. Rodriguez noted that late submissions have caused some delays in the process. Budget submissions need to occur 60 days in advance of their expiration. The case managers are responsible for collecting all the necessary information and ensuring complete, correct packets. Case managers need to do this in a timely manner to account for the additional level of review and allow for any corrections. Another delay occurs when there are errors in the packet, which then requires a request for information from the reviewer back to the case manager. Ms. Rodriguez explained that the budget sheet is an Excel spreadsheet; it is auto-populated but still needs to be filled out by someone. A request for information could also be needed for additional clinical information. There is a lot of room for error, and the case manager is responsible for making sure that the packet is in perfect order to avoid approval delays. Ms. Rodriguez informed the subcommittee that the DDS provided training for case managers and DOH staff prior to the implementation of the OR. Since then, several guides and check lists have been developed to aid the process. The first review of the OR was conducted after six months. DDS staffers continue to meet with the DRNM and case management agencies to identify process deficiencies. In addition, the DDS meets monthly with the Association of Developmental Disabilities Community Providers (ADDCP) and oversight reviewers to stay focused on these issues. Ms. Rodriguez admits that the budget documentation packets are in excess of 200 pages and need to be streamlined. She said the DDS is working with oversight reviewers to identify what documentation is necessary.

In response to the presentation, the subcommittee addressed the following topics with the panel:

- clarification about the OR process, including the various steps and who administers it;
- questions regarding Qualis Health, its function and its scope of work;

- the implications of the *Waldrop* lawsuit;
- the use of medical justification of services for ensuring that clients receive the services they need;
- the importance of the interdisciplinary team in justifying service needs;
- the shift toward person-centered planning;
- other technical errors that have caused issues in budget submissions;
- the process for addressing technical denials and fair hearings;
- concerns about the inordinate amount of paperwork required by case managers;
- New Mexico's current process for review of the DD waiver, and the DOH's intention to incorporate the OR process into the state's application for renewal of the DD waiver;
- the contract with UNM as an OR administrator;
- the cost of the contract for OR, which was \$800,000 for the first year and \$1.4 million for the second year;
- plans for additional hiring at UNM for the OR contract;
- the potential to eliminate the SIS and out-of-state contracts; and
- concern over the need for extensive administrative oversight of budgets versus random audits.

Public Comment

Mr. Kegel addressed the subcommittee in response to the email from Ms. Stevenson regarding the SIS. The email was sent to subcommittee members informing them about priority needs in the system. Mr. Kegel stated that prior to any changes in policy, the DOH is, by law, required to collect public input. He emphasized that the lack of public input was how the state ended up with the SIS in the first place. State law does not provide for the OR, and if the DOH is out of compliance with federal law, Mr. Kegel argues, it needs to come to the legislature to properly address the issue. Requiring case managers to travel to Santa Fe to receive OR training is not acceptable. Mr. Kegel questioned how the DOH can justify not being able to afford an adequate number of therapists to meet needs, yet it has the funds to pay for individuals to review budget submissions. The extended length of time to review budgets has resulted in providers having to provide services without compensation. The claim that New Mexico's DD waiver is the most expensive waiver in the country is false, according to Mr. Kegel. He stressed that the DOH needs to comply with existing state law.

Ellen Pinnes, Disability Coalition, noted that federal funds pay for at least a part of some contracts related to DD waiver budgets. Shari Roanhorse-Aguilar, bureau chief, Exempt Services and Programs Bureau, Medical Assistance Division, Human Services Department (HSD), clarified that the Qualis Health contract is paid from matching federal funds. The federal government pays for 75 percent of the contract. One requirement to qualify for federal matching funds is that the entity be certified by the CMS, which Qualis Health is.

Mr. Kivitz noted that the issues related to the SIS itself have not been addressed. Administering the SIS costs \$700 per assessment. Adelante has been consistently owed reimbursements ranging from \$100,000 to \$250,000 for services rendered over the last several years. Legally, providers are not supposed to be providing services without a current budget in place, yet providers are not given the choice to deny services. The *Jackson* lawsuit added the usage of case managers, which has been a good addition. Mr. Kivitz believes that having one individual who is trained on submission requirements attending meetings with the interdisciplinary team and case managers could eliminate many of the budget issues and save money. The plaintiffs from the *Jackson* lawsuit are supposed to be meeting with the state on this issue. Mr. Kivitz questioned why the state has not eliminated the SIS altogether.

Ms. Stevenson explained that the email referenced by Mr. Kegel was directing UNM to prioritize certain persons for the SIS. Under the current waiver, the DDS is required to administer the SIS. Ms. Stevenson contended that prioritization will save money because the focus will be placed on those individuals who need an SIS so that they can receive services.

A member of the subcommittee requested a breakdown by age of individuals on the DD waiver wait list. Ms. Stevenson responded that there are currently 137 children receiving the DD waiver and agreed to follow up with the subcommittee regarding a breakdown of the wait list. Mr. Kegel suggested that the information also include persons under the age of 22 who might be receiving services through the school system.

Update: Developmental Disabilities Planning Council (DDPC)

John Block, executive director, DDPC, addressed the subcommittee with an update on the activities of the council. The mission of the DDPC is to promote advocacy, capacity-building and systemic change to improve the quality of life for individuals with DD and their families. Every state and territory in the United States has a council; there are 56 councils. In addition, there is also a university branch and a protection and advocacy branch. Mr. Block noted that New Mexico's DDPC works well with its counterparts around the state, but it remains its own agency, which he believes is an asset in getting more done. New Mexico is also the only state in the nation to have its guardianship program under the DDPC. Over half of the membership either has a disability or has a family member with one. This provides the council with an understanding and first-hand experience of needs. Mr. Block provided members with a folder containing information on the DDPC, its membership, the state plan development process, needs assessment criteria, federal program projects and the "Logic Model".

Sandy Skaar, chair, DDPC, explained the makeup of the council for the subcommittee. Overall, there are 22 members on the DDPC. Some have family members with disabilities while others are self advocates. Ten members are representatives from

state agencies and other key organizations such as DRNM. The DDPC meets on a quarterly basis, with the next meeting scheduled for November 4, 2016.

Barbara Ibaniz, DDPC, explained that every council is required to establish a five-year state plan. Ms. Ibaniz provided information to the subcommittee on how data were gathered from all areas of the state to develop the plan. Following a period of surveys and self-advocacy meetings, five top priorities were identified: 1) formal and informal community supports; 2) employment; 3) health; 4) self-advocacy leadership; and 5) education and early childhood. Council member work groups were created for each of the five priority areas. The work groups reviewed the surveys and input results; drafted goals, objectives and activities; and reported back to the full DDPC. These drafts became the foundation for the council's new goals, objectives and activities and were incorporated into the five-year plan. After completion of the draft, public input was sought prior to final approval. The plan was then edited and finalized for approval by the council on July 29, 2016. Council members provided further insight and input, which resulted in approval of the finalized 2017-2021 five-year state plan, which is available online.

Mr. Block added that the council is working to build a new data system and will be migrating data from the old database. It currently has a waiting list due to a shortage of attorneys who can take care of persons in need of guardianship in outlying areas. In terms of the DDPC's budget, efforts have been made to keep it flat. Costs have increased by \$13,000 for property insurance, and there have been increases in charges from the Department of Information Technology. The DDPC will be requesting a van to replace its bus in hopes of reducing fuel expenses. Mr. Block addressed the recent allegations of embezzlement by a DDPC employee. All of the recommendations from the Office of the State Auditor following the investigation have been implemented, and Mr. Block anticipates good results from the external audit. He reported that the investigation has since been turned over to the New Mexico State Police. Mr. Block added that the DDPC is going to begin looking at the new WIOA regulations, the Achieving a Better Life Experience Act of 2014, also called the "ABLE Act", and self-directed savings accounts.

Update: Notice of Public Meetings to Solicit Comment on Proposed Changes to Waiver Programs

Ms. Roanhorse-Aguilar provided the subcommittee with an update regarding public meeting notices for proposed changes to state waiver programs. The HSD has two distinct processes and various requirements for gathering public input on 1915(c) waiver programs, including informal public input meetings and formal public input meetings. (Please see handout for full descriptions of the processes.) Ms. Roanhorse-Aguilar stated that the HSD is currently preparing formal public comment activities for the Mi Via waiver amendment and the DD waiver renewal. An outline for the upcoming hearings for both waivers is included in the handout. The HSD will be submitting the DD waiver to the CMS for approval in February.

Mr. Kegel stated that he is unaware of any individual who has received notice for the June meeting and that the notice for public comment on the Mi Via waiver was sent out late. Mr. Kegel believes that having meetings with only a few days notice is not good enough, and he wants state agencies to follow state law. It was noted that mailings regarding the DD waiver would have to be sent by the DDS, not the HSD.

Melanie Buenviaje, deputy bureau chief, Exempt Services and Programs Bureau, HSD, explained that the town hall meetings that took place in August were only for Mi Via participants. The purpose of the informal process is to solicit comments and gather information. The formal process will have, in detail, every single proposed change in the waiver. During the formal comment period, notice will be going out to all stakeholders. Ms. Buenviaje assured members that the HSD will be following state law during the formal comment period. The department has forms for oral, written and email comment submissions. The Mi Via website also has an open comment section where the public can submit feedback. All comments from hearings are compiled and published on the HSD website at the end of the comment period. Ms. Buenviaje stated that the addresses that the HSD uses are taken from the case system, noting that from the last Mi Via mailing, only three pieces of mail were returned to the department.

Public Comment

Gay Finlayson, a local representative of Autism Speaks, believes that the age cap for services needs to be removed from New Mexico insurance mandates. The 2009 mandate has an age cap of 18 or 22, depending on whether the individual is still in high school. It also had a monetary cap, which was removed through a bulletin from the Office of Superintendent of Insurance (OSI). The OSI believes that the age cap does not align with the federal Patient Protection and Affordable Care Act or with the federal Mental Health Parity Act of 1996. The OSI further believes that legislation may be required to correct this. Ms. Finlayson questioned whether this action could be taken by a bulletin. She also questioned why Medicaid has an age cap of 21 on applied behavior analysis therapy. Ms. Finlayson suggested that Lori Unumb, who is going to be at the Southwest Conference on Disability next month, be included on the agenda for the next DCS meeting.

Liz Thomson, former state representative, expressed concern over the amount of money being spent on oversight of the DD waiver budgets. She noted that the Mi Via waiver budget per person is set at \$70,000 regardless of need, and she cited several examples of misuse. There needs to be a balance between too much oversight and not enough oversight in the waiver system. Ms. Thomson also claims that she has never received any mailings or notices regarding the public hearings by the HSD and DOH. Autism programs in New Mexico are 20 years behind other states. Pending cuts for autism services are troublesome. Ms. Thomson is worried that the small system that the state has been able to develop is being dismantled due to funding constraints.

Adjournment

There being no further business before the subcommittee, the third meeting of the DCS adjourned at 5:15 p.m.

Revised: October 6, 2016

**TENTATIVE AGENDA
for the
FOURTH MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**October 7, 2016
Picuris Room, Albuquerque Convention Center
Southwest Conference on Disability**

Friday, October 7

- 9:00 a.m. **Welcome and Introductions**
—Senator Nancy Rodriguez, Vice Chair
- 9:10 a.m. (1) **Update on State Budget Impacts on Services for Persons with Disabilities**
—Eric Chenier, Fiscal Analyst, Legislative Finance Committee
- 9:45 a.m. (2) **Supports Waivers and Renewal of State Waivers**
—Cathy Stevenson, Director, Developmental Disabilities Supports Division (DDSD), Department of Health (DOH)
—Robert Kegel, Advocate
- 11:15 a.m. (3) **Public Comment**
- 12:00 noon **Lunch (to coincide with conference luncheon and keynote address)**
- 2:00 p.m. (4) **Final Centers for Medicare and Medicaid Services Rule on Home- and Community-Based Services**
—Rachel Morgan, Senior Committee Director, Health and Human Services, State and Federal Relations Department, National Conference of State Legislatures
—Jennifer Rodriguez, Community Programs Bureau Chief, DDSD, DOH
—Melanie Buenviaje, Deputy Bureau Chief, Exempt Services and Programs Bureau, Human Services Department (HSD)
—Tallie Tolen, Bureau Chief, Long Term Services and Supports Bureau, HSD
- 3:00 p.m. (5) **Intellectual and Developmental Disabilities Employment Services Supports**
—Carrie Roberts, DDSD Supported Employment Lead, DOH
- 3:30 p.m. (6) **Insurance Coverage for Autism: Aligning State and Federal Law**
—Michael Hely, Staff Attorney, Legislative Council Service
- 4:00 p.m. (7) **Public Comment**
- 5:00 p.m. **Adjourn**

**MINUTES
for the
FOURTH MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE**

**October 7, 2016
Picuris Room, Albuquerque Convention Center
Southwest Conference on Disability
Albuquerque**

The fourth meeting of the Disabilities Concerns Subcommittee (DCS) of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Nancy Rodriguez, vice chair, on October 7, 2016 at 9:18 a.m. in the Picuris Room at the Albuquerque Convention Center in Albuquerque.

Present

Sen. Nancy Rodriguez, Vice Chair
Rep. Miguel P. Garcia
Sen. Linda M. Lopez

Absent

Rep. Tim D. Lewis, Chair
Sen. Craig W. Brandt

Advisory Members

Rep. Deborah A. Armstrong
Sen. Gerald Ortiz y Pino

Sen. Ted Barela
Rep. Nora Espinoza

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, LCS
Alexandria L. Tapia, Contractor, LCS

Minutes Approval

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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=DISC.

Friday, October 7

Welcome and Introductions

Senator Rodriguez welcomed members to the fourth meeting of the DCS, which was hosted by the 2016 Southwest Conference on Disability. Members of the subcommittee and staff introduced themselves. The subcommittee was welcomed to the Albuquerque Convention Center by conference director Anthony Cahill, Ph.D., director, Division of Disability and Health Policy, Center for Development and Disability, University of New Mexico (UNM). Dr. Cahill informed the subcommittee that the keynote address for the conference would be given by Lorri Unumb, vice president of state government affairs, Autism Speaks.

Update on State Budget Impacts on Services for Persons with Disabilities

Eric Chenier, fiscal analyst, Legislative Finance Committee (LFC), addressed the subcommittee with a post-special-session recap of state revenue projections, Department of Health (DOH) budget and the developmental disabilities (DD) waiver (please see handout for more information). Mr. Chenier explained the impact of legislation passed during the special session that resulted in a \$169.4 million reduction to appropriations in addition to previous fund sweeps, capital outlay cuts, closure of tax loopholes and changes to public fund distributions. For adjustments to fiscal year (FY) 2017 General Fund appropriations, all state agencies and programs received appropriation reductions and were directed to implement those reductions within their respective departments. The exceptions to these reductions included the DOH's Developmental Disabilities Supports Division (DDSD) and Facilities Division; the Human Services Department's (HSD's) Medicaid and Medicaid behavioral health programs; the Children, Youth and Families Department (CYFD); and the Department of Public Safety. Overall, the FY 2017 operating budget for the DOH was reduced by \$4.7 million during the 2016 special session.

Mr. Chenier discussed intellectual and developmental disabilities (IDD) services in the state. New Mexico is one of only 12 states not operating IDD institutions. In FY 2013, New Mexico ranked sixteenth in the nation on per capita federal home and community-based services (HCBS) waiver spending. The DDSD budget request for FY 2018 is in line with the FY 2017 request. The current budget includes \$800,000 for 40 DD waiver slots and nonreverting language; while no reductions were taken, the measures are still insufficient to reduce the wait list for the waiver. The DD waiver wait list is over 10 years long and the need continues to outpace slot availability, growing at a rate of 5.5% per year. As requested at a previous DCS meeting, Mr. Chenier shared some information about how other states administer their DD waiver programs. It was noted that a state-by-state cost comparison is problematic because each state offers different services and extends services to different groups, and some states have separate supports waivers. Nationally, about one-half of the states offer a waiver for individuals with autism, and almost all of the states have a separate waiver specifically for children with IDD. Colorado has five waiver programs for individuals with IDD: a children's autism waiver; children's extensive support waiver; children's habilitation waiver for those in foster care;

supported living services waiver for adults; and a persons with DD adult waiver. Colorado also offers six other waivers, including ones for the elderly and for persons with brain injuries.

Cathy Stevenson, director, DDS, noted that New Mexico has a waiver for the medically fragile, which is no longer limited to children. Ms. Stevenson provided the subcommittee with a spreadsheet detailing the DDS's contracts for FY 2016 and FY 2017. Because budget cuts were restored during the special session, the DDS will be revising the spreadsheet, and it will be provided to the subcommittee at a later date.

Members of the subcommittee and the presenters discussed several topics, including:

- interest expressed over the interim for a supports services waiver in New Mexico;
- limitations and coverage of existing waivers;
- the pros and cons of diversifying services under new waivers;
- the potential customizing of waivers to fit needs;
- limitations under the current state budget;
- the DD waiver renewal process and status;
- the possibility of setting up a supports services waiver for future implementation;
- the number of elderly in HCBS;
- concern about cuts made during the special session to public health and other health services; and
- inquiries about Colorado's waiver programs.

Supports Waiver and Renewal of State Waivers

Ms. Stevenson addressed the subcommittee regarding the current status of the renewal process of the DD waiver. Under the current DD waiver, participants are required to demonstrate need for a level of care every year with the help of an interdisciplinary team. Ms. Stevenson provided an overview of the outside review process (see handout for full details). The state is required to comply with rules from the Centers for Medicare and Medicaid Services (CMS) in order to draw down federal matching funds. The DD waiver is up for renewal by the CMS, and the state now has the opportunity to make any changes to the process for participants. New Mexico received an extension until February 2017 to submit the DD waiver for approval. The DDS will be releasing a draft of the renewal soon; there will be a period for individuals to provide feedback on the changes. Ms. Stevenson noted that the draft has eliminated the requirement of the Supports Intensity Scale (SIS), which has drawn much criticism. The approach behind the draft renewal is that once a participant has been clinically approved for services, there is no need for reapproval of those services unless the condition has changed. The DDS is working to reduce the administrative burden of the process. These changes are in response to the feedback from advocates and providers. In closing, Ms. Stevenson thanked DDS staff for their work on the DD waiver renewal.

Robert Kegel, advocate, expressed appreciation for the efforts of the subcommittee in addressing issues regarding the DD waiver. Mr. Kegel believes that the state needs to do a better

job during the appropriation process to ensure proper funding of programs such as DD. A member of the subcommittee noted that part of the challenge of a part-time legislature is the issue that not all legislators are fully informed on every program and service, creating a disconnect during the appropriations process. Mr. Kegel also expressed the need to keep public input at the forefront of changes regarding the DD waiver and DD services. According to Mr. Kegel, there were several issues with the DDS's public hearing period. Many advocates, caregivers and case managers did not receive any information or notice about upcoming public hearings; a total of only 16 comments were documented. Ms. Stevenson acknowledged that no letters were sent out and notice about the meetings was only sent via email. The DDS typically does not send out any correspondence by mail because it has been ineffective. The division does not maintain a database of addressees. Ms. Stevenson added that the DDS is working on this issue and is seeking better methods of outreach for future use.

In response to questions raised during the August 4 meeting of the DCS, Mr. Kegel prepared two presentations for the subcommittee: 1) a survey and comparison of disability waivers that provide services to children with autism; and 2) a survey and comparison of Medicaid disability supports waivers. The presentations included detailed information about waivers and services provided in several states. Mr. Kegel is advocating for a separate autism waiver for New Mexicans, positing that if individuals get early intervention therapy, their care costs in the long-run are substantially reduced. Currently, 14 states offer waivers specifically for autism services. Total program costs range from \$337,000 to \$33 million, and the number of participants ranges from 47 to 1,500. The costs do not reflect the respective state's share of these costs, which can range from 50% to around 70% depending on the relative wealth of the state and the federal match rate; New Mexico's share is about 30%.

While the DD waiver has a component specifically for children, the time on the wait list is at least 10 years. In addition to comprehensive waivers, most states offer a supports waiver with an average cost of \$15,000 per person in both federal and state funds. With approximately 6,000 individuals on the wait list, a supports waiver in New Mexico could tremendously benefit those on the wait list, specifically children, until they are approved for the DD waiver. Mr. Kegel would like to see three waivers in place — a children's, a supports and a comprehensive. With the implementation of separate waivers, the state could better leverage federal dollars and stimulate job creation. Leveraging funds for autism services alone would reduce General Fund costs to \$53 million. Mr. Kegel urged the members to address the issue of the wait list during the upcoming session and to begin reassessing the needs of the state through the budgeting process.

On questioning, Mr. Kegel and Ms. Stevenson discussed the following topics with the subcommittee:

- the need to follow current law to avoid future litigation;
- the impact of state budget cuts during the special session, specifically cuts to the DOH;
- the likelihood of additional cuts during the 2017 regular session;

- a need to better leverage federal funds;
- a comparison of the renewal process for the Mi Via waiver;
- services being provided by non-Medicaid programs;
- the potential for individuals being excluded from services with the expansion of the waiver program;
- existing programs for children, including the Family, Infant, Toddler Program;
- eligibility for the medically fragile waiver;
- inquiries about funding for particular services and administrative costs;
- lack of coverage for autism services under the Children's Medical Services Program;
- a comparison of services provided in other states;
- a current DD waiver wait list age breakdown; and
- a request that Mr. Kegel draft a public input plan to share with the DOH.

Public Comment

Elisheva Levin is a self-advocate with autism. Ms. Levin addressed the subcommittee to voice the needs of adults with autism who do not qualify for the DD waiver or for Medicaid services. These individuals have the potential to be great contributing members to society, but they need specific services. For example, Ms. Levin stated that assistance in the development of soft skills is crucial to not only acquire a job, but to be successful in the job. Another issue facing adults with autism is the lack of providers for diagnosis — many individuals end up self-diagnosing. Ms. Levin shared that she was diagnosed out of state. She acknowledged the importance of early intervention for children, but wants to bring attention to those adults that were not diagnosed at an early age.

Gay Finlayson told the subcommittee that advocates have been seeking an autism waiver for several years. The most recent attempt, last year, sought early and periodic screening, diagnosis and treatment (EPSDT) services for children. New Mexico's current Medicaid program for children with autism who do not need specialty care is adequate. Ms. Finlayson would like to see an autism waiver that would cover a basic package for families. She also expressed concern about insurance copays, noting that some families cannot afford to pay multiple copays for services that are provided several times a week or month, and that some families terminate services for this reason. There is a need for an estimated \$10 million for autism services in the state; about \$3 million is currently being spent. Ms. Finlayson wondered how much the managed care organizations (MCOs) are spending on children's autism services and how much is being spent on out-of-state residential treatment. A member of the subcommittee expressed interest in receiving more information on this matter.

Wendy Corry works with individuals with disabilities and believes that a closer look at how much money MCOs are spending on out-of-state services needs to be taken. There are huge advantages for families to receive services within the state, including keeping spending in New Mexico, better support networks for families and job creation. Ms. Corry echoed the statements made by Ms. Finlayson and Mr. Kegel. She noted the importance of keeping the needs and wants of the individual with a disability at the forefront when providing services. In looking at

the potential for additional waivers, the state needs to consider the tremendous cost of building infrastructure, capacity and the provider network. Ms. Corry believes that more attention needs to be given to independent living and to helping individuals develop skills to live on their own.

Sandra Fortier is the mother of a child with a developmental disability and has been denied waiver services. Her child has fetal alcohol spectrum disorder (FASD), a lifelong neurodevelopmental condition that prevents individuals from being able to live independently (a handout was provided to the DCS). Ms. Fortier questioned why New Mexico residents with FASD are being denied the services and supports they need that are provided by the DD waiver. New Mexico's DD waiver eligibility determinations currently utilize an antiquated list of diagnoses that are the only specific related conditions eligible for the waiver, even if the person has a diagnosed syndrome or disorder and meets the adaptive functioning criteria. This list from 1992 was not intended to be used as a comprehensive list. FASD was on the list but was left out of the New Mexico Administrative Code. A member of the subcommittee asked Ms. Stevenson if FASD could be included in the DD waiver renewal. Due to a pending lawsuit, Ms. Stevenson was unable to comment but noted that there is a functional eligibility requirement that would qualify an individual with FASD for the DD waiver. Ms. Fortier added that FASD is not considered an intellectual disability because individuals have IQs of at least 70. A member requested that LCS staff look at current statutes and draft potential legislation for consideration by the LHHS.

Cathy Salazar, parent, informed the subcommittee that adopted children are getting services through the DD waiver and the medically fragile waiver. Ms. Salazar wanted the subcommittee to know that the medically fragile waiver works very well but it only serves 350 children statewide. She urged the subcommittee's continued support for the waiver. Medical interventions help improve the quality of life for these children, while extending their lives and keeping them out of institutional care. The medically fragile waiver supports families by providing nursing care from home health aides. Ms. Salazar stated that there has been a movement to transfer the medically fragile waiver to the purview of Centennial Care with HCBS. She believes this would be a negative move because the program is geared more for adults. The medically fragile waiver needs to stay intact as a separate waiver.

Lisa Rosignol, parent and advocate, thanked the subcommittee for its work and attention to issues relating to disabilities. Ms. Rosignol believes that all parties that work with children with special needs have good intentions but frequently lack the resources they need. Ms. Rosignol supports Mr. Kegel's views on Medicaid 1915(c) HCBS waivers. She shared a story about a young girl in the 1980s who contracted viral encephalitis while in Iowa and was unable to return home due to the extensive care costs she required. Under President Ronald Reagan, the 1915(c) waiver was signed into law. The Section 1115 demonstration waiver of the Social Security Act was later implemented in attempts to unify MCOs and services. This waiver has done a phenomenal job meeting the needs of adults, but, Ms. Rosignol cautioned, good people make bad choices due to lack of information. Centennial Care could fill the need by providing

more respite hours with an exemption from the waiver through the Aging and Long-Term Services Department.

Carol Maestas shared a handout with the subcommittee requesting the DOH and HSD to add Rett syndrome to the list of qualifying conditions for the DD waiver and Medicaid supports and services. Ms. Maestas addressed the LHHS during its September meeting regarding this issue. Until 2013, Rett syndrome was included under the autism umbrella and therefore qualified for services. Senate Memorial 81 from the 2016 regular session was introduced to look at this matter but was not passed. The sponsor has agreed to reintroduce the memorial during the 2017 legislative session. A member requested that Rett syndrome be added to the draft legislation regarding FASD for LHHS consideration.

Peter Cubra recalled the issues surrounding the SIS going back several years. He believes that there are so many elaborate mechanisms built into the system to prevent individuals from accessing the services and supports that they need by requiring them to justify services. The notion that the state was overspending on services was a false narrative. The SIS is expensive and ineffective. Mr. Cubra expressed frustration at the additional work burden being placed on case managers, leading to burnout. He acknowledged Mr. Kegel for his work and contributions as an advocate and urged the subcommittee to continue working with him. In reference to the HCBS rule presentation scheduled on the agenda, Mr. Cubra requested an end to the segregation of people with disabilities in the state. This program is still a form of segregation and is illegal. Mr. Cubra also encouraged the expansion of supportive employment, adding that more needs to be done for individuals with severe disabilities.

Dan and Barbara Taggart shared their experience with the transition planning process for bringing their son back into the state from out-of-state services. The Taggarts are 30 days away from their son's discharge, and no transition plan is currently in place. This process does not consider that New Mexico's adult placement might not meet the level of care needed by a person who ages out of adolescent placement. There is a court order for a three-year transition plan, and the family has been rejected by Molina Healthcare. The Taggarts stated that their son remains a danger to himself and others and cannot be placed in a group home. There is no place in New Mexico to care for their son. They added that just because an individual ages out of services does not mean that their needs or diagnoses have changed.

Selene Alverio has a hearing disability and is the parent of a child with autism. Ms. Alverio has had her child taken from her by the CYFD twice and is being investigated by the police. She has a bachelor's degree in social work from UNM. Ms. Alverio lost her job twice in a period of nine months because of unsubstantiated allegations by the CYFD. She believes there needs to be a change in the system to protect parents with disabilities. There should be services for parents if they are overwhelmed or if they need respite care. She would like to see a program created by the CYFD for parents and children with special needs and also a process for working with parents with disabilities.

Approval of Minutes

Upon proper motion made and seconded, the minutes for the second meeting of the DCS were approved by the subcommittee.

Final CMS Rule on HCBS

Rachel Morgan, senior committee director, Health and Human Services, State and Federal Relations Department, National Conference of State Legislatures (NCSL), addressed the subcommittee via teleconference regarding the final CMS rule on HCBS. Ms. Morgan provided some background on the rule and the long-term services and supports (LTSS) program. Medicaid is the single largest payer of LTSS, and the program provides a broad range of supports. LTSS accounts for one-third of all Medicaid spending, even though only 6.2% of the Medicaid population is receiving these services. The purpose of the final rule on HCBS was to ensure access for individuals, and it supports the United States Supreme Court ruling on *Olmstead* — a shift from the institutional setting to community-based programming. Under the new rule, Medicaid recipients receive full access to community living opportunities. The final rule provides the option to combine three different groups under the waiver. Ms. Morgan outlined the key provisions of the final rule, noting the five-year approval window and the provider payment reassignment provision. Under this provision, states are allowed to make third party payments for employee benefits; previously, states were only allowed to make payments to a practitioner. Ms. Morgan added that this is an opportunity for the state to work with some providers.

The new rule establishes criteria for qualities of HCBS settings with an emphasis on person-centered planning. Qualities for settings include: integrated settings, setting choice, individual rights, personal independence, service and provider choice. These requirements allow individuals greater access to the community, as well as more independence and control over their own lives. Individual rights must be ensured by the setting. Ms. Morgan noted that the new CMS rule does present a few challenges for the state and, with so many changes going on with Medicaid, timing may be an issue. The onus is on state agencies to implement the final rule, and CMS did not clearly define the role of MCOs. The NCSL is working with states on network adequacy as the final rule takes effect.

Jennifer Rodriguez, Community Programs Bureau chief, DDS, mentioned that the DOH was participating at the conference and had already given two presentations. Ms. Rodriguez shared a portion of the presentation that was relevant to the CMS final rule, which included a short video. The new rule frames disability rights as both human rights and civil rights. The DDS, DOH and HSD have collaborated to launch the "Know Your Rights" campaign — a statewide initiative to reaffirm values and get communities involved. The campaign seeks to act as a catalyst by changing how people think about individuals with disabilities. Ms. Rodriguez stated that the best way to learn how to be in the community is to live in the community; that is why the CMS rule is so pertinent. The DDS is promoting best practices and supporting inclusion and integration into communities. New Mexico's three waivers — the DD waiver, Mi Via waiver and medically fragile waiver — and Centennial Care are subject to the final rule from

CMS. The state must be fully compliant with the final rule by March 2019. Ms. Rodriguez shared a final video, *How Do You See Me?*, demonstrating the importance of people with IDD having the same rights and opportunities as everyone else.

Melanie Buenviaje, deputy bureau chief, Exempt Services and Programs Bureau, HSD, provided a brief update on the statewide transition plan. In March 2016, the CMS asked for more details and the state opened up a public comment period, which ended on September 20. The CMS issued more guidance and extended New Mexico's submission date to October 20, 2016. The draft transition plan is available on the HSD website. The state has completed a systemic assessment of all waivers, the code governing the waivers, provider agreements and all documents that control the waivers at the state level. Through this process, several areas have been identified as needing updates to become compliant. The HSD will begin meeting with participants in these settings to make sure that they are getting their needs met in line with the final rule. To date, only Indiana and Idaho have met all of the requirements of the final rule. CMS has invited New Mexico to participate with a five-state group to discuss these transition plans.

Tallie Tolen, bureau chief, Long-Term Services and Supports Bureau, HSD, oversees the long-term care program under Centennial Care. Ms. Tolen noted that there are also long-term care services under Centennial Care's 1115 demonstration waiver. The two departments are working to integrate all of these various programs together.

In response to questions from subcommittee members, the panel addressed the following:

- further inquiries regarding the scope of the final rule;
- the impact of the final rule on the elderly in long-term care;
- the impact on providers, particularly in rural areas;
- implementation of *Olmstead* plan principles into the final rule;
- the absence of an *Olmstead* plan in New Mexico;
- efforts by the HSD and DOH to seek input from advocacy groups and the public;
- the CMS's request for the inclusion of assisted living, home health aides and the medically fragile waiver into Centennial Care;
- concern about requiring integration and limiting association;
- the availability of technical assistance to help existing programs with compliance;
- hiring efforts at the HSD for staff with disabilities and family members; and
- the scope of the HSD's Exempt Services and Programs Bureau.

Intellectual and Developmental Disabilities Employment Services Supports

Carrie Roberts, DDS supported employment lead, DOH, provided the subcommittee with an update on employment services in New Mexico for IDD and DD. Ms. Roberts noted that the timing is optimal for promoting employment in light of the CMS final rule; she is also a member of the Know Your Rights campaign. Many different departments, divisions and organizations are collaborating in a partnership with a vision to increase capacity for employment

of New Mexicans with IDD and DD. Focus is being placed on training and technical assistance for employers. Ms. Roberts shared information about recent events held to promote employment, including a symposium and webinar. The training for partners for employment had a total of 1,736 participants. Ms. Roberts highlighted the following key initiatives.

Sell Teams. Sell teams conduct outreach to meet people where they are and provide networking opportunities for local leaders and job developers.

Certified Employment Professional Exam. The certified employment professional exam is an effort to evaluate employment supports professionals. In the initial testing, 14 of the 16 people who took the examination passed, which is better than the national average. The voluntary exam will be back in 2017, and the DDS will offer 24 scholarships for individuals wanting to take the exam.

Employment First Plan. The DDS is taking the lead on the "employment first" plan. This process asked individuals with IDD leading questions relating to informed choice. The intent of this policy and procedure is to give some guidance and direction in determining good employment options. Ms. Roberts will participate in a statewide tour to meet with providers and answer questions about this process.

Informed Choice Project. This project is being piloted in Los Lunas and is related to the *Jackson* lawsuit. The DDS has identified 119 individuals who are *Jackson* clients and is working with them to conduct "discovery activities".

Office Worker's Program. The existing office worker's program has been revamped to give people more experience in the community. This program will fund trial work experiences and the opportunity for a person to have the person's own business. Of the 18 participants in this program, eight have started new businesses and three have been hired by others. This program also helps individuals write their resumes.

Central Registry Unit. An additional grant is being introduced to help individuals in the registry between ages 18 and 25 with employment supports on the job. This includes additional options for transportation and other nontraditional supports.

Data Project. The most recent national data for individuals in services with an employment goal is from 2014 (data are from 2013). Approximately 18.6% of individuals with DD are employed nationally; in New Mexico, that number is closer to 36%. Currently, billed services are being tracked but not outcomes. The project seeks to track outcomes on a quarterly basis by looking at how long people have been in their jobs and how they are spending their days.

Community Life Engagement Pilot. This pilot, done through a competitive grant bid process, partners with ARCA to help people engage in community life. Out of 11 states that applied, New Mexico and the District of Columbia were awarded the grant. The "Tool Kit" pilot

consists of four guideposts: individualized supports, promoting community membership and contribution, using human and social capital instead of paid supports and ensuring that supports are outcome oriented and regularly monitored. The national team will be coming to New Mexico in October.

Following Ms. Roberts' presentation, members of the subcommittee asked questions about some of the outlined projects and initiatives. A member noted that a lot of places do not know what "employment first" means and more needs to be done to promote employment over other supports and to encourage work as part of community life. Ms. Stevenson added that there is no fiscal or resource commitment from the CMS with the final rule other than technical support. All of the states are getting a slow start at implementing the final rule, and Ms. Stevenson anticipates a corrective action plan for those that are not in compliance. There is concern with the overall state budget situation and the impact it will have on programs and CMS compliance. The likelihood of limited financial resources would mean fewer services to fewer people.

Insurance Coverage for Autism: Aligning State and Federal Law

Mr. Hely addressed the subcommittee with an overview of different federal and state laws relating to autism spectrum disorder (ASD) insurance coverage (please see handout). Mr. Hely discussed the various federal and state laws, noting that there are multiple layers of law in effect. Under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), autism is classified as a mental condition and, therefore, must be covered. Mental health parity also applies to the federal Employee Retirement Income Security Act of 1974 plans and Medicaid. Under the federal Patient Protection and Affordable Care Act (ACA), preventive service has to be provided, including ASD screening and diagnosis. Essential health benefits under the ACA include rehabilitative and habilitative services. Under the Social Security Act, states must cover ASD screenings, diagnosis and treatment under the EPSDT program for individuals under the age of 21. States may elect to include ASD services on state plans for individuals over the age of 21 or provide services through an HCBS waiver.

New Mexico currently has a mental health parity law. Under the New Mexico Insurance Code, private plans must provide coverage for diagnosis, speech therapy, occupational therapy and applied behavior analysis (ABA) therapy. State law allows state private plans to limit ASD benefits and services to individuals age 18 and under, or under age 22 if enrolled in high school. Annual and lifetime caps on the dollar value of benefits and services are also permitted. Additionally, private plans are allowed to establish copays for ASD screenings of children. New Mexico Medicaid does not provide ABA services for persons over the age of 21, which is in violation of the federal mental health parity law.

In March 2015, the Office of Superintendent of Insurance (OSI) issued a bulletin clarifying that commercial, individual and small group plans may not have limits in autism coverage pursuant to the ACA. This bulletin informs insurers that large group plans may not have limits pursuant to the MHPAEA and also indicates that the OSI will seek to change the state

law "at the earliest opportunity". The OSI has the authority to enforce federal law. Some other portions of state law violate federal law, but are preempted by federal law.

Senator Rodriguez mentioned the letter (in the meeting file) to the OSI regarding multiple copays for services requested at the last meeting of the DCS. The letter is requesting the OSI to see if anything can be done to address the additional hardship on families. Senator Rodriguez hopes to receive a response prior to the 2017 legislative session in case legislation is necessary to address the issue. Members of the subcommittee discussed the presentation by Mr. Hely, noting the need for addressing existing statutes to come into compliance with federal law.

Ms. Unumb, keynote speaker, agreed with the information presented and added that adults on Medicaid cannot access ABA. If the state is able to change statute, Ms. Unumb urged the members not to codify the Diagnostic and Statistical Manual of a Mental Disorders V (DSM), but recommends language that refers to the DSM that was in effect at the time of diagnosis. This approach has been taken by other states and does not negatively affect children.

Public Comment

Nat Dean and Lindsey Sloan addressed the subcommittee regarding the abuse of service and emotional support animals usage. According to Ms. Dean, the incidence of individuals claiming pets as service animals is very high, creating problems and dangers for individuals with actual service animals. Ms. Dean thanked Senator Rodriguez for sponsoring Senate Bill 320 (2013), which made it a misdemeanor to falsely pass off a pet as a service animal. However, this misdemeanor is not being enforced by law and may require additional legislation and education about the issue. Under the federal Americans with Disabilities Act of 1990, no certification or vest is required for service animals. Ms. Sloan stated that she was forced to retire her service dog because it was attacked on a bus by another dog that was being falsely identified as a service animal. Ms. Sloan noted that bus drivers are unaware of their right to ask owners to leave. Properly trained service dogs cost between \$30,000 to \$70,000, making it extremely expensive to replace them. Ms. Dean and Ms. Sloan want to bring attention to the issue and are advocating for the education of businesses and transportation to better distinguish service animals from pets.

Cindy Padilla, consultant, Mi Via waiver program, wanted to share some positive feedback with the subcommittee about some of her clients. One of her clients obtains services from Very Special Arts in Albuquerque. This client, who is confined to a wheelchair, receives person-centered planning and has demonstrated major improvements and growth through his participation. Ms. Padilla wants legislators to be mindful that some beneficial programs are not considered integrated services and, therefore, would not comply with the new CMS rule. These are valuable programs that are very important to clients and the community. Ms. Padilla hopes these programs do not get left out or eliminated by the CMS final rule.

MaryBeth Weeks has six children, three of whom are waiver participants — two on the medically fragile waiver and one on the DD waiver. Ms. Weeks emphasized that the majority of participants on the two waivers are unable to self-advocate. Many of the medically fragile waiver

participants get incorporated into rules without consultation of the family members or caregivers. Under the CMS final rule, Ms. Weeks and her household will be considered a "provider". Taking her children into the community creates a lot of logistical issues, and no programs will come into the home to provide services. Ms. Weeks shared that her medically fragile daughter recently caught a cold and passed away a few days later. She noted that this is a very fragile group of people who really cannot participate in a lot of the programs that are required under the CMS final rule. This population needs to be considered in any decisions and rule changes.

Ms. Stevenson, responding to a question from the subcommittee, clarified that the CMS final rule applies to all HCBS. The CMS is asking states to do validation and verification of services. The DOH is arguing that services in the home of a child are not subject to these rules; however, if the state is receiving Medicaid funding, the state must comply with the rules set forth by Medicaid. Members offered their condolences to the Weeks family and expressed the need for more advocates for the medically fragile. It was noted that gathering feedback from medically fragile caregivers and family is more difficult and must go beyond simple invitation to meetings.

Ms. Finlayson stated that she had met with the OSI over the summer regarding age limits in insurance plans. According to Ms. Finlayson, some families with children in private plans are being informed that they are "aging out" of services. She has talked to Medicaid about expanding ABA therapy for adults and the importance of expanding these services. The use of ABA has made significant impacts on individuals' progress and ability to succeed.

Elizabeth Thomson, former state representative, thanked the members of the DCS for their dedication to these issues and acknowledged Ms. Stevenson's attendance and participation in meetings. Ms. Thomson questioned the methods being used to gather public input and to advertise notice of meetings and program changes. She believes the DOH could make better use of existing listservs for autism and Down syndrome, as well as social media, to get information to stakeholders. Ms. Thomson expressed concern with the continual practice of putting money into programs that sound good but do not have any real impact on individuals' well-being; saying "employment first" does nothing if people are not actually employed. Ms. Thomson shared some of the issues she is having with private insurance covering services for her son. The state needs to look at the families that are trying to help the system by buying private insurance and not overburdening Medicaid.

Mr. Kegel stressed the importance of looking at how the state builds the budget. The budgets were built by a consultant who captured every cent of the large providers' budgets. This will have a big impact on small and rural providers. He believes the state's rate structure is a disaster; adding these additional requirements without giving providers an appropriate rate structure will result in serious problems. Mr. Kegel reiterated his concern about the lack of public comment and the need for the DDSD to compile a thorough mailing list.

Adjournment

There being no further business before the subcommittee, the final meeting of the DCS for the 2016 interim adjourned at 5:01 p.m.

ENDORSED LEGISLATION

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; AMENDING A SECTION OF THE PUBLIC ASSISTANCE ACT TO REMOVE BEHAVIORAL HEALTH SERVICES FROM THOSE SERVICES THAT THE HUMAN SERVICES DEPARTMENT PROVIDES TO MEDICAID RECIPIENTS THROUGH MANAGED CARE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 27-2-12.6 NMSA 1978 (being Laws 1994, Chapter 62, Section 22) is amended to read:

"27-2-12.6. MEDICAID PAYMENTS--MANAGED CARE.--

A. The department shall provide for a statewide, managed care system to provide cost-efficient, preventive, primary and acute care for medicaid recipients [~~by July 1, 1995~~].

B. The managed care system shall ensure:

(1) access to medically necessary services,

underscored material = new
[bracketed material] = delete

1 particularly for medicaid recipients with chronic health
2 problems;

3 (2) to the extent practicable, maintenance of
4 the rural primary care delivery infrastructure;

5 (3) that the department's approach is
6 consistent with national and state health care reform
7 principles; and

8 (4) to the maximum extent possible, that
9 medicaid-eligible individuals are not identified as such except
10 as necessary for billing purposes.

11 C. The department shall exclude behavioral health
12 services from any services that it provides to medicaid
13 recipients through a managed care system.

14 [~~G.~~] D. The department may exclude nursing homes,
15 intermediate care facilities for the mentally retarded,
16 medicaid in-home and community-based waiver services and
17 residential and community-based mental health services for
18 children with serious emotional disorders from the provisions
19 of this section.

20 E. As used in this section, "behavioral health
21 service" means a professional or ancillary service for the
22 treatment, habilitation, prevention and identification of
23 mental illness, behavioral symptoms associated with
24 developmental disability, a substance abuse disorder or trauma
25 spectrum disorders."

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC EDUCATION; AMENDING THE PUBLIC SCHOOL CODE TO REQUIRE THAT EACH PUBLIC SCHOOL DISTRICT EMPLOY A MINIMUM OF ONE FULL-TIME, LICENSED REGISTERED SCHOOL NURSE; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 22-8-9 NMSA 1978 (being Laws 1967, Chapter 16, Section 63, as amended) is amended to read:

"22-8-9. BUDGETS--MINIMUM REQUIREMENTS.--

A. A budget for a school district shall not be approved by the department that does not provide for:

(1) a school year and school day as provided in Section 22-2-8.1 NMSA 1978; ~~and~~

(2) a pupil-teacher ratio or class or teaching load as provided in Section 22-10A-20 NMSA 1978; and

underscored material = new
[bracketed material] = delete

underscoring material = new
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1 (3) a full-time, department-licensed
2 registered school nurse employed in the school district.

3 B. The department shall, by rule, establish the
4 requirements for an instructional day, the standards for an
5 instructional hour, ~~and~~ the standards for a full-time teacher
6 and for the equivalent thereof.

7 C. Except as provided in Subsection D of this
8 section, the department shall promulgate rules for the
9 implementation of the minimum requirement for a full-time,
10 department-licensed registered school nurse in all school
11 districts in New Mexico.

12 D. The department may promulgate rules to allow for
13 a waiver of the requirement in Paragraph (3) of Subsection A of
14 this section for a rural school district with a student MEM of
15 less than two hundred fifty; provided that:

16 (1) the school district demonstrates that it
17 can meet the requirements of this section by hiring a part-
18 time, department-licensed registered school nurse; or

19 (2) the school district:
20 (a) is not able to hire a qualified
21 nurse or contract with a third party for a qualified nurse
22 because of insufficient availability of such nurses in its
23 geographic vicinity; and

24 (b) requesting a waiver documents its
25 unsuccessful attempts to hire or contract with a department-

underscored material = new
[bracketed material] = delete

1 licensed, registered school nurse."

2 SECTION 2. APPROPRIATION.--One million six hundred fifty
3 thousand dollars (\$1,650,000) is appropriated from the general
4 fund to the public education department for expenditure in
5 fiscal year 2018 to assist school districts that have student
6 enrollments of less than two hundred fifty MEM to employ a
7 department-licensed registered school nurse for the 2017-2018
8 school year. Any unexpended or unencumbered balance remaining
9 at the end of fiscal year 2018 shall revert to the general
10 fund.

11 SECTION 3. EFFECTIVE DATE.--The effective date of the
12 provisions of this act is July 1, 2017.

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; AMENDING SECTIONS OF THE RURAL PRIMARY HEALTH CARE ACT TO PROVIDE FOR FUNDING OF ELIGIBLE CLINICAL PROGRAMS, ELIGIBLE WORKFORCE DEVELOPMENT PROGRAMS AND ELIGIBLE WORKFORCE RECRUITMENT PROGRAMS IN UNDERSERVED AREAS OF THE STATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 24-1A-2 NMSA 1978 (being Laws 1981, Chapter 295, Section 2, as amended) is amended to read:

"24-1A-2. PURPOSE OF ACT.--The purpose of the Rural Primary Health Care Act is to ~~recruit~~ better serve the health needs of the public by:

A. developing evidence-based training models and training through eligible workforce development programs;

B. recruiting and ~~retain~~ retaining health care

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1 personnel through eligible workforce recruitment programs; and
2 [~~assist~~]

3 C. assisting in the provision of primary health
4 care services through eligible clinical programs in underserved
5 areas of the state [~~in order to better serve the health needs~~
6 ~~of the public~~]."

7 SECTION 2. Section 24-1A-3 NMSA 1978 (being Laws 1981,
8 Chapter 295, Section 3, as amended) is amended to read:

9 "24-1A-3. DEFINITIONS.--As used in the Rural Primary
10 Health Care Act:

11 A. [~~"health care underserved areas" means a~~
12 ~~geographic area in which it has been determined by the~~
13 ~~department of health, through the use of indices and other~~
14 ~~standards set by the department, that sufficient primary health~~
15 ~~care is not being provided to the citizens of that area]~~

16 "department" means the department of health;

17 B. "eligible clinical programs" means nonprofit
18 community-based entities that provide or commit to provide
19 primary health care services for residents of health care
20 underserved areas and includes rural health facilities and
21 those serving primarily low-income populations;

22 [~~G. "department" means the department of health;~~
23 ~~and~~

24 D. [~~"primary health care" means the first level of~~
25 ~~basic or general health care for an individual's health needs,~~

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1 ~~including diagnostic and treatment services;]~~

2 C. "eligible workforce development programs" means
3 public or private nonprofit organizations with a minimum of
4 five years of experience in providing comprehensive,
5 community-based health career training programs working with
6 public school students, undergraduates and graduates to
7 encourage and provide specific programming to support rural and
8 underserved populations entering health careers, including
9 residency program development;

10 D. "eligible workforce recruitment programs" means
11 public or private nonprofit organizations with a minimum of
12 five years of experience in providing health care personnel
13 recruitment and retention programming in health care
14 underserved areas;

15 E. "health care underserved area" means a
16 geographic area in which it has been determined by the
17 department, through the use of indices and other standards set
18 by the department, that sufficient primary health care is not
19 being provided to the residents of that area; and

20 F. "primary health care" means the first level of
21 basic or general health care for an individual's health needs,
22 including diagnostic and treatment services."

23 SECTION 3. Section 24-1A-4 NMSA 1978 (being Laws 1981,
24 Chapter 295, Section 4, as amended) is amended to read:

25 "24-1A-4. RULES ~~[AND REGULATIONS]~~.--Subject to the State

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1 Rules Act, the department shall adopt rules [~~and regulations~~]
2 for the development of evidence-based models for training and
3 recruiting and rules for training, recruiting and retaining
4 health care personnel in health care underserved areas [~~and~~].
5 The department shall establish [~~a formula~~] formulas for
6 distribution of financial assistance to eligible clinical
7 programs, [~~which~~] to eligible workforce development programs
8 and to eligible workforce recruitment programs. The funding
9 formula for all three categories of programs shall take into
10 account the relative needs of applicants for assistance;
11 provided that funds [~~may~~] distributed to these programs shall
12 not be expended for land or facility acquisition or debt
13 amortization; and further provided that a local match of ten
14 percent shall be required from each [~~local recipient~~] eligible
15 clinical program, eligible workforce development program and
16 eligible workforce recruitment program for each request for
17 assistance."

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE PUBLIC ASSISTANCE ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO REQUIRE COVERAGE OF ARTERY CALCIFICATION SCREENING FOR EARLY DETECTION OF CARDIOVASCULAR DISEASE IN CERTAIN INDIVIDUALS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage for eligible enrollees to receive artery calcification screening.

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1 B. Coverage provided pursuant to this section
2 shall:

3 (1) be limited to the provision of an artery
4 calcification screening to an eligible enrollee once every five
5 years; and

6 (2) not be subject to a deductible.

7 C. The provisions of this section shall not apply
8 to short-term travel, accident-only or limited or specified-
9 disease policies, plans or certificates of health insurance.

10 D. As used in this section:

11 (1) "artery calcification screening" means a
12 computed tomography scan measuring coronary artery
13 calcification for atherosclerosis and abnormal artery structure
14 and function; and

15 (2) "eligible enrollee" means an enrollee:

16 (a) who is: 1) a male older than thirty
17 years of age and younger than seventy-six years of age; or 2)
18 a female older than forty years of age and younger than
19 seventy-six years of age; and

20 (b) who has a risk of developing
21 coronary heart disease based on at least one of the following:
22 hypertension, hyperlipidemia, diabetes, smoking or family
23 history of heart disease."

24 SECTION 2. A new section of the Public Assistance Act is
25 enacted to read:

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1 "[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

2 A. By January 1, 2018 and in accordance with
3 federal law, the secretary shall adopt and promulgate rules
4 that provide medicaid coverage for eligible recipients to
5 receive artery calcification screening.

6 B. Medicaid coverage provided pursuant to this
7 section shall be limited to the provision of an artery
8 calcification screening to an eligible recipient once every
9 five years.

10 C. As used in this section:

11 (1) "artery calcification screening" means a
12 computed tomography scan measuring coronary artery
13 calcification for atherosclerosis and abnormal artery structure
14 and function; and

15 (2) "eligible recipient" means a recipient:

16 (a) who is: 1) a male older than thirty
17 years of age and younger than seventy-six years of age; or 2)
18 a female older than forty years of age and younger than
19 seventy-six years of age; and

20 (b) who has a risk of developing
21 coronary heart disease based on at least one of the following:
22 hypertension, hyperlipidemia, diabetes, smoking or family
23 history of heart disease."

24 SECTION 3. A new section of Chapter 59A, Article 22 NMSA
25 1978 is enacted to read:

.204678.1

1 "[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

2 A. An individual or group health insurance policy,
3 health care plan and certificate of health insurance delivered
4 or issued for delivery in this state shall provide coverage for
5 eligible insureds to receive artery calcification screening.

6 B. Coverage provided pursuant to this section
7 shall:

8 (1) be limited to the provision of an artery
9 calcification screening to an eligible insured once every five
10 years; and

11 (2) not be subject to a deductible.

12 C. The provisions of this section do not apply to
13 short-term travel, accident-only or limited or specified-
14 disease policies, plans or certificates of health insurance.

15 D. As used in this section:

16 (1) "artery calcification screening" means a
17 computed tomography scan measuring coronary artery
18 calcification for atherosclerosis and abnormal artery structure
19 and function; and

20 (2) "eligible insured" means an insured:

21 (a) who is: 1) a male older than thirty
22 years of age and younger than seventy-six years of age; or 2)
23 a female older than forty years of age and younger than
24 seventy-six years of age; and

25 (b) who has a risk of developing

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1 coronary heart disease based on at least one of the following:
2 hypertension, hyperlipidemia, diabetes, smoking or family
3 history of heart disease."

4 SECTION 4. A new section of Chapter 59A, Article 23 NMSA
5 1978 is enacted to read:

6 "[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

7 A. A group or blanket health insurance policy,
8 health care plan or certificate of health insurance that is
9 delivered, issued for delivery or renewed in this state shall
10 provide coverage for eligible insureds to receive artery
11 calcification screening.

12 B. Coverage provided pursuant to this section
13 shall:

14 (1) be limited to the provision of an artery
15 calcification screening to an eligible insured once every five
16 years; and

17 (2) not be subject to a deductible.

18 C. The provisions of this section do not apply to
19 short-term travel, accident-only or limited or specified-
20 disease policies, plans or certificates of health insurance.

21 D. As used in this section:

22 (1) "artery calcification screening" means a
23 computed tomography scan measuring coronary artery
24 calcification for atherosclerosis and abnormal artery structure
25 and function; and

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1 (2) "eligible insured" means an insured:
2 (a) who is: 1) a male older than thirty
3 years of age and younger than seventy-six years of age; or 2)
4 a female older than forty years of age and younger than
5 seventy-six years of age; and
6 (b) who has a risk of developing
7 coronary heart disease based on at least one of the following:
8 hypertension, hyperlipidemia, diabetes, smoking or family
9 history of heart disease."

10 SECTION 5. A new section of the Health Maintenance
11 Organization Law is enacted to read:

12 "[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

13 A. An individual or group health maintenance
14 organization contract that is delivered, issued for delivery or
15 renewed in this state shall provide coverage for eligible
16 enrollees to receive artery calcification screening.

17 B. Coverage provided pursuant to this section
18 shall:

19 (1) be limited to the provision of an artery
20 calcification screening to an eligible enrollee once every five
21 years; and

22 (2) not be subject to a deductible.

23 C. The provisions of this section do not apply to
24 short-term travel, accident-only or limited or specified-
25 disease policies, plans or certificates of health insurance.

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1 D. As used in this section:

2 (1) "artery calcification screening" means a
3 computed tomography scan measuring coronary artery
4 calcification for atherosclerosis and abnormal artery structure
5 and function; and

6 (2) "eligible enrollee" means an enrollee:

7 (a) who is: 1) a male older than thirty
8 years of age and younger than seventy-six years of age; or 2)
9 a female older than forty years of age and younger than
10 seventy-six years of age; and

11 (b) who has a risk of developing
12 coronary heart disease based on at least one of the following:
13 hypertension, hyperlipidemia, diabetes, smoking or family
14 history of heart disease."

15 SECTION 6. A new section of the Nonprofit Health Care
16 Plan Law is enacted to read:

17 "[NEW MATERIAL] ARTERY CALCIFICATION SCREENING COVERAGE.--

18 A. An individual or group health care plan that is
19 delivered, issued for delivery or renewed in this state shall
20 provide coverage for eligible subscribers to receive artery
21 calcification screening.

22 B. Coverage provided pursuant to this section
23 shall:

24 (1) be limited to the provision of an artery
25 calcification screening to an eligible subscriber once every

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1 five years; and

2 (2) not be subject to a deductible.

3 C. The provisions of this section do not apply to
4 short-term travel, accident-only or limited or specified-
5 disease policies, plans or certificates of health insurance.

6 D. As used in this section:

7 (1) "artery calcification screening" means a
8 computed tomography scan measuring coronary artery
9 calcification for atherosclerosis and abnormal artery structure
10 and function; and

11 (2) "eligible subscriber" means a subscriber:

12 (a) who is: 1) a male older than thirty
13 years of age and younger than seventy-six years of age; or 2)
14 a female older than forty years of age and younger than
15 seventy-six years of age; and

16 (b) who has a risk of developing
17 coronary heart disease based on at least one of the following:
18 hypertension, hyperlipidemia, diabetes, smoking or family
19 history of heart disease."

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING SECTIONS OF THE GROUP BENEFITS ACT, CHAPTER 59A, ARTICLE 22 NMSA 1978, CHAPTER 59A, ARTICLE 23 NMSA 1978, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO BAN DISCRIMINATION AGAINST ANY HEALTH CARE PRACTITIONER WORKING WITHIN THE SCOPE OF THAT PRACTITIONER'S LICENSE OR CERTIFICATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Group Benefits Act is enacted to read:

"[NEW MATERIAL] BAN ON HEALTH CARE PRACTITIONER DISCRIMINATION.--

A. With respect to participation in a group health coverage plan, a group health plan shall not discriminate against any health care practitioner who is acting within the

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1 scope of that practitioner's license or certification.

2 B. The provisions of this section shall not be
3 construed to:

4 (1) require a group health plan to contract
5 with any health care practitioner willing to abide by the terms
6 and conditions for participation established by the group
7 health plan; or

8 (2) prevent a group health plan from
9 establishing varying reimbursement rates based on quality or
10 performance measures.

11 C. As used in this section, "health care
12 practitioner" means any individual licensed or certified to
13 provide health care in the ordinary course of business."

14 SECTION 2. A new section of Chapter 59A, Article 22 NMSA
15 1978 is enacted to read:

16 "[NEW MATERIAL] BAN ON HEALTH CARE PRACTITIONER
17 DISCRIMINATION.--

18 A. With respect to participation in health coverage
19 pursuant to an individual health insurance plan, policy or
20 certificate of insurance, an insurer shall not discriminate
21 against any health care practitioner who is acting within the
22 scope of that practitioner's license or certification.

23 B. The provisions of this section shall not be
24 construed to:

25 (1) require an insurer to contract with any

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1 health care practitioner willing to abide by the terms and
2 conditions for participation established by the insurer; or

3 (2) prevent an insurer from establishing
4 varying reimbursement rates based on quality or performance
5 measures.

6 C. As used in this section, "health care
7 practitioner" means any individual licensed or certified to
8 provide health care in the ordinary course of business."

9 SECTION 3. A new section of Chapter 59A, Article 23 NMSA
10 1978 is enacted to read:

11 "[NEW MATERIAL] BAN ON HEALTH CARE PRACTITIONER
12 DISCRIMINATION.--

13 A. With respect to participation in health coverage
14 pursuant to a group or blanket health insurance plan, policy or
15 certificate of insurance, an insurer shall not discriminate
16 against any health care practitioner who is acting within the
17 scope of that practitioner's license or certification.

18 B. The provisions of this section shall not be
19 construed to:

20 (1) require an insurer to contract with any
21 health care practitioner willing to abide by the terms and
22 conditions for participation established by the insurer; or

23 (2) prevent an insurer from establishing
24 varying reimbursement rates based on quality or performance
25 measures.

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1 C. As used in this section, "health care
2 practitioner" means any individual licensed or certified to
3 provide health care in the ordinary course of business."

4 SECTION 4. A new section of the Health Maintenance
5 Organization Law is enacted to read:

6 "[NEW MATERIAL] BAN ON HEALTH CARE PRACTITIONER
7 DISCRIMINATION.--

8 A. With respect to participation in individual or
9 group health coverage pursuant to a health maintenance
10 organization contract, a carrier shall not discriminate against
11 any health care practitioner who is acting within the scope of
12 that health care practitioner's license or certification.

13 B. The provisions of this section shall not be
14 construed to:

15 (1) require a carrier to contract with any
16 health care practitioner willing to abide by the terms and
17 conditions for participation established by the carrier; or

18 (2) prevent a carrier from establishing
19 varying reimbursement rates based on quality or performance
20 measures.

21 C. As used in this section, "health care
22 practitioner" means any individual licensed or certified to
23 provide health care in the ordinary course of business."

24 SECTION 5. A new section of the Nonprofit Health Care
25 Plan Law is enacted to read:

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1 "[NEW MATERIAL] BAN ON HEALTH CARE PRACTITIONER

2 DISCRIMINATION.--

3 A. With respect to participation in an individual
4 or group health care plan, a health care plan shall not
5 discriminate against any health care practitioner who is acting
6 within the scope of that health care practitioner's license or
7 certification.

8 B. The provisions of this section shall not be
9 construed to:

10 (1) require a health care plan to contract
11 with any health care practitioner willing to abide by the terms
12 and conditions for participation established by the health care
13 plan; or

14 (2) prevent a health care plan from
15 establishing varying reimbursement rates based on quality or
16 performance measures.

17 C. As used in this section, "health care
18 practitioner" means any individual licensed or certified to
19 provide health care in the ordinary course of business."

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; ENACTING THE INDOOR TANNING ACT; BANNING THE USE OF TANNING DEVICES BY INDIVIDUALS UNDER THE AGE OF EIGHTEEN; ESTABLISHING SAFETY MEASURES FOR INDOOR TANNING; ESTABLISHING CIVIL PENALTIES; PROVIDING FOR RULEMAKING AND TANNING FACILITY LICENSURE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Indoor Tanning Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the Indoor Tanning Act:

A. "department" means the department of environment;

B. "health care practitioner" means an individual licensed or certified to deliver health care in the ordinary

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1 course of business;

2 C. "minor" means an individual who is under
3 eighteen years of age;

4 D. "operator" means a person that owns, leases or
5 manages a tanning facility;

6 E. "phototherapy device" means equipment that emits
7 ultraviolet radiation and is used in the diagnosis or treatment
8 of disease or injury;

9 F. "tanning device" means equipment that emits
10 electromagnetic radiation having wavelengths in the air between
11 two hundred and four hundred nanometers and that is used for
12 tanning of human skin and any equipment used with that
13 equipment, including protective eyewear, timers and handrails.
14 "Tanning device" does not include a phototherapy device used,
15 or prescribed for use, by a physician; and

16 G. "tanning facility" means any premises where an
17 individual may access a tanning device, regardless of whether a
18 fee is charged for access to the premises or the tanning
19 device, including a common area of a private facility but
20 excluding the interior of a private home.

21 SECTION 3. [NEW MATERIAL] TANNING DEVICES--PROHIBITION ON
22 USE BY MINORS--SIGNAGE--WRITTEN STATEMENT.--

23 A. It is unlawful for a minor to use any tanning
24 device in a tanning facility.

25 B. An operator shall post in a conspicuous place in

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1 each tanning facility a sign that contains a notice that
2 conforms to department rules, states that the operator owns,
3 leases or operates a tanning facility and states that:

4 (1) it is unlawful for a tanning facility or
5 operator to allow an individual under the age of eighteen to
6 use any tanning device;

7 (2) a tanning facility or operator that
8 violates a provision of the Indoor Tanning Act shall be subject
9 to a civil penalty;

10 (3) an individual may report a violation of
11 one or more provisions of the Indoor Tanning Act to the
12 department; and

13 (4) the health risks associated with tanning
14 include skin cancer, premature aging of skin, burns to the skin
15 and adverse reactions to certain medications, foods and
16 cosmetics.

17 C. An operator shall give to each individual that
18 uses a tanning device at a tanning facility under the
19 operator's control a written statement that shall be signed by
20 the user before the user's initial use of the tanning device
21 and each year thereafter that the user uses the tanning device.
22 The written statement shall conform to department rules and
23 contain the following:

24 (1) the notices and warnings set forth in
25 Paragraphs (1) through (4) of Subsection B of this section;

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1 (2) language in which the user acknowledges
2 that the user understands the notices and warnings set forth in
3 Subsection B of this section; and

4 (3) language in which the user agrees that the
5 user will use protective eyewear.

6 SECTION 4. [NEW MATERIAL] TANNING FACILITIES--OPERATING
7 REQUIREMENTS.--The operator of a tanning facility shall ensure
8 that:

9 A. a minor does not use a tanning device in the
10 operator's tanning facility;

11 B. during operating hours, an individual is present
12 at the tanning facility who has been trained in minimizing the
13 risks associated with the use of tanning devices and who is
14 able to inform users about, and assist users in, minimizing the
15 risks associated with using a tanning device;

16 C. each tanning device is properly sanitized after
17 each use;

18 D. before each user begins to use a tanning device,
19 the user is provided, at no cost to the user, with properly
20 sanitized and securely fitting protective eyewear that protects
21 the wearer's eyes from ultraviolet radiation and allows enough
22 vision to maintain balance;

23 E. a user does not use a tanning device unless the
24 user wears protective eyewear;

25 F. each user is shown how to use such physical aids

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1 as handrails and markings on the floor to maintain a proper
2 exposure distance from the tanning device in accordance with
3 manufacturer recommendations;

4 G. a timing device that is accurate within ten
5 percent of any selected timer interval is used and is remotely
6 located so users cannot set their own exposure time in the
7 tanning devices they use;

8 H. each tanning device is equipped with a mechanism
9 that allows the user to turn the tanning device off;

10 I. each user's exposure time is limited to the
11 amount of time recommended by the manufacturer for the user's
12 skin type;

13 J. users are not allowed to use a tanning device
14 more than once in any twenty-four-hour period;

15 K. the interior temperature of the tanning facility
16 does not exceed one hundred degrees Fahrenheit; and

17 L. the following records are maintained:

18 (1) copies of all consent forms signed by
19 users at that tanning facility;

20 (2) a record of each user's total number of
21 tanning visits to the tanning facility;

22 (3) the dates and durations of each user's
23 tanning exposures; and

24 (4) for each user, any injury report made for
25 a period of three years after the injury report is made.

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1 SECTION 5. [NEW MATERIAL] TANNING FACILITIES--USER

2 DUTIES.--An individual shall not use a tanning device at a
3 tanning facility unless the individual complies with all of the
4 following:

5 A. immediately before the user's first use of a
6 tanning facility and every year thereafter, signs a statement
7 acknowledging that the user has read and understands the
8 written statement and the warning sign required pursuant to
9 Section 3 of the Indoor Tanning Act; and

10 B. uses protective eyewear at all times while using
11 a tanning device.

12 SECTION 6. [NEW MATERIAL] EXCLUSION.--The provisions of
13 the Indoor Tanning Act do not apply to the use of a
14 phototherapy device:

15 A. by a health care practitioner;

16 B. by a patient of any age pursuant to a valid
17 prescription of a health care practitioner;

18 C. in the office or treatment room of a health care
19 practitioner; or

20 D. in a health facility that the department of
21 health licenses.

22 SECTION 7. [NEW MATERIAL] PENALTIES.--

23 A. The department shall impose on an operator that
24 violates a provision of the Indoor Tanning Act or any rule
25 promulgated pursuant to that act a civil penalty of not more

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1 than two hundred fifty dollars (\$250) for the first violation
2 and not more than five hundred dollars (\$500) for any
3 subsequent violation.

4 B. In addition to the penalty described in
5 Subsection A of this section, the department may suspend or
6 revoke the license issued to the tanning facility at which the
7 violation occurred.

8 SECTION 8. [NEW MATERIAL] RULEMAKING--TANNING FACILITY
9 LICENSE.--

10 A. The department is authorized to make inspections
11 and investigations and to adopt rules to carry out the
12 provisions of the Indoor Tanning Act. At a minimum, these
13 rules shall establish fees and procedures for an annual
14 application for tanning facility licensure.

15 B. On an annual basis and in accordance with
16 department rules, an operator shall obtain a tanning facility
17 license from the department for each tanning facility that the
18 operator owns or operates. An operator shall not operate a
19 tanning facility without a tanning facility license issued by
20 the department. The operator shall display each tanning
21 facility's license in a conspicuous place at the tanning
22 facility.

23 SECTION 9. [NEW MATERIAL] PREEMPTION.--The provisions of
24 the Indoor Tanning Act shall not preempt any local ordinance
25 that provides for more restrictive regulation of tanning

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1 facilities than the Indoor Tanning Act establishes.

2 SECTION 10. [NEW MATERIAL] SEVERABILITY.--If any part or
3 application of the Indoor Tanning Act is held invalid, the
4 remainder or its application to other situations or persons
5 shall not be affected.

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

DISCUSSION DRAFT

AN ACT

RELATING TO EMPLOYMENT; ENACTING THE CAREGIVER LEAVE ACT TO PROVIDE EMPLOYEES OF PRIVATE ENTITIES WHO HAVE ACCRUED PAID SICK LEAVE WITH THE OPPORTUNITY TO USE SICK LEAVE FOR FAMILY CAREGIVING; ENACTING THE PUBLIC EMPLOYEE CAREGIVER LEAVE ACT TO PROVIDE PUBLIC EMPLOYEES THE RIGHT TO USE ACCRUED SICK LEAVE FOR FAMILY CAREGIVING.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 3 of this act may be cited as the "Caregiver Leave Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the Caregiver Leave Act:

A. "eligible employee" means an individual who is in the employ of an employer and who, in accordance with the

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1 employer's policies, is eligible to accrue sick leave;

2 B. "employer" means a person that employs one or
3 more employees and that offers eligible employees sick leave;

4 C. "family member" means an individual who is
5 related within a third degree of consanguinity or affinity to an
6 eligible employee; and

7 D. "sick leave" means a leave of absence from
8 employment for which an employer pays an eligible employee due
9 to illness or injury or to receive care from a licensed or
10 certified health professional. "Sick leave" does not include
11 leave to which an employee is entitled under the federal Family
12 and Medical Leave Act of 1993, regardless of whether the
13 employee uses sick leave during that leave.

14 SECTION 3. [NEW MATERIAL] ACCUMULATED SICK LEAVE--
15 APPLICATION TO FAMILY CAREGIVING.--

16 A. An employer that provides eligible employees
17 with sick leave for an eligible employee's own illness or
18 injury or to receive health care shall permit its eligible
19 employees to use accrued sick leave to care for their family
20 members in accordance with the same terms and procedures that
21 the employer imposes for any other use of sick leave by
22 eligible employees.

23 B. If an eligible employee requests or uses
24 caregiver leave in accordance with the employer's general sick
25 leave policy, files a complaint with the workforce solutions

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1 department for violation of the Caregiver Leave Act, cooperates
2 in an investigation or prosecution of an alleged violation of
3 the Caregiver Leave Act or opposes any policy, practice or act
4 that is prohibited by the Caregiver Leave Act, the eligible
5 employee's employer shall not:

6 (1) discharge or threaten to discharge the
7 eligible employee;

8 (2) demote the eligible employee;

9 (3) suspend the eligible employee; or

10 (4) retaliate or discriminate in any manner
11 against the eligible employee.

12 C. Nothing in this section shall require an
13 employer to provide sick leave to its employees.

14 D. The provisions of the Caregiver Leave Act are
15 nonexclusive and cumulative and are in addition to any other
16 rights or remedies afforded by contract or under other
17 provision of law. The Caregiver Leave Act does not prohibit an
18 employer from providing greater sick leave benefits than are
19 provided pursuant to that act.

20 E. The secretary of workforce solutions shall adopt
21 and promulgate rules to implement the provisions of the
22 Caregiver Leave Act. These rules shall include, at a minimum,
23 grievance procedures for according eligible employees recourse
24 for violations of the Caregiver Leave Act.

25 SECTION 4. A new section of Chapter 10 NMSA 1978 is

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1 enacted to read:

2 "[NEW MATERIAL] SHORT TITLE.--Sections 4 through 6 of this
3 act may be cited as the "Public Employee Caregiver Leave Act"."

4 SECTION 5. A new section of Chapter 10 NMSA 1978 is
5 enacted to read:

6 "[NEW MATERIAL] DEFINITIONS.--As used in the Public
7 Employee Caregiver Leave Act:

8 A. "eligible employee" means a salaried officer or
9 employee or legislator of the state who, in accordance with the
10 policies of the state agency employing the officer or employee,
11 is eligible to accrue sick leave;

12 B. "family member" means an individual who is
13 related within a third degree of consanguinity or affinity to an
14 eligible employee;

15 C. "sick leave" means a leave of absence from
16 employment for which a state agency pays an eligible employee
17 due to illness or injury or to receive care from a licensed or
18 certified health professional. "Sick leave" does not include
19 leave to which an employee is entitled under the federal Family
20 and Medical Leave Act of 1993, regardless of whether the
21 employee uses sick leave during that leave; and

22 D. "state" or "state agency" means the state of New
23 Mexico or any of its branches, agencies, departments, boards,
24 instrumentalities or institutions."

25 SECTION 6. A new section of Chapter 10 NMSA 1978 is

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1 enacted to read:

2 "[NEW MATERIAL] ACCUMULATED SICK LEAVE--APPLICATION TO
3 FAMILY CAREGIVING.--

4 A. A state agency that provides eligible employees
5 with sick leave for an eligible employee's own illness or
6 injury or to receive health care shall permit its eligible
7 employees to use accrued sick leave to care for their family
8 members in accordance with the same terms and procedures that
9 the state agency imposes for any other use of sick leave by
10 eligible employees.

11 B. If an eligible employee requests or uses
12 caregiver leave in accordance with the state agency's general
13 sick leave policy, files a grievance for violation of this
14 section, cooperates in an investigation or prosecution of an
15 alleged violation of this section or opposes any policy,
16 practice or act that is prohibited by the Public Employee
17 Caregiver Leave Act, the state agency employing the eligible
18 employee shall not:

19 (1) discharge or threaten to discharge the
20 eligible employee;
21 (2) demote the eligible employee;
22 (3) suspend the eligible employee; or
23 (4) retaliate or discriminate in any manner
24 against the eligible employee.

25 C. Nothing in this section shall require a state

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1 agency to provide sick leave to its employees.

2 D. The provisions of the Public Employee Caregiver
3 Leave Act are nonexclusive and cumulative and are in addition
4 to any other rights or remedies afforded by contract or under
5 other provision of law. The Public Employee Caregiver Leave
6 Act does not prohibit a state agency from providing greater
7 sick leave benefits than are provided pursuant to that act.

8 E. Each state agency director shall adopt and
9 promulgate policies to implement the provisions of the Public
10 Employee Caregiver Leave Act. These policies shall include, at
11 a minimum, grievance procedures for according eligible
12 employees recourse for violations of the Public Employee
13 Caregiver Leave Act. As used in this section, "state agency
14 director" means:

15 (1) the director of the state personnel office
16 for those state agencies to which the provisions of the
17 Personnel Act apply; and

18 (2) the director of a state agency to which
19 the provisions of the Personnel Act do not apply."

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SENATE MEMORIAL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A MEMORIAL

RECOGNIZING THE ECONOMIC CONTRIBUTION OF INFORMAL OR FAMILY
CAREGIVERS AND SUPPORTING MEASURES TO PROVIDE THEM WITH
MEANINGFUL FINANCIAL RELIEF.

WHEREAS, as of 2015, approximately twelve percent of New
Mexico's population under the age of sixty-five and more than
forty percent of its population aged sixty-five or older are
persons with a disability; and

WHEREAS, according to the United States census bureau, New
Mexico's population of persons over seventy-nine years old will
increase more than eighty percent in the next fifteen years;
and

WHEREAS, an "informal or family caregiver" is "an unpaid
family member, friend or neighbor who provides care to a person
with an acute or chronic condition and who needs assistance to

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1 manage a variety of tasks", from bathing and dressing "to tube
2 feeding and ventilator care"; and

3 WHEREAS, informal or family caregivers "remain the
4 backbone of our nation's long-term care system"; and

5 WHEREAS, informal or family caregivers take on many roles
6 in addition to caring for the basic emotional and physical
7 needs of a loved one, including medication management,
8 providing transportation to medical appointments, providing
9 care following discharge from a hospital or rehabilitation
10 facility and serving as overall health care coordinators; and

11 WHEREAS, according to the Pew research center, in 2015,
12 there were forty million four hundred thousand unpaid informal
13 or family caregivers for persons over the age of sixty-five in
14 the nation, with nine out of ten caring for an aging relative
15 who is in most cases a parent; and

16 WHEREAS, most informal or family caregivers are between
17 forty-five and sixty-four years old; and

18 WHEREAS, twenty-seven percent of these caregivers provide
19 help to two or more adults over the age of sixty-five, with one
20 in five providing care on a daily basis; and

21 WHEREAS, six in ten informal or family caregivers are
22 employed, with one-half working full time; and

23 WHEREAS, when a family caregiver over the age of fifty is
24 forced to leave the workforce to care for a parent, "the
25 economic toll is stunning", with the caregiver losing on

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1 average over three hundred thousand dollars (\$300,000) in wages
2 and social security and pension benefits over a lifetime; and

3 WHEREAS, the financial toll on a woman who assumes the
4 role of caretaker in midlife exceeds on average three hundred
5 twenty-five thousand dollars (\$325,000) and may "substantially
6 increase" her risk of "living in poverty and receiving public
7 assistance" when she herself is aged; and

8 WHEREAS, New Mexico informal or family caregivers
9 participating in a 2015 AARP survey expressed frustration that,
10 while they earn too much to qualify for medicaid benefits, they
11 did not earn enough to support the needs of their loved ones;
12 and

13 WHEREAS, sixty percent of those surveyed reported having
14 used their own funds to provide care, with thirty-four percent
15 reporting that they were financially strained due to their
16 caregiving responsibilities; and

17 WHEREAS, nationwide, out-of-pocket costs for caregivers of
18 persons over fifty years old averaged five thousand five
19 hundred thirty-one dollars (\$5,531) in 2007; and

20 WHEREAS, according to the New Mexico state plan for family
21 caregivers, each year, four hundred nineteen thousand informal
22 or family caregivers in New Mexico provide two hundred seventy-
23 four million hours of unpaid services, with one out of five
24 Hispanics serving as a family caregiver and ninety percent of
25 long-term care in Indian country provided by family members;

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1 and

2 WHEREAS, seventy-one percent of New Mexico family
3 caregivers report being responsible for medical or nursing
4 tasks, and seventy-four percent report being responsible for
5 medication management; and

6 WHEREAS, the New Mexico state plan for family caregivers
7 estimates the total economic value of care provided by informal
8 or family caregivers in New Mexico at three billion one hundred
9 million dollars (\$3,100,000,000) annually; and

10 WHEREAS, the economic value of this care does not take
11 into account cost savings attributable to informal or family
12 caregiving: over two thousand dollars (\$2,000) per day for
13 hospital inpatient care in New Mexico; two hundred fourteen
14 dollars (\$214) per day for nursing home care in New Mexico; and
15 three thousand three hundred thirty-three dollars (\$3,333) per
16 month for assisted living in New Mexico; and

17 WHEREAS, as of 2015, the average cost for home health care
18 in New Mexico was twenty-one dollars (\$21.00) per hour, and the
19 median hourly wage of a home health aide or personal care
20 attendant was less than ten dollars (\$10.00) per hour;

21 NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE
22 OF NEW MEXICO that, as recommended by the AARP public policy
23 institute, meaningful financial assistance for informal and
24 family caregivers through state or federal tax credits or other
25 mechanisms be provided to ease the financial costs of

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1 caregiving and improve their financial security; and

2 BE IT FURTHER RESOLVED that, as recommended by the AARP
3 public policy institute, reforms such as social security
4 caregiver credits for time spent out of the workforce for
5 family caregiving be enacted; and

6 BE IT FURTHER RESOLVED that, as recommended by the AARP
7 public policy institute, the state seek to expand publicly
8 funded home- and community-based services programs that allow
9 payment to informal or family caregivers of consumers in its
10 renewal of the state's medicaid waiver; and

11 BE IT FURTHER RESOLVED that the human services department
12 be requested to require in its contracts with medicaid managed
13 care organizations that informal or family caregivers be
14 reimbursed for care coordination activities; and

15 BE IT FURTHER RESOLVED that copies of this memorial be
16 transmitted to each member of New Mexico's congressional
17 delegation; each member of the New Mexico legislature; the
18 tribal leadership of every Indian nation, tribe and pueblo
19 located wholly or in part in New Mexico; the secretary of
20 health; the secretary of human services; the secretary of aging
21 and long-term services; and every member and participant of the
22 New Mexico family caregiver task force convened by the aging
23 and long-term services department in 2014 pursuant to House
24 Joint Memorial 4.

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING SECTIONS OF THE GROUP BENEFITS ACT, THE PUBLIC ASSISTANCE ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO ESTABLISH REIMBURSEMENT PARITY BETWEEN PHARMACISTS AND CERTAIN OTHER LICENSED HEALTH PROFESSIONALS FOR THE SAME PHARMACEUTICAL CLINICAL SERVICES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Group Benefits Act is enacted to read:

"[NEW MATERIAL] PHARMACIST SERVICES--REIMBURSEMENT PARITY.--A group health plan shall not discriminate with respect to reimbursement under the group health plan against any pharmacist who is acting within the scope of that pharmacist's license. The group health plan shall reimburse

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1 any pharmacist who provides a service at the same rate that the
2 group health plan reimburses, for the same service under that
3 group health plan, any physician or physician assistant
4 licensed pursuant to the Medical Practice Act or the
5 Osteopathic Medicine Act or any advanced practice certified
6 nurse practitioner licensed pursuant to the Nursing Practice
7 Act."

8 SECTION 2. A new section of the Public Assistance Act is
9 enacted to read:

10 "[NEW MATERIAL] PHARMACIST SERVICES--REIMBURSEMENT
11 PARITY.--The department shall ensure that any medical
12 assistance program or contractor providing services to the
13 medical assistance program does not discriminate with respect
14 to reimbursement under the medical assistance program against
15 any pharmacist who is acting within the scope of that
16 pharmacist's license. The medical assistance program or its
17 contractor shall reimburse any pharmacist who provides a
18 service at the same rate that the medical assistance program
19 reimburses, for the same service under that program, any
20 physician or physician assistant licensed pursuant to the
21 Medical Practice Act or the Osteopathic Medicine Act or any
22 advanced practice certified nurse practitioner licensed
23 pursuant to the Nursing Practice Act."

24 SECTION 3. A new section of Chapter 59A, Article 22 NMSA
25 1978 is enacted to read:

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1 "[NEW MATERIAL] PHARMACIST SERVICES--REIMBURSEMENT
2 PARITY.--An insurer shall not discriminate with respect to
3 reimbursement pursuant to an individual health insurance
4 policy, health care plan or certificate of health insurance
5 that is delivered, issued for delivery or renewed in this state
6 against any pharmacist who is acting within the scope of that
7 pharmacist's license. The insurer shall reimburse any
8 pharmacist who provides a service pursuant to a health
9 insurance plan, policy or certificate of health insurance at
10 the same rate that the health insurance policy, health care
11 plan or certificate of health insurance reimburses, for the
12 same service pursuant to that policy, plan or certificate, any
13 physician or physician assistant licensed pursuant to the
14 Medical Practice Act or the Osteopathic Medicine Act or any
15 advanced practice certified nurse practitioner licensed
16 pursuant to the Nursing Practice Act."

17 SECTION 4. A new section of Chapter 59A, Article 23 NMSA
18 1978 is enacted to read:

19 "[NEW MATERIAL] PHARMACIST SERVICES--REIMBURSEMENT
20 PARITY.--An insurer shall not discriminate with respect to
21 reimbursement pursuant to a group or blanket health insurance
22 policy, health care plan or certificate of health insurance
23 that is delivered, issued for delivery or renewed in this state
24 against any pharmacist who is acting within the scope of that
25 pharmacist's license. The insurer shall reimburse any

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1 pharmacist who provides a service pursuant to a health
2 insurance plan, policy or certificate of health insurance at
3 the same rate that the health insurance policy, health care
4 plan or certificate of health insurance reimburses, for the
5 same service pursuant to that policy, plan or certificate, any
6 physician or physician assistant licensed pursuant to the
7 Medical Practice Act or the Osteopathic Medicine Act or any
8 advanced practice certified nurse practitioner licensed
9 pursuant to the Nursing Practice Act."

10 SECTION 5. A new section of the Health Maintenance
11 Organization Law is enacted to read:

12 "[NEW MATERIAL] PHARMACIST SERVICES--REIMBURSEMENT
13 PARITY.--A carrier shall not discriminate with respect to
14 reimbursement pursuant to an individual or group health
15 maintenance organization contract that is delivered, issued for
16 delivery or renewed in this state against any pharmacist who is
17 acting within the scope of that pharmacist's license. The
18 carrier shall reimburse any pharmacist who provides a service
19 pursuant to an individual or group contract at the same rate
20 that the carrier reimburses, for the same service under that
21 individual or group contract, any physician or physician
22 assistant licensed pursuant to the Medical Practice Act or the
23 Osteopathic Medicine Act or any advanced practice certified
24 nurse practitioner licensed pursuant to the Nursing Practice
25 Act."

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HUMAN SERVICES; ENACTING A NEW SECTION OF THE
PUBLIC ASSISTANCE ACT TO DIRECT THE HUMAN SERVICES DEPARTMENT
TO CHANGE THE BASIS FOR REIMBURSEMENT OF PREVENTIVE AND EARLY
INTERVENTION SERVICES FOR CHILDREN.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Assistance Act is
enacted to read:

"[NEW MATERIAL] MEDICAL ASSISTANCE--PREVENTIVE AND EARLY
INTERVENTION SERVICES--BASIS FOR REIMBURSEMENT.--The secretary
shall seek any necessary authority under federal law to adopt
and promulgate rules under the state medical assistance program
to provide for the reimbursement of preventive and early
intervention services delivered to children on the basis of
need without specifying as a condition of reimbursement that a

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1 child be identified as a child with a mental health diagnosis
2 or be diagnosed as having a serious emotional disturbance."

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

DISCUSSION DRAFT

AN ACT

RELATING TO HEALTH; ESTABLISHING THE DIABETES COMMITTEE TO IDENTIFY GOALS AND BENCHMARKS FOR STATE ENTITIES TO REDUCE THE INCIDENCE OF DIABETES AND COSTS AND COMPLICATIONS RELATING TO DIABETES STATEWIDE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] DIABETES COMMITTEE--CREATION-- DUTIES--DIABETES PLAN.--

A. The secretary of health shall convene a "diabetes committee" that shall consist of representatives from:

- (1) the department of health;
- (2) the corrections department;
- (3) the human services department;
- (4) the interagency benefits advisory

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1 committee;

2 (5) the university of New Mexico health
3 sciences center; and

4 (6) a telehealth program operated by a
5 university in New Mexico with a medical school, pursuant to
6 which a multidisciplinary team provides training, advice and
7 support to assist primary care health care providers in
8 delivering best-practice health care for underserved
9 populations with complex health problems, including diabetes.

10 B. The diabetes committee shall meet at the call of
11 the secretary of health and collaborate to identify goals and
12 benchmarks while developing individual constituent entity
13 programs to reduce the incidence of diabetes in the state,
14 improve diabetes care statewide and control complications
15 associated with diabetes.

16 C. The diabetes committee shall collect data from
17 existing sources under the constituent entities' control and
18 identify:

19 (1) the incidence of diabetes statewide and
20 the incidence among constituent entities' covered populations
21 individually;

22 (2) the geographic distribution of diabetes
23 cases statewide;

24 (3) the demographic categories in which to
25 divide diabetes-related data, including, at a minimum, age,

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1 gender, race and ethnicity;

2 (4) complications associated with diabetes;

3 and

4 (5) any other data that will assist the
5 diabetes committee in devising a statewide plan to execute its
6 duties pursuant to this section.

7 D. The diabetes committee shall submit a report in
8 writing, and, upon legislative request, in person, to the
9 legislative health and human services committee and the
10 legislative finance committee by December 1, 2018, and on
11 December 1 every two years thereafter. The report shall
12 include an analysis of the data collected pursuant to
13 Subsection C of this section. The report shall include a
14 description of the following:

15 (1) the financial impact of diabetes statewide
16 for each constituent entity and for each covered population;

17 (2) the health impact for individuals
18 statewide and for each covered population;

19 (3) the diabetes prevention and control
20 programs that the constituent entities are currently
21 implementing, including each program's:

22 (a) purpose;

23 (b) target population;

24 (c) funding source; and

25 (d) opportunities for improving diabetes

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1 care;

2 (4) the level of coordination among the
3 constituent entities in implementing their respective diabetes
4 prevention and control programs; and

5 (5) a statewide diabetes control and
6 prevention plan for the subsequent two-year reporting period,
7 including:

8 (a) any recommendations for legislation
9 or rulemaking to address diabetes statewide;

10 (b) the plan's expected outcomes;

11 (c) benchmarks controlling and
12 preventing diabetes statewide; and

13 (d) a detailed budget blueprint that
14 identifies the costs and resources required to implement the
15 plan, including a proposed legislative budget for implementing
16 the plan.

17 E. The diabetes committee shall exclusively analyze
18 data from the sources and programs in effect as of the
19 effective date of this act; provided that a constituent entity
20 may use otherwise unobligated funding to expand its review of
21 diabetes-related data and programs and share its findings with
22 the diabetes committee.

23 F. As used in this section:

24 (1) "constituent entity" means the corrections
25 department, the department of health, the human services

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1 department, the interagency benefits advisory committee, the
2 university of New Mexico health sciences center or the
3 telehealth program described in Paragraph (6) of Subsection A
4 of this section;

5 (2) "covered population" means the population
6 that each constituent entity of the diabetes committee serves
7 and the family members of individuals in that covered
8 population;

9 (3) "diabetes" means type one or type two
10 diabetes mellitus; complications related to diabetes mellitus;
11 or pre-diabetes;

12 (4) "interagency benefits advisory committee"
13 means the group of state agencies that consolidates health care
14 purchasing pursuant to the Health Care Purchasing Act,
15 including the:

16 (a) risk management division and the
17 group benefits committee of the general services department;

18 (b) retiree health care authority;

19 (c) public school insurance authority;

20 and

21 (d) publicly funded health care program
22 of any public school district with a student enrollment in
23 excess of sixty thousand students; and

24 (5) "telehealth" means the use of electronic
25 information, imaging and communication technologies, including

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1 interactive audio, video and data communications as well as
2 store-and-forward technologies, to provide and support health
3 care delivery, diagnosis, consultation, treatment, transfer of
4 medical data and education.

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HOUSE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO EMPLOYMENT; ENACTING THE PREGNANT WORKER
ACCOMMODATION ACT; PROHIBITING DISCRIMINATION IN EMPLOYMENT ON
THE BASIS OF PREGNANCY OR CHILDBIRTH OR A RELATED CONDITION;
REQUIRING THAT EMPLOYERS MAKE REASONABLE ACCOMMODATION OF AN
EMPLOYEE'S OR JOB APPLICANT'S PREGNANCY OR CHILDBIRTH OR A
RELATED CONDITION; PROHIBITING RETALIATION FOR AN EMPLOYEE'S OR
JOB APPLICANT'S ASSERTION OF A CLAIM PURSUANT TO THE PREGNANT
WORKER ACCOMMODATION ACT; PROVIDING FOR GRIEVANCE PROCEDURES
AND PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of Chapter 28 NMSA 1978 is
enacted to read:

"[NEW MATERIAL] SHORT TITLE.--This act may be cited as the
"Pregnant Worker Accommodation Act"."

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1 SECTION 2. A new section of Chapter 28 NMSA 1978 is
2 enacted to read:

3 "[NEW MATERIAL] DEFINITIONS.--As used in the Pregnant
4 Worker Accommodation Act:

5 A. "employer" means a person or entity, including a
6 partnership, association, corporation, business trust,
7 unassociated group or agency employing four or more employees,
8 or a person or entity acting on behalf of or as an agent of an
9 employer;

10 B. "reasonable accommodation" means a modification
11 or adaptation of the work environment, work rules or job
12 responsibilities for as long as necessary to enable an employee
13 with limitations due to pregnancy or childbirth or a related
14 condition to perform the job that does not impose an undue
15 hardship on the employee's employer; and

16 C. "undue hardship" means an employment
17 accommodation requiring significant difficulty or expense when
18 considered in light of the following factors:

- 19 (1) the nature and cost of the accommodation;
20 (2) the financial resources of the employer
21 involved in the provision of the reasonable accommodation;
22 (3) the number of persons the employer
23 employs;
24 (4) the effect of the accommodation on
25 expenses and resources;

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1 (5) the impact of the accommodation otherwise
2 upon the employer's business;

3 (6) the overall financial resources of the
4 employer;

5 (7) the overall size of the business of an
6 employer with respect to the number, type and location of its
7 facilities;

8 (8) the type of operation of the employer,
9 including the composition, structure and functions of the
10 workforce of the employer; and

11 (9) the geographic separateness or
12 administrative or fiscal relationship to the employer of the
13 employer's facilities."

14 SECTION 3. A new section of Chapter 28 NMSA 1978 is
15 enacted to read:

16 "[NEW MATERIAL] EMPLOYMENT DISCRIMINATION--PROHIBITION.--

17 A. It is an unlawful discriminatory practice for an
18 employer to:

19 (1) refuse a request for reasonable
20 accommodation or fail to make reasonable accommodation for an
21 employee or job applicant with a known limitation arising out
22 of pregnancy or childbirth or a related condition, unless the
23 employer demonstrates that the accommodation constitutes an
24 undue hardship;

25 (2) refuse to hire, discharge, refuse to

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1 promote, demote or discriminate in matters of compensation or
2 leave or terms, conditions or privileges of employment against
3 any person otherwise qualified for employment on the basis of
4 that person's pregnancy or childbirth or a related condition,
5 including failing to treat an employee or job applicant
6 affected by pregnancy or childbirth or a related condition in
7 the same manner as other persons similar in ability to work for
8 all employment-related purposes, including receipt of benefits
9 under fringe benefit programs, unless based on a bona fide
10 occupational qualification;

11 (3) print or circulate or cause to be printed
12 or circulated any statement, advertisement or publication; use
13 any form of application for employment; or make any inquiry
14 regarding prospective employment that expresses, directly or
15 indirectly, any limitation, specification or discrimination as
16 to pregnancy or childbirth or a related condition, unless based
17 on a bona fide occupational qualification; and

18 (4) require an employee to take paid or unpaid
19 leave if another reasonable accommodation can be provided to
20 the known limitations related to the employee's pregnancy or
21 childbirth or related condition.

22 B. It is an unlawful discriminatory practice for an
23 employer to refuse to list, properly classify for employment or
24 refer a person for employment in a known available job for
25 which the person is otherwise qualified on the basis of the

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1 person's pregnancy or childbirth or related condition, unless
2 the employer's action is based on a bona fide occupational
3 qualification.

4 C. It is an unlawful discriminatory practice for an
5 employer's agent to comply with a request from an employer for
6 referral of applicants for employment if the request indicates,
7 directly or indirectly, that the employer discriminates in
8 employment on the basis of pregnancy or childbirth or a related
9 condition, unless that discrimination is based on a bona fide
10 occupational qualification.

11 D. An employer may require a medical certification
12 concerning the employee's need for reasonable accommodation to
13 the same extent a certification is required for other temporary
14 disabilities."

15 SECTION 4. A new section of Chapter 28 NMSA 1978 is
16 enacted to read:

17 "[NEW MATERIAL] PREGNANCY ACCOMMODATION NOTICE.--

18 A. An employer shall provide written notice of an
19 employee's rights pursuant to the Pregnant Worker Accommodation
20 Act to be free from discrimination related to pregnancy or
21 childbirth or a related condition, including the right to
22 reasonable accommodation for conditions related to pregnancy or
23 childbirth or a related condition, to:

- 24 (1) job applicants;
25 (2) new employees at the commencement of

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1 employment;

2 (3) existing employees within one hundred
3 twenty days after the effective date of the Pregnant Worker
4 Accommodation Act; and

5 (4) within ten days of an employee giving an
6 employer notice of pregnancy or childbirth or a related
7 condition.

8 B. The notice provided pursuant to this section
9 shall also be conspicuously posted at an employer's place of
10 business in an area accessible to employees."

11 SECTION 5. A new section of Chapter 28 NMSA 1978 is
12 enacted to read:

13 "[NEW MATERIAL] RETALIATION PROHIBITED.--It is a violation
14 of the Pregnant Worker Accommodation Act for an employer or any
15 other person to discharge, demote, deny promotion to or in any
16 other way discriminate against an employee in the terms or
17 conditions of employment in retaliation for the person
18 asserting a claim or right pursuant to the Pregnant Worker
19 Accommodation Act, for assisting another person to assert a
20 claim or right pursuant to the Pregnant Worker Accommodation
21 Act or for informing another person about employment rights or
22 other rights provided by law."

23 SECTION 6. A new section of Chapter 28 NMSA 1978 is
24 enacted to read:

25 "[NEW MATERIAL] GRIEVANCE PROCEDURE.--

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1 A. A person claiming to be aggrieved by an unlawful
2 discriminatory practice in violation of the Pregnant Worker
3 Accommodation Act may seek relief under the Human Rights Act
4 pursuant to the process set out in Sections 28-1-10 through
5 28-1-13 NMSA 1978.

6 B. In addition to any judgment awarded to the
7 plaintiff of actual damages and reasonable attorney fees, a
8 court may order:

9 (1) in its discretion, treble damages;

10 (2) appropriate injunctive relief, including
11 requiring an employer to post in the place of business a notice
12 describing violations by the employer, as determined by the
13 court or a copy of a cease and desist order applicable to the
14 employer;

15 (3) appropriate equitable relief, including
16 employment reinstatement or promotion; and

17 (4) in its discretion, punitive damages to an
18 employee or job applicant."

19 SECTION 7. A new section of Chapter 28 NMSA 1978 is
20 enacted to read:

21 "[NEW MATERIAL] HUMAN RIGHTS ACT--APPLICABILITY.--Nothing
22 in the Pregnant Worker Accommodation Act shall be construed to
23 invalidate or limit the remedies, rights and procedures of the
24 Human Rights Act or a union-negotiated agreement or an
25 employee-negotiated agreement, or the law of any jurisdiction

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1 that provides greater or equal protection for workers affected
2 by pregnancy or childbirth or a related condition. A person
3 shall not construe the Pregnant Worker Accommodation Act to
4 create a negative inference as to the applicability of the
5 Human Rights Act to discrimination based on pregnancy or
6 childbirth or a related condition."

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PAROLE; REQUIRING THE DIRECTOR OF THE ADULT PROBATION AND PAROLE DIVISION OF THE CORRECTIONS DEPARTMENT TO IDENTIFY AND AUTHORIZE THE RELEASE OF ELIGIBLE INMATES ON MEDICAL OR GERIATRIC PAROLE; REQUIRING RULEMAKING; REQUIRING REPORTING; REPEALING SECTION 31-21-25.1 NMSA 1978 (BEING LAWS 1994, CHAPTER 21, SECTION 3).

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 31-21-5 NMSA 1978 (being Laws 1978, Chapter 41, Section 1, as amended) is amended to read:

"31-21-5. DEFINITIONS.--As used in the Probation and Parole Act:

A. "probation" means the procedure under which an adult defendant, found guilty of a crime upon verdict or plea, is released by the court without imprisonment under a suspended

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1 or deferred sentence and subject to conditions;

2 B. "parole" means the release to the community of
3 an inmate of an institution by decision of the board or by
4 operation of law, subject to conditions imposed by the board
5 and to its supervision;

6 C. "institution" means the state penitentiary and
7 any other similar state institution hereinafter created;

8 D. "board" means the parole board;

9 E. "director" means the director of the field
10 services division of the corrections department or any employee
11 designated by him; ~~and~~

12 F. "adult" means any person convicted of a crime by
13 a district court;

14 G. "geriatric inmate" means a male or female
15 offender who:

16 (1) is under sentence to or confined in a
17 prison or other correctional institution under the control of
18 the corrections department;

19 (2) is sixty-five years of age or older;

20 (3) suffers from a chronic infirmity, illness
21 or disease related to aging; and

22 (4) does not constitute a danger to the
23 offender's own self or to society;

24 H. "permanently incapacitated inmate" means a male
25 or female offender who:

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1 (1) is under sentence to or confined in a
2 prison or other correctional institution under the control of
3 the corrections department;

4 (2) by reason of an existing medical
5 condition, is permanently and irreversibly physically
6 incapacitated; and

7 (3) does not constitute a danger to the
8 offender's own self or to society; and

9 I. "terminally ill inmate" means a male or female
10 offender who:

11 (1) is under sentence or confined in a prison
12 or other correctional institution under the control of the
13 corrections department;

14 (2) has an incurable condition caused by
15 illness or disease that would, within reasonable medical
16 judgment, produce death within six months; and

17 (3) does not constitute a danger to the
18 offender's own self or to society."

19 SECTION 2. Section 31-21-17.1 NMSA 1978 (being Laws 1994,
20 Chapter 21, Section 2) is amended to read:

21 "31-21-17.1. ~~[ADMINISTRATION BY]~~ MEDICAL OR GERIATRIC
22 PAROLE--PROCEDURES--DUTIES OF THE DEPARTMENT--DUTIES OF THE
23 BOARD.--

24 A. The corrections department, in collaboration
25 with the board, shall promulgate rules to govern and shall

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1 implement a "medical and geriatric parole program" by July 1,
2 2017.

3 B. The director shall identify geriatric,
4 permanently incapacitated and terminally ill inmates, consider
5 applications for medical or geriatric release and authorize the
6 release of those inmates who are eligible for medical or
7 geriatric [or medical] parole [based on rules established by
8 the board. The department shall forward], whose release is not
9 incompatible with the welfare of society and who were not
10 convicted of first degree murder.

11 C. An inmate who seeks release on medical or
12 geriatric parole, or the inmate's representative, shall submit
13 an application and documentation in support of parole
14 eligibility to the [board within thirty days of receipt of an
15 application from an inmate] director. The documentation
16 submitted in support of an application for medical or geriatric
17 parole shall include information concerning the inmate's age,
18 medical history and prognosis, institutional behavior and
19 adjustment and criminal history. [The inmate or inmate's
20 representative may submit an application to the board.]

21 D. Inmates who have not served their minimum
22 sentences may be considered eligible for parole under the
23 medical and geriatric parole program. Medical and geriatric
24 parole consideration shall be in addition to any other parole
25 for which a geriatric, permanently incapacitated or terminally

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1 ill inmate may be eligible.

2 E. When considering an inmate for medical or
3 geriatric parole, the director may request that certain medical
4 evidence be produced or that reasonable medical examinations be
5 conducted.

6 F. When determining an inmate's eligibility for
7 geriatric or medical parole, the director shall consider the
8 following criteria concerning the inmate:

9 (1) age;

10 (2) severity of illness, disease or
11 infirmities;

12 (3) comprehensive health evaluation;

13 (4) institutional behavior;

14 (5) level of risk for violence;

15 (6) criminal history; and

16 (7) alternatives to maintaining the geriatric,
17 permanently incapacitated or terminally ill inmate in
18 traditional settings.

19 G. The director shall review an application and
20 supporting documentation and, within thirty days of receipt of
21 the application, shall make a determination of the applicant's
22 eligibility for medical or geriatric parole. Within seventy-
23 two hours of making a determination that an inmate is eligible
24 for medical or geriatric parole, the director shall authorize
25 the board to release the inmate.

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1 H. The parole term of a geriatric, permanently
2 incapacitated or terminally ill inmate on medical or geriatric
3 parole shall be for the remainder of the inmate's sentence,
4 without diminution of sentence for good behavior.

5 I. The board shall:

6 (1) release an inmate on medical or geriatric
7 parole upon receipt of authorization from the director to
8 release the inmate;

9 (2) determine the appropriate level of
10 supervision following an inmate's release on medical or
11 geriatric parole and develop a comprehensive discharge plan for
12 those geriatric, permanently incapacitated and terminally ill
13 inmates; and

14 (3) at the time of an inmate's release on
15 medical or geriatric parole, prescribe terms and conditions of
16 the inmate's parole, including medical supervision and
17 intervals of periodic medical evaluations.

18 J. The director shall report annually to the
19 appropriate legislative interim committee the:

20 (1) number of applications for medical and
21 geriatric parole received by the director;

22 (2) nature of the illnesses, disease or
23 condition of the applicants;

24 (3) reason any application for medical or
25 geriatric parole was denied; and

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1 (4) number of persons on medical or geriatric
2 parole who have been returned to the custody of the department
3 and the reasons for their return."

4 SECTION 3. REPEAL.--Section 31-21-25.1 NMSA 1978 (being
5 Laws 1994, Chapter 21, Section 3) is repealed.

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SENATE BILL

53RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2017

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; AMENDING AND ENACTING SECTIONS OF THE LYNN
AND ERIN COMPASSIONATE USE ACT TO PROVIDE FOR PRESUMPTIVE
ELIGIBILITY AND THREE-YEAR CERTIFICATION AND TO ESTABLISH NEW
CONTENT AND POSSESSION STANDARDS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 26-2B-1 NMSA 1978 (being Laws 2007,
Chapter 210, Section 1) is amended to read:

"26-2B-1. SHORT TITLE.--~~[Sections 1 through 7 of this
act]~~ Chapter 26, Article 2B NMSA 1978 may be cited as the "Lynn
and Erin Compassionate Use Act" in honor of Lynn Pierson and
Erin Armstrong."

SECTION 2. Section 26-2B-3 NMSA 1978 (being Laws 2007,
Chapter 210, Section 3) is amended to read:

"26-2B-3. DEFINITIONS.--As used in the Lynn and Erin

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1 Compassionate Use Act:

2 A. "adequate supply" means an amount of cannabis,
3 in any form approved by the department, possessed by a
4 qualified patient or collectively possessed by a qualified
5 patient and the qualified patient's primary caregiver [~~that is~~
6 ~~determined by rule of the department to be no more than~~
7 ~~reasonably necessary to ensure the uninterrupted availability~~
8 ~~of cannabis for a period of three months]~~ in accordance with
9 Section 5 of this 2017 act and that is derived solely from an
10 intrastate source;

11 B. "debilitating medical condition" means:
12 (1) cancer;
13 (2) glaucoma;
14 (3) multiple sclerosis;
15 (4) damage to the nervous tissue of the spinal
16 cord, with objective neurological indication of intractable
17 spasticity;
18 (5) epilepsy;
19 (6) positive status for human immunodeficiency
20 virus or acquired immune deficiency syndrome;
21 (7) admitted into hospice care in accordance
22 with rules promulgated by the department; or
23 (8) any other medical condition, medical
24 treatment or disease as approved by the department;

25 C. "department" means the department of health;

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1 D. "licensed producer" means any person or
2 association of persons within New Mexico that the department
3 determines to be qualified to produce, possess, distribute and
4 dispense cannabis pursuant to the Lynn and Erin Compassionate
5 Use Act and that is licensed by the department;

6 E. "practitioner" means a person licensed in New
7 Mexico to prescribe and administer drugs that are subject to
8 the Controlled Substances Act;

9 F. "primary caregiver" means a resident of New
10 Mexico who is at least eighteen years of age and who has been
11 designated by the patient's practitioner as being necessary to
12 take responsibility for managing the well-being of a qualified
13 patient with respect to the medical use of cannabis pursuant to
14 the provisions of the Lynn and Erin Compassionate Use Act;

15 G. "qualified patient" means a resident of New
16 Mexico who has been diagnosed by a practitioner as having a
17 debilitating medical condition and has received written
18 certification and a registry identification card issued
19 pursuant to the Lynn and Erin Compassionate Use Act;

20 H. "registry identification card" means a document
21 that the department issues:

22 (1) to a qualified patient that identifies the
23 bearer as a qualified patient and authorizes the qualified
24 patient to use cannabis for a debilitating medical condition;

25 or

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1 (2) to a primary caregiver that identifies the
2 bearer as a primary caregiver authorized to engage in the
3 intrastate possession and administration of cannabis for the
4 sole use of a qualified patient who is identified on the
5 document;

6 I. "THC" means tetrahydrocannabinol, a substance
7 that is the primary psychoactive ingredient in cannabis; and

8 [~~H.~~] J. "written certification" means a statement
9 in a patient's medical records or a statement signed by a
10 patient's practitioner that, in the practitioner's professional
11 opinion, the patient has a debilitating medical condition and
12 the practitioner believes that the potential health benefits of
13 the medical use of cannabis would likely outweigh the health
14 risks for the patient [~~A written certification is not valid for~~
15 ~~more than one year from the date of issuance]."~~

16 SECTION 3. Section 26-2B-7 NMSA 1978 (being Laws 2007,
17 Chapter 210, Section 7) is amended to read:

18 "26-2B-7. REGISTRY IDENTIFICATION CARDS--DEPARTMENT
19 RULES--DUTIES--PRESUMPTIVE ELIGIBILITY.--

20 A. [~~No later than October 1, 2007, and~~] After
21 consultation with the advisory board, the department shall
22 promulgate rules in accordance with the State Rules Act to
23 implement the purpose of the Lynn and Erin Compassionate Use
24 Act. The rules shall:

25 (1) govern the manner in which the department

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1 will consider applications for registry identification cards
2 and for the renewal of identification cards for qualified
3 patients and primary caregivers;

4 ~~[(2) define the amount of cannabis that is~~
5 ~~necessary to constitute an adequate supply, including amounts~~
6 ~~for topical treatments;~~

7 ~~(3)]~~ (2) identify criteria and set forth
8 procedures for including additional medical conditions, medical
9 treatments or diseases to the list of debilitating medical
10 conditions that qualify for the medical use of cannabis.

11 Procedures shall include a petition process and shall allow for
12 public comment and public hearings before the advisory board;

13 ~~[(4)]~~ (3) set forth additional medical
14 conditions, medical treatments or diseases to the list of
15 debilitating medical conditions that qualify for the medical
16 use of cannabis as recommended by the advisory board;

17 ~~[(5)]~~ (4) identify requirements for the
18 licensure of producers and cannabis production facilities and
19 set forth procedures to obtain licenses;

20 ~~[(6)]~~ (5) develop a distribution system for
21 medical cannabis that provides for:

22 (a) cannabis production facilities
23 within New Mexico housed on secured grounds and operated by
24 licensed producers; and

25 (b) distribution of medical cannabis to

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1 qualified patients or their primary caregivers to take place at
2 locations that are designated by the department and that are
3 not within three hundred feet of any school, church or daycare
4 center;

5 [~~(7)~~] (6) determine additional duties and
6 responsibilities of the advisory board; and

7 [~~(8)~~] (7) be revised and updated as necessary.

8 B. The department shall issue registry
9 identification cards to a patient and to the primary caregiver
10 for that patient, if any, who submit the following, in
11 accordance with the department's rules:

12 (1) a written certification;

13 (2) the name, address and date of birth of the
14 patient;

15 (3) the name, address and telephone number of
16 the patient's practitioner; and

17 (4) the name, address and date of birth of the
18 patient's primary caregiver, if any.

19 C. The department shall presume eligible and issue,
20 within thirty days of receipt of application completed in
21 accordance with Subsection B of this section and department
22 rules, a registry identification card to any person who applies
23 for a registry identification card. The department shall
24 verify the information contained in an application submitted
25 pursuant to Subsection B of this section [~~and shall approve or~~

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1 ~~deny an application within thirty days of receipt~~. The
2 department may deny an application only if the applicant did
3 not provide the information required pursuant to Subsection B
4 of this section or if the department determines that the
5 information provided is false. A person whose application has
6 been denied shall not reapply for six months from the date of
7 the denial unless otherwise authorized by the department.

8 D. ~~[The department shall issue a registry~~
9 ~~identification card within five days of approving an~~
10 ~~application, and a card shall expire one year after the date of~~
11 ~~issuance.]~~ A registry identification card shall contain:

12 (1) the name, address and date of birth of the
13 qualified patient and primary caregiver, if any;

14 (2) the date of issuance and expiration date
15 of the registry identification card; and

16 (3) other information that the department may
17 require by rule.

18 E. A person who possesses a registry identification
19 card shall notify the department of any change in the person's
20 name, address, qualified patient's practitioner, qualified
21 patient's primary caregiver or change in status of the
22 qualified patient's debilitating medical condition within ten
23 days of the change.

24 F. Possession of or application for a registry
25 identification card shall not constitute probable cause or give

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1 rise to reasonable suspicion for a governmental agency to
2 search the person or property of the person possessing or
3 applying for the card.

4 G. The department shall maintain a confidential
5 file containing the names and addresses of the persons who have
6 either applied for or received a registry identification card.
7 Individual names on the list shall be confidential and not
8 subject to disclosure, except:

9 (1) to authorized employees or agents of the
10 department as necessary to perform the duties of the department
11 pursuant to the provisions of the Lynn and Erin Compassionate
12 Use Act;

13 (2) to authorized employees of state or local
14 law enforcement agencies, but only for the purpose of verifying
15 that a person is lawfully in possession of a registry
16 identification card; or

17 (3) as provided in the federal Health
18 Insurance Portability and Accountability Act of 1996."

19 SECTION 4. A new section of the Lynn and Erin
20 Compassionate Use Act is enacted to read:

21 "[NEW MATERIAL] REGISTRY IDENTIFICATION CARD--RENEWAL--
22 WRITTEN CERTIFICATION.--The department shall require a
23 qualified patient to reapply for a registry identification card
24 as follows:

25 A. for a qualified patient whose certification of a
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1 debilitating medical condition indicates that the patient's
2 debilitating medical condition is a chronic condition, no
3 sooner than three years from the date the patient's current
4 registry identification card is issued; and

5 B. for a qualified patient whose certification of a
6 debilitating medical condition does not indicate that the
7 patient's debilitating medical condition is a chronic
8 condition, no sooner than one year from the date the patient's
9 current registry identification card is issued."

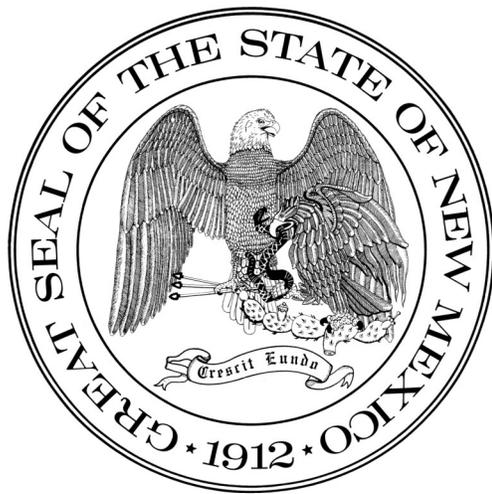
10 SECTION 5. A new section of the Lynn and Erin
11 Compassionate Use Act is enacted to read:

12 "[NEW MATERIAL] ADEQUATE SUPPLY--BAN ON RESTRICTION OF THC
13 CONTENT.--

14 A. A qualified patient or a primary caregiver shall
15 possess no more than five ounces of cannabis during any thirty-
16 day period.

17 B. A licensed producer shall possess no more than
18 one thousand cannabis plants during any three-month period.

19 C. The department shall not limit the amount of THC
20 concentration in a cannabis-derived product that a qualified
21 patient or a primary caregiver possesses."



LEGISLATIVE COUNCIL SERVICE
SANTA FE, NEW MEXICO