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

October 19-21, 2015
State Capitol, Room 322
Santa Fe

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on October 19, 2015 by Senator Gerald Ortiz y Pino, chair, at 8:42 a.m. in Room 322 in 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 (10/19, 10/20)
Sen. Mark Moores
Sen. Benny Shendo, Jr.

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

Advisory Members
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Sen. Linda M. Lopez (10/19, 10/20)
Rep. James Roger Madalena (10/19, 10/21)
Sen. Cisco McSorley (10/19, 10/20)
Sen. Howie C. Morales (10/19, 10/20)
Sen. Bill B. O'Neill (10/19, 10/20)
Sen. Mary Kay Papen (10/19, 10/20)
Sen. Nancy Rodriguez
Rep. Patricio Ruiloba (10/20)
Sen. William P. Soules
Sen. Mimi Stewart (10/19, 10/21)

Sen. Sue Wilson Beffort
Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
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
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 19

Welcome and Introductions

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

International Statistical Classification of Diseases (ICD-10) Medical Codes

Steven Kanig, M.D., representing the New Mexico Medical Society, described the switch on October 1, 2015 to a new system of medical billing codes called the tenth revision of the International Statistical Classification of Diseases that contains five times as many diagnoses (70,000) as the old system (14,000). The costs to physicians of preparing for and implementing the ICD-10 have been enormous, he said, and include paying for upgraded electronic health records and new billing systems (see handout). No one really knows at this point who is going to benefit from the new system or whether it will expedite claims processing, a concern of many physicians since insurance companies can take up to 45 days to pay a claim, he said. The federal Centers for Medicare and Medicaid Services (CMS) has implemented several safeguards for physicians during the first year of transition, including authorizing advance payments if problems extend beyond the time limit for submission. In New Mexico, some private payers have agreed to similar safeguards. Dr. Kanig said he has prepared a more detailed examination of the history of the ICD-10 that he would be happy to share with committee members.

Jana Burdick, vice president and chief service officer, Presbyterian Health Plan (PHP), described PHP's team effort, utilizing outside experts, to focus on potential issues and responses to the ICD-10. The fact that the CMS implementation deadline was pushed back several times gave PHP more time to test responses, and now a standing committee reviews any denials so they can be immediately addressed. So far, the implementation has been going very well, Ms. Burdick said, with a rejection rate of just .004 percent. PHP also has a policy of helping to finance providers who are encountering problems, she stated.

Janice Torrez, divisional vice president of external affairs and chief of staff, BlueCross BlueShield of New Mexico (BCBSNM), also described a big investment in resources and training for the ICD-10. BCBSNM is offering support with a dozen dedicated provider advocates in New Mexico and a dedicated phone line for questions. A coordinated team of program experts meets daily to assist providers, Ms. Torrez said, and BCBSNM does not anticipate any problems for policyholders.

Elaine Jacobs, director of finance and analytics, Molina Healthcare (Molina), said her company's goal has been to make the ICD-10 transition as smooth as possible for providers. The more specific codes now being used in the new system have reduced the amount of time previously dedicated to "claims editing", she said, and now they just "fly" through the system; out of 25,000 new claims that have been submitted, only 92 were denied. Molina providers were eager to test the new code, and, because of their preparedness, the wave of anticipated phone calls never happened.

Carla Parmoon, director of network operations, United Healthcare, said that preparation for the ICD-10 has been a challenge, but United Healthcare has provided one-on-one training and coding practice with look-up tools and guides, as well as town hall meetings and webinars. United Healthcare also utilizes a special committee that meets daily and a call center that monitors problems with the ICD-10 and can assist providers in resubmitting a claim, she said. So far, Ms. Parmoon said, there have been very few provider issues.

OptumHealth New Mexico was invited to participate in this panel discussion and did not attend, but provided a handout describing its ICD-10 implementation efforts and reporting that there have been no provider complaints or calls (see handout).

In discussing implementation of the new code, committee members suggested that the LHHS closely follow the progress of this system over the next several years with an eye on how it improves patient care.

Medicaid Coverage for Pediatric Neuropsychological Services

Noah K. Kaufman, Ph.D., diplomate, American Board of Professional Neuropsychology, and diplomate, American Board of Pediatric Neuropsychology, stated that current state Medicaid and managed care organization (MCO) policies limit the number of reimbursable hours for a neuropsychological evaluation. Dr. Kaufman stated that this not only is unfair to the evaluator, who ends up either working pro bono or abbreviating the report, but it also is short-sighted for early identification and treatment of the troubled children being evaluated (see handout). Neuropsychology involves the clinical evaluation of problematic human behavior, and the five to seven hours (units) currently allowed for this evaluation are not nearly enough, Dr. Kaufman maintained. He is asking that this evaluation time be increased to 12 hours. Some MCOs are requiring that a practitioner who is unfamiliar with neuropsychology — a highly specialized field with few practitioners — make any determination of "medical necessity". These determining practitioners' lack of familiarity with neuropsychology leads them to deny services, according to Dr. Kaufman.

Wayne Lindstrom, Ph.D., director, Behavioral Health Services Division (BHSD) of the Human Services Department (HSD), who was in the audience, was invited by the chair to join the conversation. Dr. Lindstrom said increased hours of testing may be necessary in some cases, but it should be the exception rather than the rule. One committee member stated that this may

be a scope-of-practice issue, and another suggested it might be brought to the attention of the Medicaid Advisory Committee.

Mental Health Parity

Harris Silver, M.D., drug policy analyst and advocate and co-chair, Bernalillo County Opioid Abuse Accountability Initiative, told the LHHS that in the U.S., New Mexico ranks number one in alcohol-related deaths, number two in overdose deaths and number three in suicide deaths. The federal Mental Health Parity and Addiction Equity Act was signed into law in 2008 to correct common discriminatory health insurance practices against people with mental health and substance use disorders and to curb the ways that plans commonly limit access to care when compared to access for medical and surgical disorders (see handout). The law applies broadly to individual, small business group plans for over 50 employees, governmental and all Medicaid MCOs, children's insurance plans and alternative benefit plans. There are exceptions for some governmental programs — the Indian Health Service, Veterans Administration and Medicare Fee-for-Service or Medicare Advantage plans. In New Mexico, Dr. Silver said, almost none of the individual and family policies inside or outside the exchange offer residential treatment for behavioral health or substance use disorders. None of the Medicaid MCOs offer this except BCBSNM, which offers it as a value-added service when a physical disease is also present. Few of the large employers and almost none of the smaller employers offer this benefit, and when it is offered, it is only after the failure of outpatient treatment.

Dr. Silver described numerous problems with parity between behavioral health and physical health benefits in New Mexico, asserting that insurers are basically ignoring it and there is no enforcement of the law. He recommended that violations be reported to the superintendent of insurance and the attorney general and to the federal Department of Labor, the U.S. Department of the Treasury and the U.S. Department of Health and Human Services. He also urged legislators to convene a task force that includes representatives of the HSD, the Medicaid MCOs and providers to determine what parity should look like in New Mexico and to determine how "medical necessity" will be defined in various circumstances.

Lou Duran, community outreach coordinator, Turning Point Recovery Center, an alcohol detoxification (detox) and drug treatment program in Albuquerque, related the history of her own son who became addicted to prescription opioids and died of an overdose his sophomore year in college. New Mexico lacks resources, and patients are turned away from hospitals and sent home with medication unless they are in acute withdrawal. There are very few state-funded programs for treatment, she said, but you have to be detoxed first. Detox that is of a duration shorter than indicated for optimal outcomes contributes to relapse right after release. Ms. Duran urged legislators to make the changes necessary to save lives; addiction is a disease.

On questioning, committee members, Dr. Silver and Ms. Duran discussed the following issues:

- the need for further education of the public and providers about the law on parity;
- the possible role of crisis triage centers in providing detox;
- the use of the "medical necessity" determination as a means to deny services;
- a task force memorial for a broad study and clarification of parity issues; and
- the use of a waiver instead of a license, discouraging new companies from providing rehab services for New Mexicans.

The Helping Families in Mental Health Crisis Act of 2015 (H.R. 2646)

Pennsylvania Congressman Tim Murphy, who also is a practicing clinical psychologist and sponsor of the federal H.R. 2646, told committee members that people with serious mental illness can and do get better if they get early treatment from qualified providers. As a nation, the U.S. falls far short when it comes to treating mental illness, and more people die from complications of mental illness than from breast cancer. Congressman Murphy has been on the road in Florida, New York, Nebraska and Ohio explaining the details of H.R. 2646 and said he is happy to be in New Mexico today (see handouts). In a PowerPoint presentation, Congressman Murphy described the impetus for H.R. 2646 as the result of a systemic overview by the U.S. House Energy and Commerce Subcommittee on Oversight and Investigations of all federal programs, policies and spending on mental health. This investigation revealed numerous shortcomings, including: the warehousing of those with mental illness in detention facilities; racial disparities in treatment; provider and bed shortages throughout the nation; a lack of meaningful data collection; and uneven use of best practices, among many other findings. Of the $130 billion spent annually on mental health in the U.S., most of it goes to disability payments; very little trickles down to community services.

The intent of H.R. 2646 is to remove federal barriers to care by transferring all authority of the Substance Abuse and Mental Health Services Administration (SAMHSA) to a new assistant secretary for mental health and substance use disorders who will coordinate and report on research, treatment and services across all departments, agencies and organizations, Congressman Murphy said. It also would create a National Mental Health Policy Laboratory to establish standards for grant reform and restructuring, including: additional funding through block grants to states that have assisted outpatient treatment laws; amending both the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act of 1974 to allow some sharing of protected information with family and caregivers for individuals with serious mental illness or substance use disorders; eliminating the Medicare 190-day lifetime limit of inpatient psychiatric hospital services; increasing access to psychotropic prescriptions; and initiating other reforms, including a prohibition against lobbying by organizations that accept federal grant funding under the Protection and Advocacy for Individuals with Mental Illness Act.

Congressman Murphy said his bill is nonpartisan and currently has 142 co-sponsors, and he urged New Mexico legislators to ask their congressional delegation to support this bill.

On questioning, committee members and Congressman Murphy discussed the following issues:

- the importance of striking a balance between patient rights and family involvement;
- concerns that individuals with disabilities may no longer have access to advocacy;
- how the federal 16-bed limit and state funding of mental health treatment interact;
- anosognosia (lack of insight into one's own mental illness) is a small category with very big impact; and
- the importance of nationwide enforcement of mental health parity.

Ongoing Behavioral Health Topics

Jim Jackson, executive director, Disability Rights New Mexico (DRNM), said that Section 811 of H.R. 2646 would impose a gag order on his organization and all other protection and advocacy agencies throughout the country and would drastically limit their scope of services to persons with mental illness (see handout). The proposed legislation would restrict protection and advocacy agencies to addressing only abuse or neglect issues and would prohibit the use of federal funds for enforcing legal rights (40 percent of the DRNM caseload in 2014). Mr. Jackson reminded committee members that, serving as New Mexico's protection and advocacy agency, DRNM played a crucial role in helping to restore behavioral health services following the 2013 disruption of the system, activities that would be prohibited under H.R. 2646. DRNM has advocated crisis triage and more community services, he said, adding that he resents the implication that he and his colleagues are violating federal funding rules or are lobbying. Mr. Jackson also provided members with a copy of a letter (see handout) signed by 15 member agencies of the Consortium for Citizens with Disabilities and sent to the chair of the federal Energy and Commerce Committee, describing how H.R. 2646 would increase needless institutionalization, reduce privacy and eliminate legal advocacy for individuals with psychiatric disabilities and why a new bill is needed to replace it.

Patsy Romero, co-chair, Legislative Committee of the National Alliance on Mental Illness, shared the most current report from the CMS on the provision of behavioral health services in New Mexico between 2013 and 2014 (see handout). The reports coming from the state are lacking key information or data are not available, she noted, and the report does not provide any breakout by age or geographic location. It is inconclusive on whether there was an increase or a decrease of use of services over this period of time. Today, two years later, a lack of services continues to haunt New Mexico. Ms. Romero also noted that the HSD says it has suspended $11.5 million from providers accused of fraud but this is not the whole picture; it is withholding much more for claims that were pending. She urged committee members to continue to request data on this issue.

David Ley, Ph.D., board member, New Mexico Behavioral Health Providers Association, described a conundrum for behavioral health providers in schools. The state sent out a letter saying behavior modification services (BMS) could not be billed to Medicaid, and this has impacted services in many communities. There is also a letter from the CMS that states that schools are not liable third parties for services that kids need. Providers are caught in the middle of this, Dr. Ley said, and are requesting clarification from the LHHS. Dr. Lindstrom, who was seated in the audience, and who signed the first letter referenced, said that department review of practice patterns and claims data from some providers looked like BMS was being overprovided as a "teacher's aid" and not being delivered as described in regulation. Dr. Lindstrom said he was told by the HSD that the CMS guidance is not a mandate. Dr. Ley contends that, because of this conflict, kids are not getting services and providers are not getting paid.

Jeffrey Hunt, New Mexico outreach coordinator, Oxford House, spoke about high relapse rates (80 percent) for those with substance use disorders and how his nonprofit's supportive housing model dramatically reduces these numbers (see handouts). What happens to an individual after a 30-day treatment program is critical, and Oxford House provides a highly structured recovery network and safe living environment that has proven to be effective and inexpensive, at a fraction of the cost of relapse. Outreach staff provide 24/7 on-call services to help resolve conflicts and to coordinate outreach to associated treatment providers, drug courts, 12-step programs and the community at large. Oxford House currently has 135 beds in 18 houses in Albuquerque and Santa Fe. Mr. Hunt presented a proposal to increase its contract with the BHSD for fiscal year 2016-2017 to $253,402 (see handouts) to add two full-time male outreach workers and one female outreach worker and a minimum of 38 new recovery beds. Mr. Hunt noted that the Oxford House model is listed on the SAMHSA registry of programs that are evidence-based and that significantly improve treatment outcomes for substance abusers and those with co-occurring mental illness.

On questioning of panel presenters, committee members expressed frustration with the fact that no one representing OptumHealth appeared at today's hearing, since OptumHealth still holds millions of dollars that were withheld from behavioral health providers accused of fraud in 2013 while currently holding a contract to manage more than $9 million in general fund Medicaid spending. Members discussed possible ways to hold OptumHealth accountable and passed a motion to ask the HSD for copies of all audits and compliance reviews of OptumHealth. Another member who also serves on the Legislative Finance Committee (LFC) said he would take this issue to the LFC for review. Also, staff was directed by the chair to prepare a statement to the LFC regarding the conflicting letters of explanation about who pays for BMS in the schools.

Law Enforcement Assisted Diversion (LEAD)

Jason Lidyard, deputy district attorney, First Judicial District (Santa Fe, Los Alamos and Rio Arriba counties), has extensive knowledge of the heroin problem in this region. As a member of the LEAD Coordinating Committee, he provided an overview of the pre-booking diversion pilot project (see handout). Instead of taking low-level drug offenders to jail, those

who qualify are offered immediate linkages to treatment and social supports, including harm reduction and intensive case management. Providing clean needles and help with social services will keep people from resorting to property crime in order to get a bed and a meal, Mr. Lidyard said. The key is that sobriety is not required in order to participate in this voluntary program.

Casey Salazar, an officer with the Santa Fe Police Department, said that nearly every burglary suspect is also a heroin addict. When an individual is arrested, the police will ask if that person wants to participate in the LEAD program. An individual does not have to be arrested to participate. At present, there are 38 participants in the program.

Michael DeBernardi, M.D., clinical director, The Life Link, said care is being coordinated through his nonprofit community mental health center that has created partnerships for long-term housing and employment. Most of their clients are female and homeless, and more than 60 percent have a co-occurring mental illness. The LEAD program is focused on harm reduction, Dr. DeBernardi said, and, to date, no clients have died from an overdose.

Emily Kaltenbach, state director, Drug Policy Alliance, said that LEAD results in significantly lower recidivism and fewer arrests and incarceration, costing less to the correctional system. Santa Fe was one of the first cities to adopt this program in April 2014 after it began in Seattle in 2011, and it is now being looked at as a national model. Ms. Kaltenbach said that LEAD seeks an appropriation for direct services for this public-private partnership and a three-year evaluation plan that will examine outcomes in program implementation and impact.

On questioning, a committee member asked the panel presenters how the courts, media and the public are responding to LEAD. The media coverage has been very positive, presenters agreed, with many parents calling the police department to ask if their child can be in the program (a participant must be at least 18 years old), but the courts are not as enthusiastic, due to the fact that, when on probation and parole, an individual is required to obey the law. The President's Task Force on 21st Century Policing has endorsed this model, Ms. Kaltenbach said.

Public Comment

Jennifer Huff, who said she is from Southern California, testified on behalf of H.R. 2646. She is the mother of a severely mentally ill son who is incarcerated. She urged reform of civil commitment laws for the small group of people who are very ill like her son, who would never be able to live without supervision. The current system promotes civil rights to live in the gutter and die in the street, she asserted, but there is no right to treatment.

Disability rights groups do not represent people like her son, said Ms. Huff; they pursue cases against families who try to get their family members off the street. Congressman Murphy is a hero to families of the very mentally ill, and his bill is for people like her son, Ms. Huff stated.

Recess

The committee recessed at 5:25 p.m.

Tuesday, October 20

Welcome and Introductions

The meeting was reconvened at 8:45 a.m. by Senator Ortiz y Pino, chair, who welcomed those assembled and asked committee members and staff to introduce themselves.

Public Health Accreditation; 2017-19 Strategic Plan; Health System Innovation (HSI) Design; Contractor Services

Retta Ward, secretary, Department of Health (DOH), described her department's strategic plan for 2017-2019 (see handout), a planning process that defines roles, priorities and directions over a three- to five-year period. The strategic plan provides a guide for decision-making and priorities, and it is focused on results that are measurable. The state health assessment and state health improvement plan will be utilized to achieve the main goals: (1) healthier New Mexicans; (2) a high-performing workforce; and (3) administrative processes that support health status improvement.

Terry Bryant, policy and performance manager, DOH, described the plan in more detail and admitted that the DOH has had a high employee vacancy rate, that retention is the problem and that efforts are under way to address these issues. Shannon Barnes, accreditation coordinator, HSI director, DOH, described the multi-year accreditation process that documents DOH proficiency in 10 essential areas of public health and a commitment to ongoing quality improvement (see handout). In addition to recognition, accreditation can provide increased access to resources, help eliminate silos and drive organizational change, Ms. Barnes said. The DOH submitted its application in May 2013, received a site visit in December 2014 and is awaiting a final decision next month. Ms. Barnes also described a $2 million state innovation grant awarded to the DOH in partnership with the HSD to address a triple aim: reduced health care costs; enhanced experience of care; and improved population health. New Mexico's design for this grant will focus on three chronic and costly conditions — obesity, diabetes and tobacco use. The innovation grant is in the design stage; seven stakeholder committees have been assembled and input from tribal and county health councils is being included.

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

- the strategic plan focus on only DOH clients may be too narrow;
- the value of tracking teen runaways for early intervention efforts;
- accreditation is not always experienced as a guarantee of quality;
- reported DOH use of temporary employees automatically replaced after six months;
- concerns about whether a 50 percent reduction in teen pregnancy is an achievable goal;

- tobacco settlement funds not being contracted to local programs; and
- the possibility of including preventing gun violence as a DOH public health priority.

Health Assessment Data Presentation; Public Health Surveillance Indicators Report Data; Pain Study

David Selvage, chief of infectious disease epidemiology, DOH, described surveillance as the ongoing and systematic collection, analysis and interpretation of data for planning, implementation and evaluation of public health practice (see handout). Such surveillance is used to track infectious diseases like food poisoning, human plague, hepatitis B and hepatitis C, whooping cough and West Nile virus. Mr. Selvage also described several surveillance programs that partner with federal agencies to track emerging infections, health-care-acquired infections and Ebola virus preparedness in New Mexico.

Heidi Krapfl, chief, Environmental Health Epidemiology Bureau, DOH, said her bureau is a one-stop source that combines environmental exposure data with health data (https://nmtracking.org), including rates of cancer, birth defects, hospitalization, particulate and ozone exposure and other notifiable conditions such as lead or mercury poisoning (see handout). Other collections include hospital and emergency department data, birth and death certificate data and disease registries. Additional surveillance systems include behavioral risk factors, pregnancy risk assessment and monitoring and the New Mexico Youth Risk and Resiliency Survey. All data are used for making evidence-based decisions, Ms. Krapfl said. Calls that come into the bureau from the public are most frequently about mold and bedbugs.

Lois M. Haggard, Ph.D., director, community health assessment, DOH, described the important role of government in the assessment of public health in both clinical and community settings. In New Mexico, public health data are easy to access online (https://ibis.health.state.nm.us) through a website that provides a county-by-county snapshot of community health status indicators and disease registries (see handout).

Laura Tomedi, Ph.D., substance abuse epidemiologist, DOH, described the efforts of her department to put together a chronic pain study, as directed by House Memorial 98 (2015 regular session), probably with in-depth interviews by mail or by phone. However, no funding was provided. Conducting such a study would involve a major investment of staff time and resources, Dr. Tomedi said, including four full-time equivalents for one year to conduct and analyze the survey and additional resources for survey dissemination. On questioning by committee members, Dr. Tomedi estimated the cost at about $300,000, an expense one member asserted is clearly justified since New Mexico has the highest rate of drug overdose in the country.

Using Data for Achieving Better Health Care

Terry Reusser, chief information officer, DOH, said the department maintains more than 200 databases and is the custodian of the largest amount of data for the state spanning the lifetime of health care of New Mexico residents (see handout). Redundant data are being

captured, and, with various sources of the same data, it becomes a challenge to determine the best source. This also is inconvenient for constituents and those who are applying for services and programs. There has been a historic lack of standards for data, and implementing new data sources for providers is not as easy for some as for others, Mr. Reusser said. The federal Patient Protection and Affordable Care Act (ACA), the CMS and the federal Department of Health and Human Services are providing incentives for data use innovation and interoperability, he said, and opportunity exists for more collaboration and links to additional data sources to gain a robust picture of the state of health of New Mexicans. The days of siloed information are gone.

Patricia Montoya, director, New Mexico Coalition for Healthcare Value, agreed with Mr. Reusser that there are many opportunities to pull down data silos. Her employer-led nonprofit coalition of businesses and local governments received a six-year grant from the Robert Wood Johnson Foundation to help it become an innovative force for increasing the value of health care in New Mexico (see handout). Ms. Montoya provided an example of promoting value-based purchasing and more transparency in Albuquerque city government: when the city negotiated a contract with PHP, it required improvement in metrics of certain high-cost diseases and it required improved outcomes. New Mexico currently is not eligible for a lot of federal funding because it does not have an all-payer claims database, Ms. Montoya noted, and some Medicare data currently being used are two to three years old. The integrity of data and knowledge and the skill sets of those who work with it matter very much.

On questioning, a committee member suggested the discontinued New Mexico Health Policy Commission be reconvened; another member said what is needed is not a data warehouse but an umbrella, and a brain, to connect the data from various sources. New Mexico needs to move out of the planning phase, a member observed; the state does not have the tools to make intelligent policy decisions, and this just keeps getting pushed down the road.

Health Information System Act (Senate Bill 323 (2015 Regular Session)); Hospital Quality and Transparency Measures; Hospital Data Reporting

Judith Parks, deputy director, Division of Health Improvement (DHI), DOH, described the survey process for New Mexico's 53 DHI-licensed hospitals (40 acute care, four psychiatric and nine critical access) for 2015 (see handout). The surveys, directed by the CMS, examine health/program and life safety code and building issues, and plans of correction are required for serious infractions. The most common areas of noncompliance are patient rights, nursing services, infection control, pharmaceutical services and quality assurance improvement, she said, and the accuracy and timeliness of some data analyzed in these audits have been an issue.

Nandini Pillai Kuehn, Ph.D., health care systems consultant and board member of New Mexico Health Connections, said that the DOH data on hospitals are a gold mine, but that more information needs to be generated with a standardized reporting system, insurance coverage gaps need to be identified and a website should be created that is user-friendly. New Mexico has 37 hospitals with $12 million in gross revenues, but she is concerned about paralysis by analysis. Not every issue has to be solved in the first year; the database can start out with some

information. Discharge diagnosis is the standard for gathering information, and focusing on discharge data will result in savings. Pregnancy and birth are one of the highest cost areas, and the information needs to include New Mexicans who go out of state for high-risk pregnancies and cesarean sections. Emergency room data also are vital, including readmissions, since many of these could be handled by primary care. It is not necessary to wait until 2018 to set up a website, Dr. Kuehn asserted, because much of this information is available right now; blanks can be left for information that is still being developed. The DOH should be asked for a progress plan to roll this out; it is the only way to document progress, she said.

New Mexico Hepatitis C Coalition Update; Universal Vaccine Program Implementation; Vaccine Purchasing Act Implementation

Andrew Gans, manager, HIV, STD and Hepatitis Section, DOH, updated committee members on expansion of the Hepatitis C Coalition to include representation from the HSD, MCOs, corrections and community health councils, in addition to the DOH and community providers (see handout). The first meeting of the task force was in May 2014 and it is now meeting monthly, with a mission of prevention, testing and treatment to reduce the number of new infections as well as to cure the infection in those currently living with hepatitis C. Education is a primary goal to reduce stigma and health disparities and increase resources. Efforts to create a comprehensive plan are under way.

Dan Burke, chief, Infectious Disease Bureau, DOH, and Margaret Campos, manager, Immunization Program, DOH, described the accomplishments and growing pains of setting up the new program. Vaccination is one metric where the state of New Mexico has been doing well compared to the rest of the country, but primary care providers were having to absorb the costs. With the new vaccine program, the DOH estimates the total cost of vaccines for the year, requires insurers to report the number of children (0-18 years old) insured and then requires them to reimburse those costs to the state. Reporting data received by the DOH in August indicated there were 54,080 children privately insured, and the first of quarterly invoices were sent out in September totaling $5,056,564. To date, $3,475,998 has been received. Some confusion ensued over who should report these data when a third-party administrator was involved, and a few self-insured plans raised preemption issues between federal and state regulation. In addition, the invoice had incorrect contact information that will be corrected in the second quarter, Ms. Campos said. The DOH is collaborating with the Office of Superintendent of Insurance to streamline the process and to work out reporting issues.

Public Comment

Ron Hale, executive director, New Mexico Alliance of Health Councils, provided committee members with a handout about the 38 councils throughout the state, including three on tribal lands, and reminded them of the important role these councils play in coordinating programs and services at the local level. New Mexico's health councils are an effective means to ensure local health assessment, planning and coordination, especially in rural areas. During the 2010 budget crisis, state funding of $2.8 million was suspended, then partly restored in 2013 and 2015. In 2016, a $700,000 increase will enable the health councils to hire a part-time

coordinator. Mr. Hale strongly urged restoration of full funding for these vital links in the state's centralized public health system.

Jessica Gelay, policy coordinator, New Mexico Drug Policy Alliance, commented on several aspects of the new DOH regulations, including the requirement of an annual audit. There are no details on what this looks like, Ms. Gelay said. Also, there is a requirement that patients allowed to grow several of their own marijuana plants must have a sign-off from their landlord if they are renters. There was not a problem before, Ms. Gelay asserted, but there is now, as she has heard many complaints, and the new regulations require disclosure of personal health information. Lastly, she said, transparency is lacking on the process used to pick new medical marijuana producers from the large group of applicants.

Larry Love has been a cannabis patient since 2009. There are many states now that have medical cannabis programs, he said, and new regulations in New Mexico should be lightened up, not made more restrictive. Giving producers a 24-hour notice of impending inspection does nothing for the patient; anything can be cleaned up in 24 hours. Ultra Health (one of the new producers chosen by the DOH) owns another grower and has lawsuits against it in Arizona.

Recess

The committee recessed at 5:05 p.m.

Wednesday, October 21

Welcome and Introductions

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

New Mexico Medical Cannabis Program Update

Andrea Sundberg, program coordinator, Medical Cannabis Program, DOH, provided updated numbers of participants (18,343), up 6,557 over the last year, and described the new regulations that were adopted in February, including testing and labeling requirements, changes to licensing fees, provisions for approval of manufacturers, labs and couriers, and an increase in the number of plants (150 to 450) that nonprofit producers can possess. In addition, a new tracking system and database will enable the department to gather better statistics on producer inventory and sales and to track available product. The Florida vendor selected for this is BioTrack THC, also used by the states of Washington, Illinois and New York. Ms. Sundberg reported that the department recently completed a review of 86 applications for new production, and 12 of these were chosen by Secretary Ward as the most knowledgeable and able to offer a variety of products to meet enrollees needs, bringing the current total producers to 35. Awareness outreach to medical providers and to the public is ongoing, she said, and future changes will include removal of the "fail-first" requirement and confidentiality for licensed producers; at present, these names can only be released to law enforcement. Although Ms.

Sundberg did not have a program budget with her today, she said, there are plans to hire new staff for compliance and licensing.

On questioning, committee members and Ms. Sundberg discussed the following issues:

- the proper entity to conduct research on cannabis;
- problems with getting permission from landlords to allow cultivation;
- annual certification as a statutory requirement;
- testing and labeling requirements for edibles; and
- banking issues for producers.

African American Infant Mortality Pilot Project

Yvette Kaufman-Bell, director, Office on African American Affairs, reported on progress of the pilot program in Bernalillo County to address African American infant mortality and maternal health, as directed by Senate Bill 69 (2014). Ms. Kaufman-Bell said the project will need more time and more funding than the one year and $50,000 provided for the pilot (see handouts), which challenged her agency to partner with direct service providers to create a culturally competent prenatal health model for African Americans. She introduced Sunshine Lewis, pilot coordinator, and Christopher Whiteside, DOH epidemiologist, who worked on the project.

Ms. Kaufman-Bell described the choice of CenteringPregnancy (centering), a model of prenatal care that includes additional time and attention (two hours) in a group session along with each prenatal checkup (see handout). Centering teaches women to participate in their own care and has been shown to decrease pre-term birth rates by 30 percent. A contracted on-site midwife facilitates the group sessions, where participants are provided with information on a full range of options for where to give birth. The pilot project was delayed when the clinic chosen to host the pilot was moved from the University of New Mexico (UNM) campus to a North Valley community with a very low African American population. Also, the clinic director and the African American administrator left the program; no prenatal patients came with the move, and recruitment could not begin until the new clinic opened. Finding an African American provider is challenging in New Mexico, Ms. Kaufman-Bell said. There is only one African American midwife working outside of hospitals in New Mexico, and she was chosen to be a facilitator with UNM for the pilot. Eight women have signed up for the first group; the pilot is open to women of color.

Ms. Lewis showed committee members a brief video about the high rate of African American pre-term births that featured a lawyer who "did all the right things" while pregnant but still gave birth to a premature baby. Studies show the low birth weight phenomenon (three times higher for African American women) appears to be due not to race itself, but rather to chronic stress from the constant exposure to racism, Ms. Lewis said, and no level of education reduces this health disparity. Centering is being looked at as a national model to help address this issue. Centering is changing the cultural norms for patient and provider power dynamics, she said, with

the patient leading the discussion and the provider acting as facilitator. On questioning, committee members indicated their continuing support for the pilot project.

Hospital Community Benefit

Taylor Smith, a student at UNM School of Law who is working for the LCS, provided an information memorandum regarding finalized Internal Revenue Service regulations on nonprofit hospitals' charitable care mandated under the ACA (see handout). Nonprofit hospitals receive significant state and federal tax exemptions, and the increased regulation is intended to justify the value of those tax breaks. According to the new rules, nonprofit hospitals must establish written financial assistance policies, limit the amount charged for qualifying patients, make reasonable efforts to see if patients are eligible for assistance before engaging in extraordinary collection practices, conduct a community health needs assessment and adopt an implementation strategy once every three years. There are three levels of penalties for failing to comply, including the most severe penalty, loss of nonprofit status. Compliance will be mandatory as of December 29, 2015.

Report of House Memorial 113 (2015 Regular Session) Task Force on Psychology Education

Marilyn Powell, Ph.D., associate dean, School of Psychology, Walden University, presented a request for a change in state procedures to permit licensing of psychologists who receive their degrees online. Walden University, with academic offices in Minneapolis, Minnesota, is an online program that includes face-to-face components in its course work for doctorates in clinical and counseling psychology. Designed as a five-year program, Walden's offerings provide a means to address the critical shortage of psychologists in New Mexico (see handout), she said. Most Walden students are already employed, and women make up 75 percent of the student body. Currently, there are 312 New Mexico students registered in all areas of study. One of these students, Susan Kematz, described her enthusiasm for the online psychology program and said that she carries a 4.0 grade point average and is working as an intern at the Children's Treatment Center in Albuquerque. Ms. Kematz said she would like to become licensed but is prohibited by current state statute. Dr. Powell provided members with a chart that compared accreditation requirements of Walden versus three other academic programs (see handout). Many other states are more inclusive of the role of online education for psychologists, she said.

Thomas Sims, Ph.D., board member, New Mexico Psychological Association, is a member of the task force created by House Memorial 113 (2015 regular session) that has not met yet despite its December 1 deadline. The Higher Education Department has indicated that there will be a meeting in November, but a representative from Walden University was not named in the memorial as a task force member. Dr. Sims indicated his support for a proposal to change current statute to be able to license Walden graduates, and he urged inclusion of Walden on the task force. There is a problem with workforce in underserved areas, Dr. Sims said, offering an example of wanting to hire a psychologist from outside the state, but Centennial Care would not pay for reimbursement. Dr. Sims noted that state licensure laws are not always trusted by the

federal government; the U.S. Department of Veterans Affairs is the largest employer of psychologists, and it requires licensure and a degree from a nationally accredited program. Reimbursement for psychologists should be increased to help solve workforce problems, he said. Presbyterian Healthcare Services is now the backbone of behavioral health services in New Mexico, he said, and it currently has 20 openings for masters-level psychologists.

Committee members indicated that they would look forward to a progress report from the task force at the final LHHS meeting of the interim in November.

Health Information Exchange

Thomas East, Ph.D., is chief executive officer (CEO) and chief information officer of the New Mexico Health Information Collaborative (NMHIC) and the statewide Health Information Exchange (HIE) network. He described the importance of interoperability of health care information among hospitals, providers, emergency departments, diagnostic testing and others, and his collaborative's efforts to bring it together in the HIE. Since 2010, the collaborative has been contracted by the DOH to report on hospital emergency department and laboratory results, and Dr. East's presentation (see handout) listed hospitals, health systems and providers that have joined the HIE portal that went "live" in July. He also provided a sample of a complete medical-history-at-a-glance. While current fees have created a revenue stream sufficient to fund operations, the NMHIC's plans to expand statewide depend on full participation by large hospitals and health systems, regional hospitals, large provider groups and all MCOs and other commercial and governmental payers, Dr. East said. The main challenge is the cost of interfaces, but NMHIC is working with the HSD to explore using Health Information Technology Regional Extension Center funds for a 90 percent federal/10 percent state match to cover these costs. The second hurdle is getting organizations to share all elements of a common clinical data set. There is a pilot project to explore adding prescription monitoring to the HIE portal.

Services for Victims of Human Trafficking

Susan Loubet, director, New Mexico Women's Agenda, and a member of the task force on human trafficking, provided a history of legislation and memorials relating to the offense and victims' safe harbor and services (see handout). In 2015, the legislature appropriated $125,000 to the Crime Victims Reparation Commission specifically for victims of human trafficking, including emergency housing, shelter and cell phones, crisis intervention and culturally appropriate services, education, clothing and medical and prescription needs, among others. Memoranda of understanding with hotels, physicians and counselors can guarantee that services will be available even if the victim is not cooperating with law enforcement.

Frank Zubia, director, Crime Victims Reparation Commission, said trafficking victims unwilling to report to law enforcement can still access funding for primary services, but some collateral resources may be exhausted. He noted that these emergency funds for housing are not meant to be a substitute for the crime victim compensation program (see handout). Funds are administered through governmental and nonprofit agencies rather than directly to the victim and

can include help with housing, educational assistance, loss of wages, medical and dental care, child care, transportation and other related expenses.

Sharon Pino, deputy attorney general, Office of the Attorney General, described sharing a $1.5 million, three-year grant from the U.S. Department of Justice in partnership with The Life Link that seeks to enforce a three-pronged approach to the problem of human trafficking: (1) prevention; (2) prosecution; and (3) protection. No money in the grant goes to direct services, Ms. Pino said; each agency has to raise a $250,000 match that will go for services. Providing immediate services to victims is the focus, she said, adding that the New Mexico Office of the Attorney General leads the nation over the past year with a 100 percent conviction rate out of 20 cases prosecuted. Ms. Pino provided an information sheet from The Life Link detailing plans for training, community awareness and outreach and the scheduled December opening of a six-bedroom safe house for human trafficking victims, as well as copies of several other related articles (see handouts).

Asked by a committee member how many victims have been served, Ms. Loubet said that, over the past five years, 43 had been served, plus another 120 via the hotline. The $125,000 legislative appropriation just became available in July, Ms. Loubet said, and the task force will be asking for a renewal of these funds in the upcoming legislative session.

Public Comment

A member of the audience who identified himself as a minister asked members and the audience to remember victims who have been kidnapped and are being held as workers in businesses and sweatshops, noting that this is a form of slavery.

Update from Rio Arriba County Department of Health and Human Services (RACDHHS)

Lauren Reichelt, director, RACDHHS, told committee members there has been progress over the last year in Rio Arriba County, which now is seeking to expand the Rio Arriba Health Commons into a new building next door to the current location (see handout). Ms. Reichelt said that a new facility would include behavioral health and substance abuse treatment providers who would offer intense case management (Rio Arriba County has the highest heroin overdose rate per capita in the country) and a county adult daycare center and personal care services for disabled and elderly individuals, as there are very few long-term care options available. The new facility also would incorporate the HSD's Income Support Division field office for enrollment in Medicaid and other programs, assessments and services. Expansion of the health commons also will enable integration of dental care into the existing clinic.

Jon-Paul Romero, county building engineer, Rio Arriba County, presented a $6.2 million estimate of planning/zoning, design and construction costs for the proposed new building (see handout). This does not include costs for operation and maintenance. There are many potential partners for the proposed undertaking, Ms. Reichelt said, and the end result will be a much healthier community.

Generation Justice

Alden Bruce, web and video coordinator, Generation Justice, presented a 10-minute clip from the nonprofit's ongoing documentary examination of issues surrounding the behavioral health system in New Mexico. Having already produced more than 60 interviews with consumers, providers, citizens and legislators, this project provides insight into the state's fractured health care system and its human consequences. An earlier, and very successful, project of Generation Justice (heard weekly on Sunday nights on KUNM-FM) involved an examination of youth with mental health issues and is titled "When the Mask Comes Off".

Roberta Rael is director of Generation Justice, whose mission is to inspire youth to become media makers committed to social transformation. She said it is clear that the LHHS has been listening to people across New Mexico about the lack of comprehensive behavioral health services, overuse of medications, lack of providers, long waits for services and the stigma of seeking care. Generation Justice's interviews also provide some possible solutions, Ms. Rael said, and someday she hopes individuals can be interviewed about how well the system is working in New Mexico. People who have heard about the current documentary project are calling and offering to be interviewed, she said. Generation Justice would be happy to collaborate on a project with the committee.

Public Comment

Mark Johnson, CEO, Easter Seals El Mirador, said Generation Justice validated what was already known about New Mexico's behavioral health system and reinforced the fact that there is a crisis. He complimented the work of the young journalists.

Patsy Romero, chief operating officer, Easter Seals El Mirador, said there has been a statewide dismantling of comprehensive services for mental and behavioral health. Her organization lost eight clinicians, and potential new ones are fearful of relocating to New Mexico. A committee member asked Ms. Romero how much is still owed to her agency by the state for services provided before the funding freeze in 2013. It is well over $17 million, she responded, noting that her agency had to lay off 162 people and is still paying for it in unemployment benefits.

Adjournment

There being no more business before the committee, the meeting was adjourned at 4:20 p.m.