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

October 5-7, 2015
State Capitol, Room 322
Santa Fe

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on October 5, 2015 by Senator Gerald Ortiz y Pino, chair, at 8:45 a.m. in Room 322 of the State Capitol in Santa Fe.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Nora Espinoza, Vice Chair (10/5, 10/6)
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia (10/5, 10/6)
Sen. Mark Moores

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

Advisory Members
Sen. Sue Wilson Beffort (10/5)
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria (10/7)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley (10/5, 10/6)
Sen. Howie C. Morales (10/5, 10/6)
Sen. Bill B. O'Neill
Sen. Mary Kay Papen (10/6)
Sen. Nancy Rodriguez
Sen. William P. Soules
Sen. Mimi Stewart (10/5, 10/6)

Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Rep. Patricio Ruiloba
Sen. Sander Rue
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
Peter Kovnat, Staff Attorney, LCS (10/5)
Nancy Ellis, LCS
Diego Jimenez, LCS
Erin Bond, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, October 5

Welcome and Introductions

Senator Ortiz y Pino announced that the day's session would be a joint meeting with members of the Indian Affairs Committee (IAC). He introduced his vice chair, Representative Espinoza, and the co-chairs of the IAC, Representative Sharon Clahchischilliage and Senator John Pinto, and asked members of both committees and staff to introduce themselves.

Tribal Employers and the Federal Large Employer Mandate

Rachel Sibila, who is pursuing a law degree and a master's degree in health administration at the University of Oklahoma, described a study that she conducted during her second year of law school titled, "Play or Pay: Interpreting the Employer Mandate of the Patient Protection and Affordable Care Act as it Relates to Tribal Employers" (see handout). In that report, Ms. Sibila explored the many ambiguities among federal statute, Indian treaty rights and judicial interpretations of requirements of the federal Patient Protection and Affordable Care Act (ACA). Certain provisions of the ACA expressly exempt Native Americans, but the employer mandate to provide insurance does not carve out Native American employers, she said. There currently is a split among the federal circuit courts regarding legislative intent, Ms. Sibila said, so clarification by the U.S. Congress or the U.S. Supreme Court is going to be necessary.

On questioning, members of the committees and Ms. Sibila discussed the following issues:

- the effects of tribal coverage of insurance premiums;
- the assumption that tribes with casinos have greater resources than those without;
- Indian Health Service (IHS) concerns about which mandates apply; and
- confusion about coverage for non-Native American employees of a Native American employer.

Health Update from the Pueblo of Santa Clara

J. Michael Chavarria, governor of the Pueblo of Santa Clara, presented a comprehensive outline of accomplishments and challenges that face the Pueblo of Santa Clara, and he emphasized the need to work together with state agencies and others to craft new solutions. Governor Chavarria referred to a community health profile conducted by the pueblo in 2007, with alcohol and substance abuse identified as major issues. The need for transitional-living facilities remains a top priority for the pueblo, he said. Last year's joint application to the IHS from five northern pueblos seeking construction of a large regional health care facility did not get

funding, Governor Chavarria said, but the pueblos will continue to seek other resources to build this needed facility.

Issues with managed care organizations (MCOs) continue, Governor Chavarria said, as health risk assessments (HRAs) are not being completed for Native Americans enrolled in the state's Medicaid program, community health workers are not being included in meetings with care coordinators and quarterly reporting requirements to Native Americans are not being completed. The Pueblo of Santa Clara is also very concerned with new work requirements for the state's Supplemental Nutrition Assistance Program (SNAP), he stated. The Human Services Department (HSD) and the United States Department of Agriculture have a duty to ensure that SNAP is responsive to the needs of Native American participants (approximately 80,000 in New Mexico), and a tribal consultation is scheduled for October 16 at the Pueblo of Zuni.

Senior citizen programs, funded through state and federal agencies, are highly valued at the Pueblo of Santa Clara, Governor Chavarria said, and the pueblo's 2016 capital outlay request includes renovations, equipment and vehicle purchases. The Santa Clara Regional Adult Day Care Center (SCRADCC) program serves adults with special needs, both Native American and non-Native American, and the pueblo is seeking additional funding for staff, transportation and operation and maintenance. He objected to the state using $2 million from the Tribal Infrastructure Project Fund (TIF) to pay for non-Indian water users in the Taos water rights settlement at a time when there is great need for upgrading existing water infrastructure. He also noted that the delay in processing intergovernmental agreements (IGAs) has negatively affected many projects, and he asked that a performance period not begin until an IGA has been fully executed. State action also has been lagging with joint pueblo applications for federal funds following devastating impacts to the pueblo from the Las Conchas fire.

On questioning, members of the committees and Governor Chavarria discussed the following issues:

- effects of lost oil and gas tax revenue on tribal infrastructure and water projects;
- pros and cons of the state's use of TIF funds for the Taos water rights settlement;
- incomplete data from MCOs on Native American enrollments; and
- efforts to seek SCRADCC funding from additional sources.

Members of both committees approved motions to send a letter to the Aging and Long-Term Services Department seeking more funding for the SCRADCC and asking why the center's appropriation does not recur annually; and a letter to the HSD, copied to the Legislative Finance Committee (LFC), inquiring about the MCOs' lack of completed HRAs for Native Americans and details of how care is being coordinated for these individuals.

Task Force Report on Breastfeeding in Indian Communities

Lucinda Cowboy, tribal coordinator for the New Mexico Breastfeeding Task Force, described the health and bonding advantages of breastfeeding, including cost savings to families

of an estimated $1,500 a year. Native American mothers start out breastfeeding at a rate of 92 percent, but those numbers drop off quickly as they return to work or do not get the support that they need to continue, Ms. Cowboy said. The goal of the nonprofit task force is to provide support for new mothers through education, advocacy and partnering with community resources. Ms. Cowboy described coordinated efforts in the pueblos and the Navajo Nation, and she urged increased funding for peer counselors, better education for employers and support for expanded family leave policies. The IHS has been a leader in baby-friendly hospitals that support breastfeeding, she said.

Diné Food Sovereignty Alliance

Gloria Ann Begay, project manager of the Diné Food Sovereignty Alliance, and Noreen Kelly, a project volunteer, described the two percent tribal tax on unhealthy foods vetoed by the previous Navajo Nation president but supported by current President Russell Begay and signed into law in 2014. Ms. Begay, a retired educator who now works as an advocate, said there is a scarcity of healthy foods in stores in the Navajo Nation, as well as a lack of jobs, housing, access to services and transportation (see handout). In the Navajo culture, living well is interconnected with food and language, Ms. Kelly explained. Health disparities drove this tax initiative, and environmental issues continue to challenge, with 70 percent of Navajo farmlands currently idle due to lack of water or to contamination. Backyard gardening in residential areas is supposed to be against the law in many areas in the Navajo Nation, she said, but some individuals are gardening in residential areas, and their children now are starting to understand where food actually comes from. Traditional foods, plants and remedies are being restored. Fresh food distribution is very challenging on the huge reservation. Ms. Kelly noted that data from the recent Colorado Gold Mine spill are hard to come by, but she does not believe that there is no residual contamination.

Junk Food Taxation

Revenue from the Navajo Nation tax on certain "unhealthy foods" is being placed into a community wellness development fund, according to Moroni Benally, director of the Diné Policy Institute, with $300,000 raised after just the first quarter. Administration of the tax and retailer interpretation is a complex matter (see handout), with definitions of "healthy" food sometimes difficult to pinpoint. SNAP recipients are not subject to the tax, he noted, and they are in a group reported to have some of the worst eating habits. The tax dollars raised go to all chapters and are disbursed based on per capita population; each community is to design its own wellness project under strict legal guidelines. Reduced rates of diabetes and obesity will signal success of the effort.

Care Coordination at Kewa Pueblo

Marcia Clark, chief executive officer (CEO) of the Kewa Pueblo Health Corporation, provided her perspective on Centennial Care and its four MCOs, whose services include physical health, behavioral health and long-term care and community benefits (see handout). Ms. Clark reminded members of the committees that New Mexico's tribes had strenuously opposed the state's Medicaid waiver that included mandatory enrollment of all Native Americans into managed

care. Ultimately, the federal Centers for Medicare and Medicaid Services (CMS) agreed with the tribes, allowing enrollment to be optional, except for those needing nursing facility level of care and those who are dually eligible; individuals in these latter groups would be required to enroll in managed care. Ms. Clark detailed the MCOs' community benefit meant to help keep individuals in their homes, but she asserted that services and coordination are so lacking as to be detrimental to their care. Citing quarterly reports from all four MCOs indicating that more than one-half of Native American enrollees had not completed the HRA to determine their needed levels of care coordination, she asserted that the state's lack of concern about these figures was troubling for taxpayers as well: Native Americans in long-term care are considered high-risk, and MCOs are receiving the highest capitated rate of $3,700 a month, 2.7 times the annual income level of a single Medicaid recipient.

Ending her presentation with what she termed a positive note, Ms. Clark said that the CMS is moving in the direction of changing regulations for Native Americans, and soon New Mexico will no longer be able to argue that it is necessary to enroll Native Americans in managed care. At that time, there will be increased opportunities for facilities such as her own to address long-term care and improved care coordination for Native American members.

Recess

There being no more business before the committees, the LHHS meeting was recessed and the IAC meeting was adjourned at 3:25 p.m.

Tuesday, October 6

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:48 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

Substance Use Disorder and Overdose Update

Laura Tomedi, Ph.D., M.P.H., head of substance abuse epidemiology at the Department of Health (DOH), described New Mexico's slight improvement in its drug overdose death rate for 2013, moving from number one in the nation to number three, now behind West Virginia and Kentucky. Prescription drug overdose is epidemic in the United States, Dr. Tomedi said, with the amounts of prescription drugs prescribed and sold quadrupling between 1999 and 2013 with no change in the amount of pain reported by Americans (see handout). Presenting a series of charts and graphs showing death rates by gender, age, county and drug class, Dr. Tomedi enumerated risk factors for drug overdose, including overlapping prescriptions, combining them with other drugs and being poor and living in a rural area. Prescription monitoring programs (PMPs) in nearly all states are beginning to affect high-risk prescribing practices, but consistent use of the program in New Mexico varies by professional provider board rules. Efforts to increase and mainstream Naloxone (the antidote to opioid overdose) prescribing are under way, as is a major public education and awareness campaign. Dr. Tomedi urged increased access to treatment, including medication-assisted treatment, a strengthening of the state's PMP rules, better data

collection and enhanced surveillance. A four-year $3.54 million grant is assisting the DOH's efforts to address this public health crisis.

Harris Silver, M.D., a drug policy analyst and co-chair of the Bernalillo County Opioid Abuse Accountability Initiative, said that despite the good news reported by the DOH, there has been a 20 percent increase in overdose deaths in New Mexico, and these numbers would be much worse without the state's robust Naloxone program. Users have been moving from opioids to heroin, and some to methamphetamines, Dr. Silver asserted, with 80 percent of those on heroin reporting that they began with prescription opioids. An unintentional consequence of the ACA is that with expansion of Medicaid, individuals now can get a bottle of opioids for a $5.00 copay. New Mexico does not have a treatment system, according to Dr. Silver; people cannot get into treatment without detox, and the state is scaling treatment down rather than up. The 2013 disruption of the state's behavioral health provider system also contributed to this crisis. Everyone needs access to treatment, Dr. Silver said, noting there is a two-month wait to get into the program at Turquoise Lodge, and its treatment does not utilize medication that now has become the standard of care.

Steve McLaughlin, M.D., regents professor and chair, Department of Emergency Medicine, University of New Mexico Health Sciences Center (UNMHSC), said that emergency department physicians are on the front lines of managing this public health crisis (see handouts). Every day they see the complications of overdose, as well as the need for long-term treatment of pain. The current PMP in New Mexico is good, Dr. McLaughlin said, but it needs to be easier to access in real time for a provider who is often in the midst of a crisis, and medical records that can be shared across different health systems could more easily identify potential problems. Dr. McLaughlin described the symptoms of opioid overdose and its emergency treatment, including Naloxone, and urged its wider distribution to patients and first responders.

Andrew Hsi, M.D., M.P.H., heads up the Milagro and FOCUS programs at the UNMHSC's Center of Excellence. Along with a team of collaborators, Dr. Hsi provides comprehensive prenatal care and substance use disorder treatment, as well as follow-up services and home visits for children up to age three. The Milagro Program is statewide, Dr. Hsi said, and of the current 141 participants, 80 percent have an opioid addiction. The program helps mothers establish an emotional connection to their developing fetuses and engages them in the process of recovery. Addiction is a brain disease, Dr. Hsi emphasized, and medication-assisted treatment can help to change brains. Close monitoring also assures the likelihood of a full-term birth and allows for treatment of the newborn infant. With over 220 referrals a year, the FOCUS Program provides services and monitoring of child development for families and children identified as high-risk. Funding for these programs comes from Medicaid and the federal Family Infant Toddler Program, and Dr. Hsi urged that additional centers of excellence be established throughout the state to address the geographic challenges of this population.

Jennifer Miller, administrator of the Alternative Sentencing Division of San Juan County, described the Axis Program, a 60-day jail-based treatment program for substance-abusing

offenders who have been convicted within the county court system. Program objectives are to maintain a safe and secure environment, to provide the evidence-based services necessary for addiction recovery and to provide case-managed aftercare that supports the client's continued sobriety. The treatment strategies include individual and group therapy, life skills, substance abuse and health education and 12-step programs. Nexus is the 10-day intensive outpatient program to assist those who have completed the Axis jail-based treatment and is managed by a transitional coordinator and two peer mentors. Transition services include help with employment, housing and the resumption of family responsibilities and social activities. Presbyterian Healthcare Services follows up with each Nexus client for 16 weeks of additional intensive programming, followed by a minimum of nine months of aftercare. A total of 84 inmates can be in the Axis Program at any given time, Ms. Miller said, and detention officers are certified and cross-trained, as are case managers and clinical and administrative staff members. Funding is from the county's general fund, the Eleventh Judicial District Court and the Behavioral Health Services Division (BHSD) of the HSD.

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

- the new president of the Board of Pharmacy's decision to restrict Naloxone prescribing;
- MCO monitoring of opioid prescriptions and possible use of "lock-ins";
- the role of marketing in the dramatic rise of opioid prescribing;
- concerns that MCOs have been directed not to pay for residential drug treatment;
- the importance of legitimate pain sufferers being able to fill needed prescriptions;
- limited resources for San Juan County to track Axis/Nexus outcomes; and
- the possibility of expanding the Milagro treatment model into southern New Mexico.

Update on Pain Management

Joanna Katzman, M.D., M.S.P.H., is director of the UNM Pain Center, the state's only interdisciplinary pain management clinic that includes the co-location of mental health and addiction services (see handout). The pain center accepts referrals, regardless of ability to pay, from primary care providers throughout the state and educates clinicians on safe opioid prescribing and screening for addiction. An interdisciplinary team provides care for more than 7,500 patients with chronic pain each year, but the wait time for an appointment is currently five to six months, Dr. Katzman said. Chronic pain affects an estimated 100 million American adults and costs up to $635 billion in medical treatment and lost productivity; pain sufferers have greater rates of depression and anxiety and are more likely to commit suicide. In July 2014, the UNM Pain Center began co-prescribing Naloxone with every prescription for chronic pain in a trial that aims to reduce opioid overdose deaths in New Mexico, which is a major public health issue. The pain center collaborates with multiple state boards and committees, as well as the DOH, the IHS and the United States Department of Veterans Affairs.

Update on Substance Abuse Treatment Centers in New Mexico

Wayne Lindstrom, Ph.D., director of the BHSD and CEO of the Interagency Behavioral Health Purchasing Collaborative, described high rates of opioid overdose and alcohol-related deaths in New Mexico (see handout). Dr. Lindstrom listed five levels of the state's "continuum of care" model and six dimensions of the American Society of Addiction Medicine assessment: (1) early intervention; (2) outpatient services; (3) intensive outpatient services; (4) partial hospitalization with low- and high-intensity residential services; (5) clinically managed residential services; and (6) medically monitored inpatient services. In New Mexico, detoxification from intoxicating substance use or dependence is a Medicaid-covered service for all MCOs, Dr. Lindstrom asserted, but the problem is that there are not enough addiction specialists. The MCOs have said they have very few denials for residential substance abuse treatment, but when there are no providers, services will not be billed to the MCOs. Dr. Lindstrom listed in a handout 10 residential detox programs in New Mexico (eight of these medical), four social detox, three acupuncture detox and seven methadone detox programs and 33 medical centers/hospitals that are able to offer detox services. He also listed 12 programs for adult inpatient residential treatment and 28 adolescent residential treatment centers, 19 intensive Medicaid-approved adult outpatient programs and 23 Medicaid-approved adolescent outpatient programs. The Board of Pharmacy's PMP is working, he said, and state initiatives have increased the distribution of Naloxone, which can reverse opioid overdose.

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

- the long delay in the release of CMS rules for behavioral health parity;
- the continuing lack of a work force for provider services;
- the need to further expand, not limit, Naloxone prescribing;
- the estimated cost of a new gap analysis for the BHSD that has not been updated since 2002;
- the doubling of the cost of Naloxone;
- the need to eliminate "we are a poor state" as an excuse for not providing services;
- BHSD emphasis on outpatient rather than residential treatment;
- why most hospitals will not admit patients for detox unless it is secondary to a medical condition;
- capital plans are in place for several triage centers, but operational funds and providers are lacking; and
- the whereabouts of an HSD report on amounts still being withheld from behavioral health providers accused of wrongdoing.

Public Comment

Jeff Hunt spoke of the success of a community-based treatment model, Oxford House, that is peer-run and allows an individual to live independently yet with support. Oxford House is a national nonprofit that came to New Mexico over five years ago and now has 135 beds — more than are currently in publicly funded treatment centers. Oxford House residents pay rent and contribute to the tax base, Mr. Hunt said, and he urged that the program be doubled, possibly even

tripled. He is putting together a $250,000 request to the legislature for that purpose, and he invited committee members to a public reception at Oxford House following the conclusion of today's meeting.

Update on Bernalillo County Behavioral Health Initiatives

Bernalillo County has experienced tragic events in the past couple of years that highlight the need to address behavioral health in the community and the risks and costs of failing to do so, noted Maggie Hart-Stebbins, chair of the Bernalillo County Commission. A new one-eighth percent gross receipts tax for behavioral health was placed on the ballot and passed by a vote of 69 percent; it went into effect on July 1 and is expected to raise $15 million a year. Commissioners have met with the state's congressional delegation, state agencies and legislators to convene and participate in the Task Force on Mental Health to fill the gaps in services and to connect the dots, Commissioner Hart-Stebbins said. The commission also passed a resolution to establish a work group of behavioral health providers and to collect data on what each local government organization is currently spending, and the commission hired a facilitator for the process. There is an immediate need for a crisis continuum to engage individuals before their illnesses become a crisis, she said, and to enable interaction with peers rather than law enforcement whenever possible.

Andy Vallejos, coordinator for the Task Force on Mental Health, presented a layout of vital elements in the current and future infrastructure of a care continuum (see handout). The group is still three to four years away from having a building to house a crisis triage center, Mr. Vallejos said, but currently there are medical and psychiatric triage and inpatient beds available in Albuquerque. Nonetheless, there is no cascading level of services following a crisis, and individuals are released to the street. Help with employment, housing and case management is needed for these individuals, and transportation is critical to help provide stability. Prevention efforts should be directed to the very young, Mr. Vallejos said. Commissioner Hart-Stebbins noted that a Housing First model for those with mental illness has just been established, and there have been significant gains in Medicaid enrollment for incarcerated individuals.

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

- focus on the highest utilizers with mobile crisis units, intermediate levels of care and support systems;
- efforts to track individual outcomes;
- a potential role of UNM on the Task Force on Mental Health;
- ways to leverage Medicaid funding with city and county funding;
- the reduction in the jail population resulting from expedited case processing; and
- how case management is being billed for Medicaid reimbursement.

Monitoring Access to Behavioral Health Services

Maggie McCowen, executive director of the New Mexico Behavioral Health Providers Association (NMBHPA), described the efforts of her organization to establish a data-driven

monitoring system to measure statewide access to behavioral health services (see handout). Her association collected input through an electronic survey, by telephone and through in-person interviews of providers, MCOs, consumer advocates, legislators and staffers, university researchers and others. David Ley, Ph.D., a board member of the NMBHPA, described a long history of haphazard and siloed data collection. A full 100 percent of those who responded to the survey agreed that there was poor access (based on how long it takes to get an appointment) to behavioral health services. Dr. Ley hailed the concept of the All Payer Claims Database and said it will help assemble many existing small caches of data that have been largely unusable. Ms. McCowen described four core issues that came out of the focus groups: (1) the need for enforcement of mental health parity; (2) the need for accurate MCO data on the utilization of services; (3) more timely MCO reporting; and (4) statewide expansion of the provider work force. Data are vitally important in policy decisions, Dr. Ley noted, and are critical for legislative decision-making.

Diabetes Prevention and Treatment Update

Ashley Noble, policy associate with the National Conference of State Legislatures, provided new data showing that by 2050, nearly one-third of Americans will have diabetes (see handouts). She described risk factors associated with diabetes, including diet, age and racial disparities, and the different types of the disease. Approximately 90 percent of the 86 million Americans who currently have prediabetes do not even know they have it, Ms. Noble said. In 2012, New Mexico spent an estimated $1.53 billion on diabetes-related costs, and, because of its high percentage of older people, the state will need to continue to provide additional funding to address this growing health crisis.

Matthew Frederick Bouchonville, M.D., is medical director of Endo ECHO, a program initiated through UNM's Project Extension for Community Healthcare Outcomes (ECHO) to improve access to care for New Mexicans with diabetes. Treating diabetes in New Mexico is a challenge, Dr. Bouchonville said, with poor access to care resulting in poor outcomes (see handout). He noted that the state has the highest rates of diabetic eye complications in the country, costing more than $100 million a year. Endo ECHO, through weekly telementoring of rural primary care providers by a panel of specialists, is improving access to care for medically underserved New Mexicans. By sharing expertise through Endo ECHO, the capacity for providing care for complex diabetic patients is rapidly expanding and resulting in cost savings through reduced hospital admissions, reduced transportation needs and fewer lost days of work. By partnering with clinicians and community health workers at health centers throughout the state, Endo ECHO already has improved access to quality diabetes care in New Mexico.

Public Comment

Jim Ogle, advocate and member of the National Alliance on Mental Illness, spoke on his own behalf to describe the need for a serious conversation about gun safety. He urged legislators to invite members of the National Rifle Association into the same room with advocates for the mentally ill. He reminded members that there are about 20,000 individuals with mental illness in

the Albuquerque area and only about 1,000 are in jails. It seems that jailed and homeless individuals get all the attention from the legislature.

Recess

The meeting was recessed at 5:05 p.m.

Wednesday, October 7

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:50 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

ACA Large Employer Mandate

Steve Byrd, president, Employee Benefits Division, HUB International Insurance Services, described several key areas impacted by the ACA mandate for employers of 50 or more individuals (see handout), including the need to measure hours to identify employee status as full-time-equivalent (30 hours a week or more). Minimum essential coverage must be offered to 95 percent of employees in 2016 in order to avoid a $2,084 penalty per employee, as well as minimum value coverage (measured to equal 60 percent of a benefit plan as available on exchanges). An employee's share of the premium cannot exceed 9.5 percent of that employee's annual household income. Noting that state and local governments also are subject to the mandate, Mr. Byrd provided examples of the effects of the new regulations on several different New Mexico employers, describing difficulties in finding affordable plans and, in some cases, the need for multiple tiers. There will be a tremendous increase in the administrative requirements for any employer health plan, Mr. Byrd said, which is compounded by a flurry of changing and sometimes conflicting notifications from the Internal Revenue Service (IRS).

Gary L. Petersen, vice president and consulting actuary of Segal Consulting, detailed the ACA's excise tax on high-cost health care plans, also known as the "Cadillac tax", intended to slow the growth rate of health care costs and help finance the expansion of health coverage (see handout). Enforcement has been delayed until 2018 and will consist of a 40 percent tax on the total cost of coverage plus an employee premium share above $10,200 for an individual and $27,500 for a family. Proponents of the tax say high-end health plans paid mostly by employers with pre-tax dollars have low or no deductibles and thus little cost-sharing by employees, who remain shielded from the true costs of care. Avoidance of the Cadillac tax is already driving businesses to perform projections and across-the-board reexaminations of their health plan designs, Mr. Petersen said, although it is unknown whether the tax will survive the political winds in Washington, D.C., beyond 2020.

Lisa Carlson, regional federal Employee Retirement Income Security Act of 1974 counsel for USI Insurance Services, presented an overview of the individual and employer mandates under the ACA and provided examples of the IRS forms 1094-C and 1095-C that will be used to determine any penalties (see handout). There are three "safe harbor" determinations that may

apply. Much like 1099 forms, these forms must be delivered to the employee by February 1 of each year and to the IRS by March 31. Information for reporting may have to be gathered from multiple sources, including a payroll vendor, benefits administrator or an insurance carrier, but liability for the reporting largely remains with the employer. Ms. Carlson urged that all employers track and collect information for these forms, due in early 2016, and monitor any changes in their health plan coverage. There is a huge range of costs associated with the new mandates, she said, and it will be important to coordinate with payroll and benefit providers to see what assistance may be available for preparation of the forms.

Don R. Heilman, area senior vice president, senior benefits consultant and team leader, Arthur J. Gallagher & Co., told committee members that the marketplace will notify an employer if an employee obtains insurance coverage with subsidies during open enrollment; the employer will have 90 days to appeal a possible penalty. Some companies are opting to pay the $2,084 fine per employee because it is less costly than providing insurance. Companies currently covering retirees and those who work less than 20 hours a week now might simply send them to the exchange to buy coverage. Because self-insured plans are not subject to this fine, more employers may be driven to become self-insured. There are many factors that should be taken into consideration in designing a health care plan, Mr. Heilman said, including complex mechanisms for funding and risk management.

Juvenile Justice Summit Report; Review of Legislation and Committee Correspondence

David Gold, facilitator from the September 23 Summit on Juvenile Justice (a joint meeting of the LHHS and the Courts, Corrections and Justice Committee), provided a detailed report (see handout) of the afternoon roundtable discussions. Two dialogue sessions took place examining three topics: Sequoyah Treatment Center; the Cambiar New Mexico model of treatment; and youth diversion and empowerment. For each topic, participants discussed whether it was working; if there were concerns with current practice and what might improve it or provide an alternative; and whether there is a role for legislators.

Sequoyah: In both sessions, the majority of participants were not convinced that the Building Bridges model is working, although the lack of consistent data impedes a clear picture. Unused capacity (empty beds) was a concern, as was the fact that there is not a board-certified psychologist on staff. Lack of transparency about the program budget also was of concern. The fact that mechanical restraints and isolation are no longer permitted was viewed as a positive step. Increasing outreach about the facility and the possibility of providing space for girls were suggested, as was the possibility of extending the age of participants to 21.

Cambiar New Mexico: Participants felt there was incomplete implementation of the program model, compounded by a high rate of staff turnover, and that Cambiar had barely "scratched the surface" of the Missouri model on which it is based. A former Cambiar participant reported that over-medication was taking place and that there was an overall lack of cultural sensitivity. Staff training for Cambiar seems to have been halted, but incorporating train-the-trainer in staff programs could help preserve the state's funding investment. Legislators might

focus on consistent implementation of a program that has shown significant promise for juvenile justice in other states.

Youth Diversion and Empowerment: Participants felt that diversion programs are effective and that funds spent on them are a good investment. Former diversion participants noted that these programs are more personal in their approach and staff members seem more sincere and sympathetic. While these programs do divert youth from incarceration, they do not necessarily empower them, some participants noted, and not enough emphasis is placed on skills training, mentoring and helping young people to learn to deal with their emotions. While the number of girls being incarcerated is rising, there still are very few alternative programs for them; young people who face mental health or substance abuse issues need services, not incarceration. It was agreed that education is key and that providing mentors and role models will empower youth and help move them on positive paths. Partnerships, both public/private and with agencies, will create more community-based programs, and funding for this is critical. Legislators can help by decriminalizing some nonviolent behaviors and by providing resources for programs that work.

Following the end of the roundtable discussions, participants were asked to comment on what they learned. Many said they appreciated the high level of attendance and participation from legislators and from many young people, and they liked the format of informal and direct interaction.

Mr. Hely provided copies of four pieces of legislation for members' perusal (202198.1, 202200.1, 202199.1 and 202201.1) and queried Kelly Klundt, LFC analyst, who was in the audience, about the next LFC meeting in three weeks when the budget process begins. After concern was voiced by some members about the lack of attendees at today's session, the committee agreed to send proposed legislation to the LFC without endorsement, agreeing that the end of the interim is too late for inclusion by the LFC. Mr. Hely also provided copies of four letters drafted at the behest of committee members during the LHHS September meeting.

Public Comment

Paul Tucker, a substance abuse treatment provider with more than 500 clients and over 20 years' experience, said he is very familiar with resources around the state and maintains that there is a severe lack of detox services for Medicaid clients. Molina Healthcare is the only MCO that will pay for it as a value-added service, he said; the other three MCOs say they are not required to do this. Mental health parity is federal law, Mr. Tucker said, but it is not being enforced in New Mexico. He cannot treat for substance abuse without detox first, so Mr. Tucker said he has figured out an inexpensive way to do this and is paid by the individual receiving the service. He was critical of Turquoise Lodge, which does not track outcomes, and he praised Oxford House, a far more successful program that costs a small fraction of the DOH facility. Because it is so cheap and effective, Mr. Tucker urged the state to provide more funding for Oxford House.

Child Care Contracting Practices by the Children, Youth and Families Department (CYFD)

Reina Costa, representing People for the Kids and the OLÉ Working Parents Association, provided a perspective from her coalition of preschool owners, early educators and parents with concerns about CYFD practices that hinder the goal of increasing access to high-quality early education (see handout). Testimony from coalition members included assertions that the CYFD is including child support in calculating household income even when such support has never been received. The department is also requiring women to sue abusive fathers even when written proof of the abuse is presented, thus exposing them to further danger from their abusers. The end result is that their child care contracts get canceled, and not only are their children denied access to programs, but providers are also left stranded without payment, causing extreme difficulty in budgeting and staffing. When the CYFD requires a monthly appointment for renewal of a contract, it disrupts the parent's ability to work. Another parent who is in school and also working finds it difficult without an allowance for child care services for nights or weekends. Coalition members said they have asked the CYFD to post and provide copies of the "Parents Bill of Rights" to clients, but it has done so only sporadically. There are signs in CYFD offices that state: "You May Experience a Wait Time of Two Hours or More", one coalition member testified. That member wondered why this is the normal course of business.

In questioning panel participants, committee members noted that no one from the CYFD was in attendance at today's session, and they expressed frustration that a state agency is making things more difficult for citizens. Funding for the child care program comes from the federal government through a block grant, another member pointed out; the member asked why the department wants to make parents jump through hoops. With approval from committee members, the chair directed staff to prepare a letter to Secretary of Children, Youth and Families Monique Jacobson describing these issues and inquiring as to why monthly contracts are being offered to recipients of child care assistance when Medicaid certification is for a whole year.

New Mexico Human Papillomavirus (HPV) Registry

Cosette Wheeler, Ph.D., regents professor of pathology at UNM and director of the New Mexico HPV Pap Registry, described the small DNA viruses that co-evolved with all animals as ubiquitous. There are more than 200 different types of HPV, she said, and while most of them are harmless, some high-risk types can cause cervical and other anogenital cancers as well as oropharyngeal and oral cavity cancers (see handout). Cervical cancer is the leading cause of cancer deaths worldwide, and there are more than 4,000 deaths in the United States alone each year. Through screening, vaccination and mandated reporting, New Mexico has become a world leader in research and prevention, with broad coverage of the highly effective HPV vaccine in adolescents. Vaccination programs in New Mexico target 11- and 12-year-olds, both female and male, before they become sexually active; it is voluntary, Dr. Wheeler said, and up to age 18, the current $120 cost will be covered by the state's Vaccines for Children Program. A new study co-authored by Dr. Wheeler suggests that a single dose of the vaccine Cervarix may offer as much protection as the recommended three-dose series of Gardasil, an important finding for worldwide application, especially in poorer counties. Randomized clinical trials are under way.

Dr. Wheeler said the state registry, housed at UNM through the DOH, has been funded through a grant from the National Institutes of Health; those funds will diminish through 2017, and state funds will be needed thereafter to maintain it.

Adjournment

There being no further business before the committee, the meeting was adjourned at 3:24 p.m.