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

**September 20-22, 2017**
**Science and Technology Center Rotunda**
**University of New Mexico**
**801 University Boulevard SE**
**Albuquerque**

The fourth meeting for the 2017 interim of the Legislative Health and Human Services Committee (LHHS) was called to order on September 20, 2017 by Representative Deborah A. Armstrong, chair, at 9:24 a.m. in the rotunda of the Science and Technology Center at the University of New Mexico (UNM). A quorum was present.

**Present**
Rep. Deborah A. Armstrong, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Gail Armstrong
Rep. Rebecca Dow (9/20)
Sen. Mark Moores
Sen. Bill B. O'Neill
Rep. Elizabeth "Liz" Thomson

**Absent**
Sen. Cliff R. Pirtle

**Advisory Members**
Rep. Joanne J. Ferrary
Rep. Miguel P. Garcia
Sen. Linda M. Lopez
Rep. Rodolpho "Rudy" S. Martinez (9/20, 9/21)
Sen. Cisco McSorley
Sen. Howie C. Morales
Sen. Nancy Rodriguez (9/22)
Rep. Patricia Roybal Caballero
Rep. Angelica Rubio (9/22)
Sen. William P. Soules (9/21, 9/22)
Sen. Elizabeth "Liz" Stefanics
Sen. Bill Tallman (9/22)
Rep. Christine Trujillo (9/20, 9/21)

Sen. Gay G. Kernan
Rep. Tim D. Lewis
Sen. Mary Kay Papen
Rep. Nick L. Salazar

**Guest Legislator**
Rep. Bill McCamley (9/22)

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

**Staff**
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Karen Wells, Contract Staff, LCS
Michelle Jaschke, Researcher, LCS

**Guests**
The guest list is in the meeting file

**Handouts**
Handouts and other written testimony are in the meeting file.

**Wednesday, September 20**

The chair convened the committee at 9:24 a.m. The committee members and staff introduced themselves.

**Welcome and Updates from the UNM Health Sciences Center (HSC)**

Paul Roth, M.D., chancellor for health sciences, UNM HSC, provided an update on the UNM HSC to the committee. He noted that the mission statement of the UNM HSC is centered health and health equity. He highlighted a proposal for a new medical facility. The project will be rolled out in phases, Dr. Roth said, with a total cost of $684,029,388 and an anticipated final completion date of 2025 through 2027. The benefits to New Mexicans will include access to a higher level of care with improved clinical outcomes. The construction phases will result in a positive economic impact for the state, providing up to 2,000 construction jobs, Dr. Roth noted.

Dr. Roth described many accomplishments of the UNM HSC, including increased research, a new partnership with Lovelace Health System and a healthy neighborhoods initiative. He identified key staff changes and the active search processes under way to convert interim positions to permanent ones. Improvements are under way for the Domenici Center for Health Sciences Education that will substantially improve adult learning opportunities. He highlighted recent large research grants and some clinical successes.

Dr. Roth concluded his presentation by describing several legislative proposals that UNM HSC will be bringing to the legislature in 2018. Areas identified include changes that improve the reporting of suspected child abuse; enhance the exchange of information among mental health providers; implement several recommendations of the J. Paul Taylor Early Childhood Task Force; and improve screenings for adverse childhood events in the Medicaid Centennial Care waiver program (Centennial Care). He recognized that the probability of increased funding creates a challenge.

Questions and comments from committee members covered the following topics:

- whether the UNM Board of Regents supports the project to build a new medical facility; the board is fully supportive;
- the extent to which care is provided for patients without insurance or Medicaid coverage; elective procedures require patient payment of 50% of the cost of the procedure in advance;
- whether county indigent funding could be used for procedures that are not clearly elective but that may be medically necessary; Bernalillo County does not have an indigent fund; mill levy funding supports the general operations of the hospital;
- clarification regarding the process by which decisions about medical necessity are made; the decisions are made by physicians, and patients may request a waiver if denied; the process uses the same criteria as required by Medicaid;
- why so many key leaders have decided to leave the UNM HSC at this time; according to exit interviews, there is not one single reason, but there is a perception of a lack of support for, and even hostility toward, higher education in New Mexico, as well as a perception of an unstable economy;
- clarification regarding community outreach impact; the map in the handout shows the estimated number of people served in specific areas of the state; Representative Gail Armstrong requested specific information about services provided in Omega; Dr. Roth said that he would provide the information;
- whether the UNM HSC serves Navajos on the Navajo Nation; Dr. Roth said that he is not sure;
- a request to see the new guidelines for prior authorization for medical necessity once they are established; Dr. Roth offered to provide the guidelines to the committee;
- clarification regarding how a procedure recommended by a surgeon could subsequently be denied; it is possible that a review of the prior authorization guidelines would result in overriding in a surgeon's recommendation;
- what the estimated loss of $3 billion to $5 billion under the congressional Republican Party proposal to repeal and replace the Patient Protection and Affordable Care Act (ACA) would mean to the UNM HSC; dramatic reductions in the federal match for Medicaid would result;
- clarification regarding funding sources for the UNM Comprehensive Cancer Center; Dr. Roth said that he will provide the information;
- clarification of sources for funding of capital projects; the mill levy cannot be used for this purpose; general obligation bonds are sometimes used;
- whether grant funds can be leveraged to obtain additional federal funds; no;
- whether UNM uses the method of "surprise balance billing" for care not covered by insurance; payment plans can be established that a patient can afford; the most vulnerable people's accounts are not sent to a collection agency;
- a request for information regarding communities in New Mexico where UNM is the only provider of services;
- a request for the number of new businesses that now exist as a result of UNM research projects, especially genomic research;

- recognition that any loss of funds due to health care reform will negatively impact the ability of UNM to train health care professionals; Dr. Roth noted that UNM already has to seek additional funds to cover the costs of education and research; any additional loss of Medicaid funds would have a significant impact;
- clarification regarding the annual costs to support medical residents; costs vary based on the specialty; primary care residents receive the same salary as all residents in their first year; Dr. Roth will provide the exact scale of salaries for residents;
- how UNM determines when to issue or respond to requests for proposals (RFPs), especially in rural areas; the determination is based on an evaluation of needs or capacity to respond; Dr. Roth will provide additional information;
- whether the existing UNM Hospital will remain operational once the new facility is built; outpatient services and programs located elsewhere in Albuquerque will occupy the current hospital when the new facility is complete;
- whether the new facility will expand the number of beds currently available; yes, by about 60 beds;
- concern regarding the number of patients who cannot be served at UNM and how this situation can be mitigated; partnerships with other entities can be pursued, and UNM is actively pursuing those partnerships; and
- concern that UNM is not in network with all Medicaid managed care organizations (MCOs).

**Results First**

Charles Sallee, deputy director, Legislative Finance Committee (LFC), Kristen Pendergrass, principal associate, Pew-MacArthur Results First Initiative (PMRFI), and Benjamin Fulton, senior associate, PMRFI, were invited to address the committee. Also, Mara Weinstein, senior associate, PMRFI, was introduced as a person available to provide technical assistance.

Mr. Sallee described a process of legislating for results that the LFC has been developing in partnership with the PMRFI. He discussed the elements of an evidence-based policy and budget framework. Performance measures identify priority areas, help to highlight the need for additional oversight and help to develop meaningful budgets. This approach grants agencies greater flexibility in spending within the performance measures the agencies have identified. The experience of the Children, Youth and Families Department (CYFD) was highlighted as an example of how results-based accountability supports effectiveness in service delivery and demonstrates that dollars to support programs are being spent wisely. Reliance on evidence-based approaches has allowed the LFC to partner better with the executive branch of government.

Mr. Fulton described the PMRFI's efforts to bring evidence into the budget process through program inventory and benefit-cost analysis and through using results to drive priorities. The PMRFI is working with several states, including New Mexico, to implement this approach, with great success. The PMRFI has created a Results First clearinghouse database that allows comparisons of programs with strong literature on effectiveness of approaches. A model for

benefit-cost analysis allows evaluation of programs. The PMRFI is working in 26 states and 10 counties to implement this approach. The organization has been working with New Mexico long enough to see very successful results, Mr. Fulton said.

Ms. Pendergrass identified health as a new policy area for the PMRFI. She identified what the PMRFI is and is not involved in. The focus of the program is to identify the most effective areas in which to work. The PMRFI is working with the LFC, the Human Services Department (HSD) and the Department of Health (DOH) to inventory program areas and assign responsibility to each partner. The group anticipates findings and preliminary results in the spring of 2018. The chosen areas of focus are diabetes prevention, obesity reduction, patient-centered medical homes, smoking cessation and prevention, substance abuse disorders, behavioral health integration, planned pregnancies and birth outcomes.

Committee members gave comments and offered questions in the following areas:

- an observation that New Mexico has experience in using performance data to flag problems and identify possible approaches to serve as guides in the area of health policy;
- how inconsistencies in implementation at the program level are identified; the LFC starts with the state and evaluates the high-level performers;
- clarification regarding why a program might rank higher or lower on program effectiveness but not rank well on benefit-cost analysis; based on how predictions emerge from the clearinghouse database, local choices are made in how much can be spent for what degree of results;
- clarification regarding the appropriate role of the LHHS; the LHHS has a major interest in improving the health of New Mexicans; the results reported by the LFC should help to inform policy recommendations for the future; conversely, the policy findings and priorities of the LHHS will help the LFC in setting budget priorities;
- recognition of opportunities for legislative committees, the LFC and state agencies to align initiatives;
- whether the PMRFI has been negatively affected by partisan political bias, especially relating to tobacco cessation programs; the PMRFI is focused on evidence-based research; political influence is beyond the scope of its project;
- ways in which this information could be more widely shared; it is available on the LFC website using drop-down menus;
- enthusiasm that the PMRFI and the State of New Mexico are expanding into the realm of health;
- a recommendation that it would be helpful to include national benchmarks on report cards that show New Mexico's goals; and
- a recommendation that fiscal impact reports should strive to reflect evidence-based results and benefit-cost analysis when possible.

**Centennial Care 2.0 Concerns**

David Machledt, Ph.D., senior policy analyst, National Health Law Program, provided an overview of the National Health Law Program with specific focus on Medicaid 1115 demonstration waivers (1115 waivers). He said that the purpose of 1115 waivers is to target low-income populations. He noted that, in recent years, four types of waivers have emerged: managed care waivers, delivery system reform waivers, uncompensated care pool waivers and expansion waivers. He noted that the proposed new 1115 waiver application under the state's Medicaid program, known as "Centennial Care 2.0", is a combination of all four types of waivers. Ongoing monitoring and evaluation are required with a waiver; however, efforts have fallen short in this area. In order to be approved, the 1115 waiver must demonstrate that the waiver is an experiment that is likely to promote the objectives of Medicaid.

Mr. Machledt highlighted key issues in the Centennial Care 2.0 proposal. He contended that many elements of the proposal are consistent with the federal Medicaid Act and meet the standard of an experiment; however, other elements merely seem targeted to cuts in the program and do not meet the required standards. For example, premium and cost-sharing provisions are not an experiment — at least six other states already evaluate this. Mr. Machledt contended that the provisions do not promote the objectives of Medicaid and are outside the scope of waiver authority.

Abuko Estrada, staff attorney, New Mexico Center on Law and Poverty, addressed the cuts proposed in the Centennial Care 2.0 proposal. He began by identifying ways in which Medicaid is vital to New Mexico and its economy. While there are elements of the proposal that are good and support growth in valuable programs, the cuts, overall, are damaging. Mr. Estrada contends that these cuts are ultimately costly and represent hidden taxes for low-income families. Another troublesome element in the proposal is the recommendation to end retroactive coverage, which has the potential to throw families into financial debt. Additionally, uncompensated care costs will increase for health care providers, he said. The waiver proposal would cut health benefits for parents and caretakers in deep poverty, eliminate the early periodic screening, diagnostic and treatment program for children who are 19 to 20 years old and allow for drastic cuts in the future to transportation. Finally, it proposes an end to transitional Medicaid assistance to those individuals who are moving from deep poverty to independence. He expressed hope that the LHHS would make comments in support of the good elements of the proposal, while objecting to the cuts.

Questions from the committee were deferred at the request of the chair until after the presentation by the HSD secretary.

**Medicaid Revenue Enhancement**

Jeff Dye, president and chief executive officer, New Mexico Hospital Association, reviewed the New Mexico Hospital Association's proposal on taxation. He began by emphasizing that the proposal is not a provider tax. Key elements of the proposal are that all not-for-profit, governmental and investor-owned hospitals would pay the gross receipts tax, the

estimated proceeds of which have been estimated at $107 million. The New Mexico Hospital Association proposes to appropriate the revenue as follows: $26 million for Medicaid, through the County-Supported Medicaid Fund, and $81 million to the General Fund. Together, this could generate an additional $400 million, if used exclusively for Medicaid, Mr. Dye said. The bill was carefully developed with consultant input, including input from Cindy Mann, the former director of the Centers for Medicare and Medicaid Services.

Linda Sechovec, executive director, New Mexico Health Care Association, presented a different proposal, which the New Mexico Health Care Association is willing to name as a provider fee. Her presentation highlighted opportunities and barriers associated with intergovernmental transfer (IGT) programs and provider fee programs. The New Mexico Health Care Association prefers a provider fee approach. The association has carefully analyzed this approach and the impact that it could have in New Mexico. She noted that 44 other states have laws that allow providers to contribute to the state in order to draw down the federal match. The New Mexico Health Care Association proposal would generate an estimated $26 million, $5 million of which would go to the HSD for administrative costs to fund the program. Ms. Sechovec worries that the window to establish such a program may close in the future.

Ms. Sechovec presented a grim picture of nursing facilities in the state that are so underfunded that they can no longer ensure safe care.

Committee members had questions and concerns in the following areas:

- an observation that nursing homes have no ability to pay overtime wages due to limitations in the reimbursement formula;
- clarification regarding the difference between an IGT and a provider fee; IGTs are much more complex and burdensome, while provider fees could be implemented more easily, especially since so many other states have implemented them; and
- clarification that both the hospital proposal and the nursing home proposal, though different in implementation, provide for an ability to obtain federal matching funds.

**Centennial Care 2.0 Update**

Brent Earnest, secretary, HSD, introduced Nancy Smith-Leslie, director, Medical Assistance Division, HSD. Secretary Earnest reminded the committee that a concept paper had been distributed in May. He began by presenting the time line of the process to renew Centennial Care to what is now called Centennial Care 2.0. So far, he stated, the HSD has conducted a public comment period and engaged in tribal consultations. Secretary Earnest reviewed the guiding principles of Medicaid reform, which are to develop a comprehensive delivery system, emphasize payment reform, simplify program administration and encourage personal responsibility. He gave details on how each of these elements had been addressed in the implementation of the original Centennial Care.

Centennial Care 2.0 builds on the successes of the original waiver, focusing on the improved and refined elements of the original design. The six areas of focus in Centennial Care 2.0 are as follows: care coordination; behavioral health integration; long-term services and supports (LTSS); payment reform; member engagement and personal responsibility; and administrative simplification through refinements to benefits and eligibility. He went into detail about each of these areas of focus.

1. Care coordination goals include increasing coordination at the provider level, improving transitions of care, expanding programs that work with high-needs populations, introducing activities for incarcerated individuals just prior to release, piloting a Medicaid-funded home-visiting program and obtaining 100% funding for Native American services.

2. Behavioral health integration involves expanding health homes, supporting workforce development and developing supportive housing services.

3. Opportunities for LTSS will include start-up goods for transitions to self-directed care, increasing caregiver respite hours, ensuring long-term continuation of access to community benefits services by imposing limits on some self-directed services, automatically designating nursing facility levels of care for patients whose conditions are not expected to change and using Project ECHO to provide expert help for staff.

4. Payment reform measures involve an increase in the number of providers who engage in risk-based reimbursement and the greater use of value-based payment arrangements. Changes to safety net care pool components are intended to shift focus toward quality initiatives and away from uncompensated care.

5. Member engagement and personal responsibility elements include continuing the Centennial Care rewards program, allowing providers to charge small fees for three or more missed appointments and imposing premiums for populations whose income exceeds 100% of the federal poverty level. Secretary Earnest outlined the proposed premium structure. The waiver also proposes requiring copayments for certain populations. He also outlined the structure for copayments. Tracking requirements for cost sharing and expansion of opportunities for Native American participation in Medicaid are also included, Secretary Earnest said.

6. Proposals for administrative simplification will occur through refinements to benefits and eligibility. Coverage for most adults will be consolidated under one benefit plan. Provisions to buy into dental and vision services will be provided. Retroactive eligibility will be eliminated for most beneficiaries, as is transitional Medicaid coverage. Eligibility requirements will be modified in the family planning program. Authority is sought to waive limitations imposed on institutions for mental disease to cover mental and substance abuse services and to allow former foster care individuals to be covered up to age 26. The waiver proposes enhanced administrative funding for expanded availability of long-acting reversible contraceptives (LARC).

Public meetings are scheduled in Santa Fe, Las Vegas and Las Cruces, as is an additional tribal consultation, Secretary Earnest said.

Secretary Earnest gave a brief description of the fiscal year (FY) 2018 Medicaid budget, noting that this has not yet been presented to the LFC. The bottom line is a request for $81.5 million, which could be reduced to $35 million if Congress reauthorizes the Children's Health Insurance Program (CHIP). Watching enrollment trends is crucial, Secretary Earnest said. Federal action to repeal and replace the ACA could have a significant impact. Medicaid enrollment currently appears to be leveling out, Secretary Earnest said. Enrollment growth has led to an historic low in uninsured people in the state.

Members of the previous panel were invited to join the HSD panelists to answer questions. Committee members had questions and expressed concerns in the following areas:

- clarification regarding eliminating non-emergent transportation benefits; the proposal is limited to healthy adults;
- an observation that implementation of copayments and premiums are not shown to be effective; the HSD believes that the construct for this proposal is construed tightly enough to have the desired effect;
- whether the administrative cost to impose copayments outweighs the intended purpose;
- clarification regarding the status of nurse hotlines at the MCOs; every MCO is required to have a nurse advice line;
- whether the waiver changes will impair the ability of a person to obtain needed prescription drugs when over-the-counter drugs are available; no;
- clarification regarding the meaning of "risk-based" reimbursement;
- whether the proposal includes a discontinuation of coverage for mental health services after a certain age; no;
- a recommendation that additional public meetings be held in the evenings or on a weekend;
- whether a legal challenge could be entered to block the imposition of premiums; several states have already been approved to impose premiums;
- whether the projected income from premiums is identifiable and what would be done with the revenues; there are many details to be worked out; however, it is anticipated that the MCOs would have the responsibility to collect the premiums;
- whether MCOs would collect copayments; no, providers would have that responsibility;
- whether increases in reimbursement for nursing facilities are anticipated; proposals are being developed for value-based payments; provider fees can be pursued outside of the waiver application;
- whether the Programs of All-Inclusive Care for the Elderly, known as PACE, could be expanded and incorporated into the waiver program; it might be possible to discuss outside of the waiver;

- clarification regarding access to self-directed community benefits; anyone eligible can enroll; this program is separate from the developmental disability waiver and the Mi Via waiver;
- whether any people who have attended public meetings so far are Medicaid beneficiaries; it is very hard to identify, as that question is not asked;
- concern about individuals who might not be able to access Medicaid upon elimination of retroactive eligibility;
- whether, hypothetically, if the budget shortfall could be eliminated, it would alter the proposals for cuts; it is not just a matter of passing new taxes, but that additional revenue would need to be appropriated to Medicaid;
- concern that anticipated cost savings from the waiver are not reflected in the budget; any savings from changes in Medicaid due to the waiver will not be seen in time to affect the FY 2018 budget; a member requested a detailed justification for why the waiver cost savings are not reflected in the budget projection;
- clarification regarding the governor's position on current health reform proposals in Congress; discussions with the governor have been about the impact on New Mexico residents and the recognition that New Mexico has very little room to adapt to proposed changes;
- concern that proposals in the waiver do not respect the actual needs and situations of the typical Medicaid beneficiary;
- clarification on how public comment is used; stakeholder comments result in modifications and changes to the waiver proposal; comments are tracked, summarized and answered; summaries are available;
- ways in which the HSD works to provide respite workers who communicate in multiple languages; no funding is sought in the budget for this purpose;
- why comprehensive family planning coverage is being eliminated; it is not a comprehensive program at present, and the coverage is not being changed; the goal is to make clear and simple access to a currently confusing program;
- clarification about why transitional and retroactive coverage is being limited; the HSD believes that expansions in some other areas will mitigate the need for these features;
- recognition that Medicaid expansion has had a very positive impact on the state;
- clarification regarding the percentage of New Mexicans on Medicaid; roughly 40%;
- whether the governor will review the final draft; it will be discussed with her;
- whether Medicaid premiums were approved under waivers sought during President Barack Obama's administration; yes; some states had premium programs during that time;
- whether the waiver proposes a mechanism to exempt people from premiums if they are too poor to pay them; it is a detail that will have to be worked out;
- clarification about the term "value-based purchasing"; it is a payment structure that strives to improve outcomes;
- a request to receive the contact information for all of the MCO nurse hotlines;

- whether there is currently an external evaluation of Centennial Care; yes, it is part of the waiver requirements; also, annual reports on the program are posted on the HSD website;
- a recommendation that retroactive eligibility be phased out rather than eliminated all at once;
- whether there are studies of other states that have imposed copayments and the impact of imposing copayments; yes, some of these studies are posted on the website of the National Health Law Program;
- recognition that there are legal questions that govern waiver applications, but there are also policy questions that must be considered regarding what is good policy for this population;
- an observation that there is a movement in the private insurance market to eliminate copayments altogether; the proposal does suggest not charging copayments in certain circumstances;
- concern that copayments and premiums become an administrative burden on providers and MCOs;
- whether there is consideration to try to obtain a Medicaid match for home visiting; that is the hope;
- whether there is consideration to try to provide critical dental services; the services exist today and will be continued;
- whether new revenues will be sought for the safety net care pools; no, they are proposing a restructuring to focus on quality;
- whether mechanisms proposed by the New Mexico Hospital Association and the New Mexico Health Care Association will receive consideration; the HSD is concerned because a previous iteration of a nursing home bed tax was problematic; the hospital proposal should be considered within a larger tax framework; there are technical issues that would need to be sorted out;
- recognition that there are many complex details that must be worked out before the waiver is submitted; and
- an announcement that Governor Susana Martinez has publicly opposed the latest congressional health care proposal.

**Public Comment**

Mandy Pino, advocate, spoke on behalf of Progressive Democrats of America, Central New Mexico Chapter, and the beneficiaries who face despair if they lose access to Medicaid.

Bill Jordan, New Mexico Voices for Children, reminded the committee that the Medicaid expansion more than pays for itself through 2020, according to many studies. He announced that New Mexico Voices for Children is opposed to the Centennial Care 2.0 waiver proposal. Health care is the only sector in New Mexico that has grown in the last several years, he said.

Robert Kegel has reviewed the waiver and has tried to obtain input from affected individuals. The developmental disabilities (DD) waiver is deficient in many ways, Mr. Kegel

stated. However, Jim Copeland, director of the Developmental Disabilities Supports Division of the DOH, which co-administers the DD waiver in coordination with the HSD, said that the agencies are working to correct these deficiencies. The Centennial Care 2.0 waiver remains problematic, largely due to the capitated rate paid to MCOs to manage the program. This method of reimbursement incentivizes the MCOs to not provide care in order to increase profits. A letter from Ronda Gutierrez provides a heartbreaking story of how the system is failing. Data must be more transparent.

Michelle Melendez, director of EleValle in the South Valley of Albuquerque, commented on UNM Hospital's policy of requiring 50% payment up-front for services that are deemed not medically necessary. She stated that Dr. Roth had contended that affected patients had not contacted UNM Hospital to complain about the policy; however, Ms. Melendez has seen six complaints from affected individuals. She is convinced that many more are affected. She contends that the payment plan is unfair and arbitrary.

Liza Gomez, San Juan County, commented on the fact that counties contribute to health care through county indigent funds. San Juan County provides dental services for people who are on Medicaid or who are uninsured. She supports the care coordination provisions and initiatives in the Centennial Care 2.0 proposal that will serve those who are incarcerated. She believes that the changes should focus on increasing access to care and implementing health literacy, especially for high-risk populations.

Virginia Castille Dixon is an AARP volunteer. She conveyed AARP comments on Centennial Care 2.0, which will be sent to the HSD. AARP believes that Medicaid should be looking for ways to expand coverage and that cuts will be disastrous. The AARP, she said, is supportive of measures to increase respite for family caregivers.

Colin Baillio, Health Action New Mexico, stated that his organization's main concern regards premiums and copayments and the elimination of transitional coverage. Copayments are especially burdensome for people with low incomes who have prescriptions that must be regularly filled. Shifting costs to individuals will result in higher overall costs and poorer outcomes.

Barbara Webber, executive director of Health Action New Mexico, stated that the Centennial Care 2.0 waiver proposal essentially eliminates dental coverage. Ignoring dental disease results in many complex health problems. Dental disease is the number one childhood infectious disease, and it is completely preventable, she said.

Lisa Johnson is a family therapist in private practice in Albuquerque with about 50% of her practice devoted to Medicaid families. She shared a story demonstrating the difficulty in obtaining mental health services in New Mexico.

Ellen Pinnes, The Disability Coalition, commented that the current proposal to repeal and replace the ACA will cost billions of dollars to New Mexico and should be opposed. She highlighted the recalculation of a new annual cap in the Centennial Care 2.0 proposal that could require a Medicaid beneficiary to pay a significant amount of money out of pocket. She also urged a closer look at the legal requirements for waiver applications.

Senator Ortiz y Pino suggested that the committee consider sending a letter to Dr. Roth regarding the cost-sharing requirements for surgery not considered medically necessary.

**Recess**

There being no further business, the committee recessed for the day at 7:50 p.m.

**Thursday, September 21**

**Welcome and Introductions**

Representative Deborah A. Armstrong reconvened the meeting at 9:00 a.m.

**Access to Contraceptive Coverage: Report of the LARC Task Force**

Erin Armstrong, staff attorney, American Civil Liberties Union, provided an overview of access to contraceptive coverage provided by the ACA, Medicaid and the federal Title X program, which provides coverage for uninsured or underinsured individuals. Ms. Armstrong outlined current gaps in federal requirements, noting that the ACA does not require contraceptive coverage for men, over-the-counter coverage, unless it is prescribed, or coverage for multiple months of contraceptive supplies. She further provided an analysis of legislative efforts in New Mexico to solidify some of the more vulnerable ACA rules, and she urged the committee to push the HSD to make contraceptive coverage and access to LARC explicit in the Centennial Care 2.0 waiver renewal plan.

Denicia Cadena, policy and cultural strategy director, Young Women United (YWU), presented information regarding the New Mexico LARC Workgroup convened by YWU. The workgroup's goals are to improve access to reproductive health care, specifically contraception, for women and all people in New Mexico and to leverage resources to effectively expand access to LARC in appropriate and impactful ways. Ms. Cadena gave an overview of the many organizations participating in the New Mexico LARC Workgroup, including both provider and advocate communities. Strategic priorities for the organization include policy development, advocacy, provider and staff education and training, cultural humility in outreach and education and comprehensive evaluation and shared fundraising strategies.

In response to committee members' questions, the panelists clarified the following issues:

- the wide range of costs described for intrauterine devices (IUDs) and implants relates to prior subsidies from a foundation for certain IUDs that lowered costs substantially;
- the average cost of the IUDs and implants now is around $600;

- the costs of IUDs and implants relate mainly to the cost of the devices, not to the cost of placement or implantation;
- placement and implantation of IUDs and implants both require trained clinicians;
- the federal Food and Drug Administration has approved the use of the various IUDs and implants for periods of three to 10 years; and
- the IUDs and implants are cost-effective in comparison to traditional contraceptives, given their useful life.

Ms. Cadena noted that a key element of LARC, that of immediate reversibility, is essential to reproductive freedom. Members discussed the following: the need to gather data to clarify the claim that LARC is cost-effective; the need for appropriate outreach to tribes and the Navajo Nation; and the provisions of the Centennial Care 2.0 plan with respect to LARC and male contraception. One member requested that the presenters provide an estimate to the committee regarding the cost to gather information on whether the use of LARC has an impact on the transmission of sexually transmitted infections.

A member requested that the letter drafted in response to the Centennial Care 2.0 presentation include a point regarding the importance of leaving access open for family planning throughout life, instead of the proposed cutoff point of age 50, noting that other issues of sexual health and men's capacity to reproduce well beyond age 50 bear on this issue.

Another member asked that the committee also address the issue of school-based health clinic and public health clinic closures. She noted that clinic goals can be politicized, but closures limit care, particularly preventive care.

A member remarked that unbundling LARC would be a good thing. Unbundling, she explained, is the policy of removing LARC from other health benefits and services for which a clinic receives a lump-sum payment. This allows a clinic to be reimbursed for the considerable costs associated with purchasing, storing and inserting LARC. The HSD and DOH have worked hard to come up with the Centennial Care 2.0 plan for unbundling LARC benefits from other benefits, according to this member.

**Poison and Drug Information Task Force**

Susan Smolinske, Pharm.D., director, New Mexico Poison and Drug Information Center (NMPDIC), stated that the mission of the NMPDIC is to improve the health of New Mexicans by reducing illnesses and deaths associated with poisoning and by encouraging proper use of medications. The NMPDIC operates a 24-hour emergency telephone service that provides assessment and treatment recommendations in cases of suspected poisonings, responds to drug information questions and helps emergency personnel during hazardous material incidents.

Ms. Smolinske reported that poisoning deaths are the number one cause of preventable deaths in New Mexico, having surpassed those caused by motor vehicle accidents. The total number of calls received by the NMPDIC grew steadily from 12,000 in 1977 to more than 30,000

in 2013. However, that number has decreased since 2013 to around 20,000, or 84% of total calls in FY 2017. The center's American Association of Poison Control Centers accreditation is at risk due to this drop in call volume, Ms. Smolinske said, and the NMPDIC has instituted measures to increase calls and capture more exposures since June 2017. A critical concern of the NMPDIC is the longevity of the Tobacco Settlement Permanent Fund, appropriations from which represent 27% of the center's budget.

Members discussed a range of options for funding the NMPDIC, including assessing user fees for hospitals and other providers and drawing funds from the CHIP. Ms. Smolinske reported that this is an allowable expense under the CHIP, and members agreed to include this recommendation in the letter regarding the Centennial Care 2.0 plan. Senator McSorley offered to sponsor or co-sponsor legislation to provide funding and support for the NMPDIC.

**Duty to Report Abuse and Neglect**

Shalon Nienow, M.D., medical director, Para Los Ninos, UNM HSC, and Leslie Strickler, M.D., associate professor, Department of Pediatrics, and medical director, Child Abuse Response Team, UNM HSC, addressed the committee regarding a proposed bill to provide civil immunity to health professionals and others who make good-faith reports of reasonably suspected child abuse or neglect perpetrated by someone who is not a parent, guardian or custodian. Current civil immunity language in the Children's Code applies only to reports where the parent, guardian or custodian is the suspected perpetrator. Reporting these cases often falls to medical professionals who continue to report despite the lack of immunity. Dr. Strickler asserted that providing immunity would protect and encourage providers and others to report suspected abuse. She noted that frequently the identity of a perpetrator is not initially clear.

Dr. Strickler reported that four million children in the United States are reported to child protective services agencies in the United States each year as potential victims of abuse or neglect. Many more children remain at risk for this kind of trauma. The Protective Services Division of the CYFD is reportedly not able to investigate every report in New Mexico due to a lack of resources. Significant risk factors for child abuse and neglect in New Mexico include high rates of poverty and substance abuse, Dr. Strickler said.

Dr. Nienow discussed barriers to treatment, chief among those a lack of providers and a significant lack of mental health resources for children exposed to trauma or abuse. This in turn represents a serious risk factor for poor adult health, mental health issues, risk of becoming an abuser, entry into the criminal justice system and generally becoming a non-functioning member of society. Dr. Nienow also noted that New Mexico continues to rank forty-ninth or fiftieth in the nation for virtually all measures of child well-being. She urged the committee members to take action, quoting Albert Einstein, who defined insanity as doing the same thing over and over again and expecting different results.

Committee members discussed barriers to reporting, and Dr. Nienow said that frequently teachers and school administrators are the individuals making reports. She noted that this

highlights a concern she has for younger children who are in homes where they suffer abuse or neglect but are essentially unseen by those who might report their trauma. One member expressed concern regarding non-reporting by police and others, and Dr. Strickler reported on some of the close connections under development to further a multidisciplinary approach and provide treatment and reporting options.

In response to members' questions, the panelists provided the following clarifications:

- in addition to four years of medical school and subsequent lengthy residencies, Dr. Nienow and Dr. Strickler spent an additional three years of training to become board-certified child abuse physicians;
- Dr. Nienow and Dr. Strickler are the only two board-certified child abuse physicians in New Mexico and two of only 350 in the country;
- one of these two doctors or one of two other providers, including a nurse practitioner and a CYFD staff member, are on call at all times to field child abuse trauma calls from throughout the state;
- few billable codes exist in the current system to cover the unique and critical services that Dr. Nienow and Dr. Strickler provide, although progress is being made in this regard;
- the void in high-level specialty care in New Mexico, particularly in rural areas, is driving a proposed plan to establish the UNM HSC as a regional high-level care center for child abuse trauma;
- it is important to promote collaboration in the investigatory process, as well as multidisciplinary approaches to treatment, so that this care center and the specialty care doctors can reach out to effectively meet needs throughout the state; and
- development of the care center is a long-term initiative and will require approximately $1 million annually to operate.

Committee members discussed possible funding sources for a regional center. One member asked if funds reverting from the CYFD are a possible source of funding. Other state funding sources were also mentioned, including the Land Grant Permanent Fund (LGPF). In reference to the mega-billion dollar "rainy day" LGPF, Dr. Nienow observed that, with respect to child abuse and neglect in New Mexico, "it's raining cats and dogs".

**Sexual Assault Prevention and Sexual Assault Examination Kit Update**

Representatives from the New Mexico Coalition of Sexual Assault Programs presented an overview of the organization's progress in preventing sexual assault in New Mexico and provided a plan for the coming year. Panelists stated that the road forward should include developing new services for sexual assault survivors and additional services for Native American sexual assault survivors and mandating increased training for sexual assault service providers.

Natasha Torrez, J.D., dean of students, UNM, presented an update on sexual misconduct training for students at UNM. The panelists and members discussed the high incidence of sexual

assault on campus, a survey showing that many students do not feel safe at UNM and the need to continue the sexual misconduct training even if the federal mandate for the training is removed. Panelists and members also discussed a wide range of issues related to the processing of sexual assault kits, including the ongoing backlog in processing kits in Albuquerque.

**Recess**

The committee recessed at 4:57 p.m.

**Friday, September 22**

**Welcome and Introductions**

The meeting was reconvened by Representative Deborah A. Armstrong at 9:17 a.m. Committee members introduced themselves.

**Palliative Care and End-of-Life Decisions**

Barak Wolff, M.P.H., public health advocate, provided an overview of how end-of-life issues are evolving nationally and in New Mexico. He noted that the right to self-determination is a basic underpinning of the health care system. The Uniform Health-Care Decisions Act, which became law in 1995, gives New Mexicans the right to decide when and where to start and stop care. Although there are no right answers, advance care planning is key to ensuring that individuals' rights are respected at the end of life. Mr. Wolff introduced Nancy Guinn, M.D., hospice and palliative care specialist and medical director, Presbyterian Healthcare Services, Joie Glenn, government relations, New Mexico Association for Home and Hospice Care Services, and Robert L. Schwartz, Esq., emeritus professor of law, UNM School of Law.

Dr. Guinn's remarks focused on the value of palliative care services. Palliative care is designed to provide relief from the serious symptoms of illness, regardless of diagnosis. To be most successful, it should be provided in conjunction with medical treatment. The primary focus of a palliative care approach is to preserve quality of life, Dr. Guinn said. She shared a few stories of patients who received palliative care services, and how the services benefited them. Palliative care promotes important conversations about the future and what patients want in their lives. Care can last for years, while other modes of treatment are pursued. Dr. Guinn identified barriers that keep palliative care from becoming mainstream care, including the lack of information and understanding, reluctance of physicians to offer palliative care, confusion about the difference between palliative care and hospice, and lack of reimbursement. Where programs exist, it usually indicates that a hospital or health system has decided to underwrite these services. She reminded the committee about Senate Bill 173 introduced in the 2017 session, which sought to address these barriers.

Ms. Glenn informed the committee about hospice and hospice providers. Ms. Glenn identified the number of hospices in New Mexico, the regulatory basis for hospices and the services provided by hospices. According to the Kaiser Family Foundation, an estimated 10,000 people received hospice care in New Mexico in 2016, with an average length of stay of 79 days.

She described the various types of hospice care, including in-home, inpatient and respite. She identified the reimbursement models and how the models have evolved over time. Very intensive services are reimbursed at a higher rate, Ms. Glenn said. Information about hospices is now available online at https://www.medicare.gov/hospicecompare. She emphasized the critical importance of family members and caregivers in hospice. Palliative care and home health care can serve as bridge programs until a patient is ready to accept the services that hospice provides. She noted that many people are admitted to hospice very late in the course of their illnesses, which can limit the benefits available to them from these services. Hospice can neither extend nor shorten life; however, fear, misunderstanding and rejection about end-of-life expectancy are barriers to fully realizing the benefits of hospice.

Mr. Schwartz noted that, among other professional work, he teaches in California, which has allowed him to learn about California's End of Life Option Act. He recognized the importance of the other three panelists for their contributions to end-of-life options in New Mexico. He spoke about aid in dying, an issue that the New Mexico Supreme Court requested the legislature to consider. He announced that a symposium is scheduled for Saturday, September 23, 2017, to consider constitutional and legal issues about aid in dying, as well as the role of state supreme courts on this topic. He noted that the debate about this issue includes a wide variety of opinions based on religion, values and personal experiences. He contends that aid in dying is different from assisted suicide and euthanasia. Euthanasia is not legal and not permitted in this country, he said. Assisted suicide implies the need to find an end for a desperate situation, and, generally, it does not include supportive family involvement. Aid in dying is an approach that promotes a decision that is made together with loved ones and one's physician to support compassion and choices for self-determination.

Questions and comments from committee members covered the following issues:

- potential issues that should be considered in New Mexico based on California's experience should include that:
    - California's law is modeled after Oregon's model;
    - the primary problem is that people who desire access to aid in dying are not able to gain access to it;
    - barriers appear to be mostly the result of risk-management issues; and
    - the single biggest barrier is a 15-day waiting period before one can get access to aid in dying; this is too long of a time frame, and many people die before the waiting period elapses;
- whether aid-in-dying initiates an ethical and moral slippery slope; no, rigorous requirements exist in states with aid in dying laws to prevent this;
- an observation that aid-in-dying laws require people to prove that they have decisional capacity and that they have the ability to self-administer medication;
- emphasis that aid in dying is voluntary for both patients and providers;

- whether the prescribed medication is one that can be used for other conditions; no, it would be obvious to a pharmacist that the prescription as written was only for the purpose of aid in dying;
- concern regarding allowing institutions to opt out based on a religious or ethical basis;
- whether palliative care is available in rural areas; Presbyterian Healthcare Services is working to expand the service in rural communities, and it now offers these services in Espanola;
- whether there is an end-of-life deadline in palliative care, as there is in hospice; no, the reason hospice has a six-month deadline is because that is the way Medicare created the benefit;
- what the age is for aid in dying; generally, it is 18 years of age; additionally, a diagnosis of a terminal illness is required;
- how long it takes for a person to die after ingesting the prescribed medication; it varies, but generally it takes about 30 minutes for a person to fall asleep and into a coma;
- notice that there is a movie on this topic called *How to Die in Oregon*;
- whether Narcan can be used to reverse the medication; no, the medication is a barbiturate, not an opioid;
- what states now permit aid in dying; Oregon, Washington, Montana, Colorado, California, Vermont and the District of Columbia; some states have allowed it through a ballot measure and some through statute;
- whether it is known if people travel to a state to be able to obtain access to aid in dying; it is known anecdotally;
- a request to identify positive parts of the laws from other states for New Mexico to incorporate into its law regarding:
    - decisional capacity and steps to ensure that no coercion can occur;
    - a provision to require serious interviews between a physician and a patient to ensure sound decision making;
    - a two-day waiting period before the prescription can be filled;
    - a requirement for two practitioners to include an advanced practice practitioner in addition to a physician; and
    - giving as much authority as possible to the physician and patient acting together in coming to a decision;
- whether and how hospice and palliative care could be incorporated in aid in dying; palliative care allows participation based on practitioner individual choices; hospices can support a patient's choice; this is being clarified in law;
- whether a law should permit a hospice to decline to support aid in dying; experience in Oregon shows that well over 90% of the time, patients pursuing aid in dying are already enrolled in hospice;
- an observation that in Colorado, the situation of a hospital system that has prohibited its physicians from participating in aid in dying is soon to be litigated;
- an observation that end-of-life circumstances are not always straightforward;
- a call for more public education regarding all of these issues;

- clarification regarding the percentage of people who fill prescriptions and who carry through and take the prescription; around 60% to 65% of those with prescriptions use them; this does not include those who begin the aid-in-dying process but die prior to being able to obtain the prescription;
- whether there have been follow-up surveys in states that have aid-in-dying laws; yes, generally, support for aid in dying is increasing over time;
- whether physician assistants and nurse practitioners in New Mexico have adequate prescriptive authority to engage in aid in dying; yes;
- clarification about suicide as a crime; in New Mexico, suicide is not a crime, but assisted suicide is a crime; this would need to be addressed in an aid-in-dying bill;
- clarification about the drugs that are used for aid in dying; a consistent element is that the patient must be capable of self-administration of the drug;
- whether minorities have less access to aid in dying where laws exist; data support this; however, the reasons are not fully understood;
- the importance of respecting religious and cultural influences in decision making; and
- a repeated observation that the issue of aid in dying is not, and should not be, a political issue.

**Public Comment**

Adrienne Dare told a story about her mother's experience of aid in dying in Oregon. She observed her mother practicing her ability to drink and swallow, and practicing the words she wished to say to her family when the time came.

Maya Distasio told a story about her grandfather and his journey to death. She described the physical pain as well as the pain of the loss of his independence and the knowledge that he would die before seeing loved ones again. His actual death process was very painful, leading him to choose violent suicide. He left behind a note explaining his personal decision to end his life due to the intolerable nature of his condition. Ms. Distasio's view is that what one does with one's own body and fate should be allowed. Legal aid in dying would have been a much more respectful option for him.

Elaine Brightwater expressed thanks for all of the work done during the previous legislative session on this issue, including allowing nurse practitioners to participate in aid-in-dying actions.

Sandra Adondakis, American Cancer Society, spoke to the importance of increasing access to palliative care in New Mexico. She is part of an American Cancer Society initiative to work on this issue. She supports an ongoing advisory council on palliative care and the establishment of an educational clearinghouse.

Nat Dean described her reasons for desiring the ability to make a personal choice for aid in dying. She told the story of her father and his struggle with terminal cancer and his ultimate suffocation. She believes a person who has decided it is time to die should not have to suffocate.

Lisa Rossignol, a member of the disability community who has a daughter with disabilities, expressed appreciation to the LHHS for its decision to send a letter to Dr. Roth regarding the 50% cost-sharing issue. She also urged the committee to look carefully at MCOs that take actions that create a difficult environment and limit access to care. She is opposed to the imposition of copayments in Medicaid. She is opposed to aid in dying and supports palliative care and hospice care instead.

Revathi A-Davidson expressed the reluctance of most people to talk about end-of-life wishes. She described the goals of a conversation project and its value for society. She noted that a website contains many resources, including a starter kit, to promote use of conversations.

Janice Wilson is very much in favor of aid in dying. She contends that there are questions raised by people with whom she discusses this topic, such as, "What do I do if I have a debilitating, but not terminal, disease?" and "What happens to my advance directives if I develop dementia?". These questions should be addressed in legislation to establish access to aid in dying.

Elizabeth Whitefield, a retired district court judge, had to retire because she has terminal breast cancer. She implored the committee members to do whatever it takes to pass aid-in-dying legislation.

Libby Hopkins, a hospice and palliative care nurse, shared a story about a patient that led her to support aid-in-dying legislation.

Sharon Schaefer described the loss of her sister and her belief that at the very end of life, many people share the strong emotion to "get this over with".

Nancy Abel shared the story of her brother-in-law who was diagnosed with a very aggressive cancer. He lived in Oregon at the time and took advantage of Oregon's Death with Dignity Act. She and her husband were able to be present at his death and observe the grace with which he died. His peaceful death took only 20 minutes, and he was surrounded by family.

The chair thanked all of the audience members and all of those who provided public testimony. She thanked the committee members and said she is committed to continuing to try to get aid-in-dying legislation passed.

**Adjournment**

There being no further business, the fourth meeting of the LHHS for the 2017 interim was adjourned at 12:40 p.m.