Report
to
The LEGISLATIVE FINANCE COMMITTEE

Human Services Department and Department of Finance and Administration
County-Financed Health Care and the Local DWI Grant Program
October 29, 2014

Report #14-10

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David Abbey
Director

October 29, 2014

Dr. Tom Clifford, Secretary
Department of Finance and Administration
180 Bataan Memorial Building
Santa Fe, New Mexico 87501

Ms. Sidonie Squier, Secretary
Human Services Department
2009 S. Pacheco St. – Pollon Plaza
Santa Fe, New Mexico 87505

Dear Secretaries Clifford and Squier:

On behalf of the Legislative Finance Committee (Committee), I am pleased to transmit the evaluation *County-Financed Health Care and the Local DWI Grant Program*. The program evaluation team reviewed the role of county indigent programs and funding of rural hospitals under the Safety Net Care Pool, and the effectiveness of county programs funded through the Local DWI Grant program. The report will be presented to the Committee on October 29, 2014. An exit conference was conducted with agencies on October 17, 2014 to discuss the contents of this report. The committee would like a plan to address the recommendations in the report within 30 days from the date of the hearing.

I believe this report addresses issues the committee asked us to review and hope the Department of Finance and Administration and the Human Services Department will benefit from our efforts. We very much appreciate the cooperation and assistance we received from your staff.

Sincerely,

David Abbey, Director

Cc: Representative Luciano "Lucky" Varela, Chairman, Legislative Finance Committee
Senator John Arthur Smith, Vice-Chairman, Legislative Finance Committee
Mr. Steve Kopelman, Executive Director, New Mexico Association of Counties
Mr. Keith Gardner, Chief of Staff, Office of the Governor

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EXECUTIVE SUMMARY

New Mexico spent $13.3 billion on health care in 2011. With approximately 30 percent of New Mexicans living below the poverty level not having access to insurance coverage, providing a health care safety net is a priority. In addition to the state's Medicaid program, counties have supported low-income uninsured residents through indigent care programs and rural hospitals by way of the Sole Community Provider Program. In 2014, a law was enacted altering the role counties play in supporting hospitals through the creation of the Safety Net Care Pool. Furthermore, implementation of the Affordable Care Act and Medicaid expansion will greatly reduce the need for counties to pay for indigent health care.

This evaluation reviewed the current state of county indigent programs and the impact of statutory changes related to supporting New Mexico hospitals.

The evaluation found counties allocated more revenues for indigent care than were generated by a designated 1/8th gross receipts tax increment due in part to using other taxes and revenues from hospitals. This allowed counties to use indigent funds to support a variety of other services including primary care, behavioral health and, in some cases, health care for county inmates, in addition to supporting rural hospitals through Medicaid. The evaluation concluded statutorily-mandated funding of the Safety Net Care Pool and Medicaid by counties would require reprioritization of how indigent funds are used, as well as identifying new sources of revenue since counties can no longer use funds obtained from their local hospitals.

Recommendations include amending statute to sunset the Indigent Hospital and County Health Care Act in 2020, including the Safety Net Care Pool and related rate increases for hospitals, and require counties report on indigent funds as part of the annual budget process.

Prior to 1997, New Mexico had the highest rate of alcohol-related deaths in the nation. The state enacted various interventions to address this critical public safety issue, including funding county-level programs to prevent incidents of DWI, monitor and treat offenders, and assist in enforcing the state's DWI laws. In FY14, counties spent $17 million in liquor excise tax revenues to address DWI.

The evaluation assessed how the state and counties manage programs funded though the Local DWI Grant Program, finding there is not sufficient review of county program outcomes or an emphasis on investment in programs proven to work. Moreover, the state does not have a strong mechanism for assessing where the greatest need is related to DWI, and funding has not always gone to these areas of the state.

Recommendations include creating a risk assessment tool to identify areas of greatest need for DWI funding across the state, requiring standardized outcome data to analyze program performance, and establishing a requirement for counties to use evidence-based practices.

In 2009, the 2nd 1/8th revenue source accounted for less than 40 percent of revenue for indigent funds.

Between FY09 and FY14, county indigent fund balances increased over 24 percent to over $30 million.

Statewide County Indigent Fund Balances FY09-FY14
(in thousands)

Source: County Budgets

KEY FINDINGS

New Mexico has a diminishing need for robust county operated indigent programs. In 2011, a Legislative Finance Committee program evaluation found the state had a complex patchwork of locally-financed indigent health care. Since this report, New Mexico has chosen options under federal health care reform to expand Medicaid to previously ineligible individuals, and new health care purchasing exchanges are in the implementation process, though enrollment remains low.

The report found New Mexico needs to re-evaluate the use of local taxes to see if they are adequately addressing healthcare goals or if they need to be repurposed to better leverage federal matching funds.

Historically, county spending from local indigent funds far exceeded revenue from locally-imposed 2nd 1/8th gross receipts tax increments, indicating counties have used other revenue sources for indigent care. Overall, county indigent fund revenues increased over 200 percent between FY03 and FY09, from almost $33 million to over $98 million, according to the New Mexico Health Policy Commission. County indigent fund expenditures during that same time period increased by 150 percent, from $35 million to over $87 million.

Many counties reported supporting the indigent fund with revenue from the 2nd 1/8th GRT increment, which is dedicated to indigent care, as well as with other revenue.

Because of these multiple funding streams, counties managed to support indigent care spending, contribute to Medicaid statewide, and subsidize rural hospitals all from indigent care funds. For example, many counties have not imposed the authorized 1/16th County-Supported Medicaid GRT increment, and instead use indigent funds to meet this obligation. The biggest expenditure from indigent funds was transfers for the Sole Community Provider program (SCP), totaling almost $47 million in FY09. Some counties also use indigent funds for local jail health care costs.

HSD tightened up requirements on the county revenue used to draw down federal Medicaid funds for rural hospitals to ensure compliance with federal regulations. Between 2011 and 2014, HSD sought better assurances that counties were transferring public funding from local indigent funds to the state Medicaid program for SCP, as opposed to funds that could have been grants to county indigent funds from hospitals.

Through Senate Bill 268, the state enacted changes impacting county indigent funds and how rural hospitals are financed through Medicaid. Senate bill 268 sought to amend state law to comply with new changes made by HSD to ensure compliance with federal Medicaid regulations, replace the Sole Community Provider Program for rural hospitals, and better align law with how counties were administering their indigent care programs. The legislation converted what was formally known as the county indigent fund into a health care assistance fund.

The legislation also created the Safety Net Care Pool Fund, replacing the SCP fund, and requires counties to transfer the "equivalent" of 1/12th of one percent gross receipts tax revenues into the fund managed by HSD.

One major change under this program is counties no longer have the flexibility to determine how much annually to dedicate to their own local hospitals. Further, there is no longer a direct relationship to how much a county transfers and how much in federal Medicaid a hospital will receive since local funds go into a state pool and are distributed according to a new federally-approved formula and rates paid based on use of services.

In 2011, the federal Centers for Medicare and Medicaid Services (CMS) was scrutinizing how county matching funds were acquired to ensure compliance with federal regulations.

With Medicaid expansion and new health insurance options for New Mexicans, the need for county indigent programs will diminish significantly. As the Affordable Care Act (ACA) and Medicaid expansion reduce the uninsured population, the legislative mandate and funding of county indigent care should be revisited. A focus on enrolling all Medicaid-eligible individuals is paramount in reducing costs to hospitals and counties, and ensuring the state is leveraging increased Medicaid reimbursement rates.

The Kaiser Family Foundation estimates approximately 42 thousand New Mexicans may be ineligible for coverage under the ACA.

Gaps in coverage will likely continue, primarily for immigrants not eligible for Medicaid or subsidized insurance, and for individuals opting not to sign up for available coverage. Beyond county inmates, the ACA stipulates only citizens can access care through Medicaid or the health care exchange. Therefore, resident aliens, authorized day labor, foreign students and undocumented persons would still be categorized as uncompensated care. Individuals choosing not to enroll in health coverage would account for uncompensated care. Finally, the ACA does not require Native Americans obtain health insurance.

Increased oversight at the state level is needed to ensure proper implementation of SB 268 and accounting for county indigent fund spending. The lack of comprehensive information on county indigent funds, previously provided by the Health Policy Commission (HPC), hampers state oversight and health care planning. The Department of Finance and Administration is best positioned to monitor indigent fund spending through its approval process of county budgets.

Given the risk to the state, financial audits of counties should ensure compliance with federal regulations prohibiting improper donations for drawing federal Medicaid funds.

HSD has made significant changes and improvements in Medicaid funding for rural hospitals, but program costs need monitoring. In 2011, a LFC program evaluation found problems with Medicaid administration and financing for rural sole community hospitals. SCP program costs had increased significantly, in part due to how available funding was calculated. The total program had increased in cost from $55 million in FY01 to an estimated $255 million in FY11. Although not a mandatory program, the funding formula put pressure on counties to provide the full match to available federal SCP funds. County contributions were typically more than revenue generated by the equivalent of a 1/8th GRT increment.

In FY12, counties transferred $57 million for the Sole Community Provider Program.

Some hospitals appeared to be overcompensated, receiving payments that exceeded costs of Medicaid and uninsured uncompensated care. The report found SCP reporting from hospitals to counties and HSD was often inadequate and lacked standardization statewide. The program did not specify how funds would be used by hospitals, a concern for counties, and lacked an assessment of whether Medicaid and indigent uncompensated care costs were reduced.

HSD implemented a new program for supporting rural hospitals that would provide supplemental payments and rate increases, and prevents overcompensation. In 2013, HSD reviewed and revised the formula used to calculate county-supported hospital funding to ensure compliance with federal regulations. This resulted in a significant reduction in the amount of funding HSD could pay directly to hospitals using county matching dollars.

Between FY12 and FY13, the state started to transition to a new program and hospital funding decreased to $159 million, almost entirely among private hospitals and unneeded county matching funds were returned. Counties with public hospitals appeared to continue the practice of using money from those hospitals for Medicaid federal match funding.

Many hospitals appeared to receive total Medicaid payments, including from SCP that exceeded the cost of providing care to Medicaid patients and the cost of uninsured care as well.

The new approach for supporting rural hospitals is divided into three key parts: a supplemental payment pool of funds, a rate increase, and a quality improvement component. The new program allocates $69 million to supplemental payments, primarily targeting small hospitals called the uncompensated care pool. Each former sole community hospital has to apply for the pool of funds and demonstrate Medicaid uncompensated and uninsured costs. Ninety percent of the allocation of the pool is designated for hospitals with less than 100 beds, with 10 percent for hospitals with 100-200 beds.

The second part of the approach includes rate increases for inpatient care, which primarily benefits larger hospitals given higher patient volume than very small hospitals. HSD estimates larger hospitals that treat more clients would benefit from approximately $171 million in Medicaid rate increases.

For almost all hospitals in the Safety Net Care Pool, uncompensated Medicaid and uninsured care would be significantly reduced. Based on full funding, the program would cover all Medicaid services at cost, and cover costs of uninsured care at all hospitals in the program except for three large hospitals. For hospitals under 200 beds, the program would eliminate over $100 million in uncompensated care.

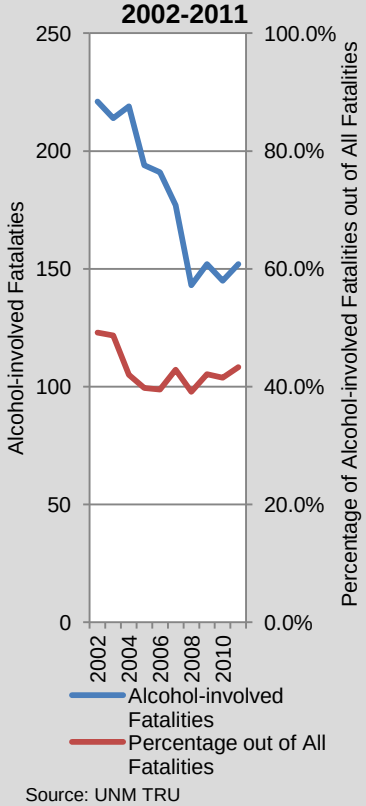
The Safety Net Care Pool is estimated to reduce Medicaid uncompensated care between 42 and 69 percent at large hospitals.

The program would reduce uncompensated care by an estimated $42 million at the three hospitals with 200 beds (Memorial Medical Center, San Juan Regional, and Christus St. Vincent). The remaining gap between total Medicaid payments and cost of care for Medicaid clients and uninsured would be about $35 million.

The overall hospital program was initially estimated to cost $192 million, but has increased to $240 million due to new estimates from Medicaid expansion.

Some risk exists since program revenues are now directly tied to GRT equivalents that could result in over or underfunding from county contributions.

Number and Percentage of Alcohol-involved Fatalities 2002-2011



Source: UNM TRU

HSD has insufficient funding to fully implement the program, due in part to high cost and lack of revenue from the counties. Going forward, the program has a total funding gap of over $36 million, including $11 million needed to match federal funds. HSD did not request funding to close the gap in its FY16 budget request and at the time of this report does not intend to seek state support from the general fund to fully fund the program.

HSD's original proposal assumed insufficient county revenue, and required a state appropriation from the general fund to support this local program for the first time. Originally, HSD estimated $60 million in state matching money would be funded approximately as follows: a $36 million transfer from counties from the equivalent of a 1/8th gross receipts tax increment, $9 million in state general fund contributions, and $14 million from a University of New Mexico Hospital intergovernmental transfer.

This new program assumes a rate increase of over $171 million, most of which will flow through managed care contractors. Hospitals will not be guaranteed the estimates provided by HSD for the program, because payments under the rate increase will be dependent on patient volume and types of inpatient services provided.

The state should continue to monitor this program and rural hospitals' financial health. The new program effectively pays full cost for Medicaid and uninsured clients, but HSD should ensure this does not result in excessive profitability. Estimated rate increases would rise to cover 80 percent of hospital costs for inpatient services, but many had already negotiated favorable rates with Medicaid managed care companies.

The LDWI Program does not target funding to high-need areas effectively, emphasize best services, or align funding to outcomes. Alcohol-related crash deaths dropped steadily in New Mexico between 1980 and 2012, following the implementation of various statutory interventions. Over a twenty-year timeframe, various legal changes may have contributed to reduced overall automobile crash deaths as well as alcohol-related crash deaths. However, most recent crash data suggests results of DWI interventions have plateaued.

The state allocates approximately $18 million annually though the LDWI program, with most going to county-based programs. Between FY09 and FY14, over half of all LDWI funding went into two program components: treatment (40 percent) and prevention (18 percent).

Counties have flexibility to prioritize funding of their LDWI program. There are three funding mechanisms for the LDWI program: distributions, competitive grants, and detoxification grants. By statute, 65 percent of LDWI competitive grant funds have to be directed to treatment. Beyond this requirement, counties apply for LDWI funding based on their county's priorities among the eight available program components. Various factors contribute to how counties use LDWI funds, including need, availability of service providers, and access to other funding sources.

Between 2007 and 2011, while overall automobile crashes and fatalities have dropped, alcohol-related crashes continue to be approximately 5 percent of total crashes and alcohol-involved fatalities remained constant around 40 percent of total traffic fatalities.

State allocation of LDWI funding is overly complicated, leads to fragmentation of funding and does not prioritize high-need areas of the state. Counties applying for LDWI funding complete extensive annual applications providing a case study supporting the county's funding request. However, DFA does not require counties report similar data points in applications to perform comparative analysis of need. Furthermore, funding has gone primarily to larger counties ahead of counties with highest need.

On average, all but six county DWI programs have not funded treatment at the statutorily-required 65 percent for LDWI grants. Between FY09 and FY14, counties overall spent an average of 48 percent of their LDWI grant funds for treatment, falling below the statutory mandate. However, the six counties that also received detoxification grants through LDWI spent 93 percent of grant funds on treatment, surpassing the statutory mandate.

The LDWI program does not sufficiently emphasize evidence-based practices, nor does it use program outcome data to ensure accountability or inform funding decisions. The LDWI program does not require programs be evidence-based. DFA does not require that counties disclose which programs meet this standard, nor is there an incentive to focus on evidence-based practices.

Between 2010 and 2013, the number of statewide DWI arrests decreased by 27 percent. Moreover, DWI conviction rates dropped by almost half from 2003 to 2013.

Counties are not required to report program outcomes, a continuing problem identified by LFC in 2003. All LDWI-related reporting counties provide to DFA focuses on financial accountability. However, counties are not required to submit data related to outcomes. While fiscal oversight is important to strong program management, how funded services are impacting DWI issues in the state is also an area of concern.

Investments in DWI prevention efforts lack evidence-based support, and proof of effectiveness. DFA does not ask for detail related to prevention programs implmented, how long the program has been used, whether the program is evidence-based, how outcomes are being measured and the associated results, nor how much programs cost.

In 2014, the Legislature enacted law which increases the distribution of liquor excise tax revenues into the LDWI grant fund from 41.5 percent to 46 percent for FY16 through FY18.

Counties also use LDWI prevention funding for non-evidence-based strategies such as media campaigns, public outreach and safe ride programs. Many counties offer alternatives through alcohol-free events as well as safe ride or designated driver programs. While all of these programs can be impactful, they are not considered evidence-based strategies and there is no way to directly measure their effectiveness in reducing DWI.

LDWI treatment programs are not fully integrated into the state's overall substance abuse treatment plan, creating potential service overlaps and opportunities to leverage Medicaid funding. Many counties employ intensive outpatient treatment programs. Medicaid lists intensive outpatient care as a service eligible for billing, so it is reasonable to assume that intensive outpatient LDWI treatment services could be eligible for Medicaid reimbursement if clients were enrolled and providers set up for billing.

Lack of consistent outcome data prevents the DWI Grant Council from allocating funds based on greatest need.

Currently, there are seven DWI courts in New Mexico located in Doña Ana, Bernalillo, Valencia, Torrance, Santa Fe, San Miguel and Eddy counties.

HSD's only LDWI program involvement is to approve county DWI prevention and treatment plans. The Behavioral Health Services Division of HSD (BHSD) approves the plans for a period of three years at a time. However, the agency could play a more active role in the LDWI program in areas such as monitoring client outcomes, benchmarking outcome and cost data against other publicly-funded substance abuse programs, or looking for overlap or duplication between programs. All of these functions would assist in creating a more cohesive and cost-effective substance abuse treatment system.

Increased LDWI funding offers an opportunity to make targeted investments in programs proven to work. Similar to drug courts, DWI courts are an evidence-based practice proven to reduce recidivism, but these courts are not being funded by counties through the LDWI program. While similar to traditional drug courts, DWI courts serve a DWI offender population. Various studies have spoken to their effectiveness in reducing recidivism.

The General Appropriation Act authorizes a fund transfer from the LDWI fund to the Administrative Office of the Courts (AOC) for drug courts. For FY14, $500 thousand was transferred from the LDWI fund to AOC, and $426 thousand was distributed by AOC to the state's DWI courts. The remainder of the total $1.5 million grant fund went to the state's drug courts.

KEY RECOMMENDATIONS

The Legislature should consider:

Amending statute to sunset the Indigent Hospital and County Health Care Act including county indigent care obligations and the authority for imposing the 2nd 1/8th GRT increment in 2020. The legislature would need to review and take action on any changes during the 2019 legislative session. If discontinued, counties could continue to support indigent programs through general purpose tax revenues;

Amending statute to sunset the Safety Net Care Pool and associated rate increases in 2020. The legislature would need to review and take action on any changes during the 2019 legislative session; and

Not providing additional support from state funds for the Safety Net Care Pool program or rate increases.

Amending statute to add the director of the Behavioral Health Services Division at HSD as a member of the DWI Grant Council.

The Human Services Department should:

Establish a fixed methodology going forward to fund hospital Safety Net Care Pool applications that incorporates a uniform set of data and methodology to forecast future uncompensated care costs and

Work with the DWI Affiliate through the New Mexico Association of Counties to inventory treatment services and providers funded through the LDWI program to eliminate duplications with Medicaid, as well as work to get LDWI treatment providers registered to bill through Medicaid.

The Office of the State Auditor should:

Direct financial auditors to review counties' spending and transfers for the Safety Net Care Pool comply with state and federal law and regulations as part of annual county financial audits.

The Department of Finance and Administration:

Require counties, as part of the budget review process, to include a schedule of detailed revenue and expenditures of the Health Care Assistance Fund and report annually to the Legislature in a similar format as the previous Health Policy Commission reports;

Establish a model for assessing DWI risk in conjunction with the Department of Health to identify high-risk counties and include this data when scoring LDWI fund applications to ensure funding is addressing need; and

Streamline annual LDWI applications to request common output and outcome data points to allow for comparative analysis of applications.

The DWI Grant Council should:

Pass a resolution requiring LDWI fund recipients for prevention and treatment invest a minimum of 50 percent of funds in evidence-based programs and report this spending in quarterly and annual financial reports and

Require LDWI fund recipients report outcome-oriented performance measures related to recidivism by intervention type (detention, community supervision, DWI court, inpatient or outpatient treatment, etc.).

Counties should:

Coordinate with neighboring counties, especially in areas of the state where providers are not readily available, to maximize available treatment resources, implement common prevention programs when applicable and coordinate evaluation of programs.

COUNTY-FINANCED HEALTH CARE PROGRAMS

County Indigent Health Care.

The Indigent Hospital and County Health Care Act provides the legal basis for counties to participate in the financing and purveyance of health care. The act authorizes counties to pay for indigent healthcare claims by dedicating revenue from a second 1/8th increment of county gross receipt tax revenues (GRT). As of 2011, thirty-one counties participated in this method of funding local indigent care. Counties may also choose to dedicate 50 percent of an optional 3rd 1/8th GRT increment to funding indigent care. Bernalillo County is a statutory exception, in that it contributes a flat $1 million per year to its indigent care fund.

Counties may use other sources of funding as well, including the sale of property, mill levy taxes, investment income, and grants. Each county independently determines eligibility for services, what services are offered, the allocation of funds and the approval of claims. Below are some key facts about county indigent funds:

- The counties decide how these funds are to be used for indigent health care;
- It is not mandatory for the county to impose these taxes. If they do, they must be dedicated to indigent care;
- Revenue in the indigent care fund cannot be matched by federal dollars;
- Funds must be used for purposes specified in the Indigent Hospital and County Health Care Act. Previously, this included transfers to the Sole Community Provider Program to meet matching requirements (i.e., once the funds were transferred into the SCP fund they can be matched); and
- These funds may also be transferred to the County-Supported Medicaid Fund to meet the 1/16th GRT increment or equivalent county funding requirement.

Sole Community Provider Program and the Safety Net Care Pool.

The Indigent Hospital and County Health Care Act also established the Sole Community Provider Program (SCP), a federal/state payment program administered by the Human Services Department (HSD), matching county funds with federal dollars. The program was designed to provide higher funding and a supplemental payment program for hospitals that are the sole source of care for individuals in a designated area. The maximum funding was based on a HSD calculation that included the prior year base plus the prior year supplemental payment plus an inflation factor. All New Mexico acute care hospitals, except for hospitals in Albuquerque, participated in the SCP program. Counties used hospital mill levies or other funds, including the county indigent care fund, to support this program. Qualified hospitals were also eligible for a related Upper Payment Limit Program (UPL) payment, which was paid to a hospital later in the year. Key elements of the program included:

- This was not a mandatory program – counties could choose not to participate;
- The Human Services Department received these funds from counties and drew down a federal match; and
- Most counties transferred funds from their County Indigent Care Fund to support SCP.

For FY13, the New Mexico Association of Counties collected data on the funding of the Sole Community Provider Program. Of the $38.9 million participating counties reported generating from leveraging the 2nd 1/8th GRT increment for indigent care, $15.9 million, or 41 percent, was directed towards the Sole Community Provider Program. Additionally, thirteen counties reported allocating a combined $11.4 million from other revenue sources into SCP.

The Sole Community Provider Program expired at the end of calendar year 2013 as part of the new Medicaid waiver creating the Centennial Care program and was replaced by the Safety Net Care Pool. Under the Safety Net Care Pool, hospitals submit an application to the Human Services Department (HSD) detailing anticipated uncompensated care needs to be considered for funding from the pool. Hospitals must also submit reporting to

counties related to uncompensated care. Different from the Sole Community Provider Program, which operated on a state fiscal year calendar, the new Safety Net Care Pool operates on a calendar year.

COUNTY DWI PROGRAMS

The Local DWI Grant Program.

Prior to 1997, New Mexico had the highest rate of alcohol-related motor vehicle crash deaths in the United States. To address this issue, the State Legislature introduced omnibus anti-DWI legislation in 1993. One of the laws, Sections 11-6A-1 through 11-6A-5 NMSA 1978, created the Local DWI Grant Program (LDWI) to assist counties in addressing the substance abuse issues and problems of people driving while intoxicated (DWI) in their communities.

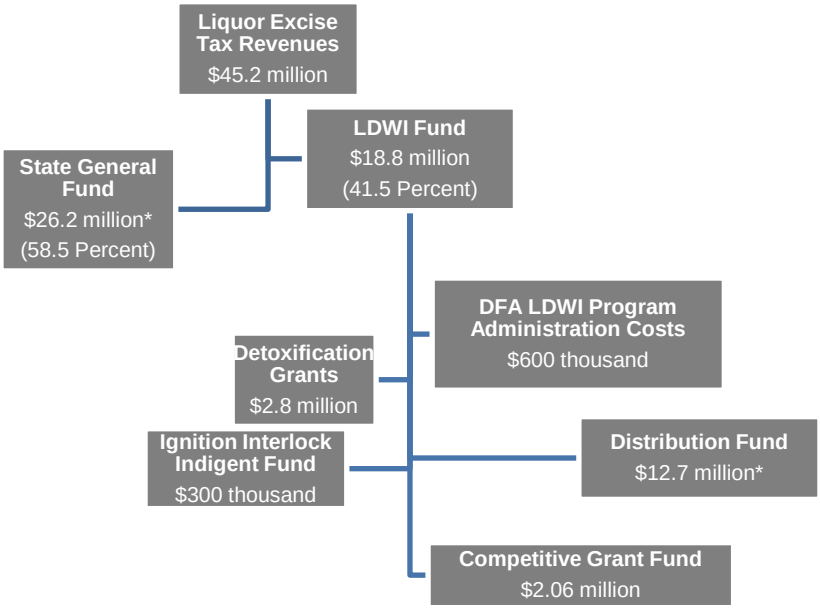
The mission of the LDWI Grant Program is to broadly impact substance abuse in New Mexico through the reduction of the incidence of DWI, alcoholism, alcohol abuse, and alcohol-related domestic violence. The DWI Grant Council oversees the distribution of funding for the program. The council consists of representatives from the New Mexico Association of Counties, the New Mexico Municipal League, the Department of Health, the Department of Transportation and the Department of Finance and Administration. The governor also appoints two members from local public bodies. The Local Government Division of the Department of Finance and Administration (LGC) administers the program by developing regulations, policies, and procedures for LDWI program administration and funding allocation as required by law.

In FY13, local DWI programs throughout the state screened 8,511 offenders, referred 4,130 offenders to treatment, provided 450 checkpoints and saturation patrols, provided prevention education in 352 schools, and monitored the compliance of 8,788 offenders to ensure they met their court-ordered sanctions.

Funding and Distribution.

The LDWI program is funded through liquor excise tax revenues, as noted in Figure 1.

Figure 1. FY13 Liquor Excise Tax Revenue Distribution Forecast

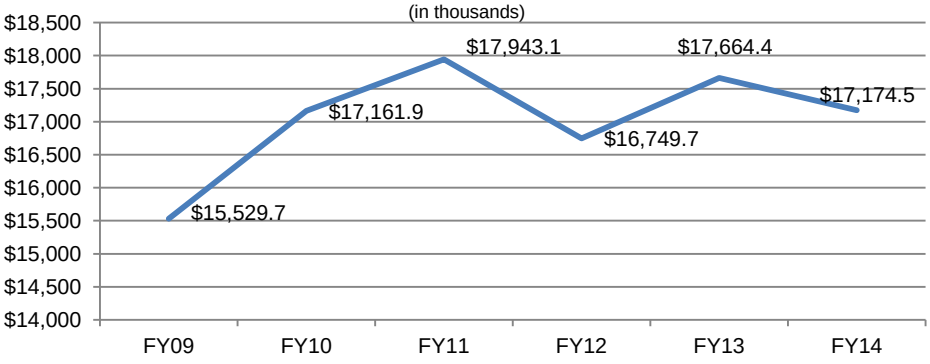


Notes: $249 thousand of state general fund dollars from liquor excise tax revenues goes to municipalities in certain Class A counties for alcohol treatment and rehabilitation services for street inebriates. $12.7 million in LDWI Distribution Funds was dictated by HB2.
Source: NM DWI Coordinators Affiliate Analysis of FY13 Consensus Revenue Forecast

Counties submit annual applications for LDWI funding. The LDWI fund also helps support the state's drug and DWI specialty courts. For FY15, the General Appropriation Act allocated $500 thousand to the Administrative Office of the Courts to be distributed to drug and DWI courts. The Drug Court Advisory Committee awards grants from combined LDWI and general fund revenues through a competitive process amongst the state's drug and DWI courts..

LDWI funding grew an average of 10.6 percent between FY09 and FY14, totaling $17.2 million for FY14**.** Until FY15, LDWI funding was allocated to all 33 counties through three different funding streams: distributions, competitive grants, and six alcohol detoxification grants. The distributions are made on a quarterly basis and LGD requires each county program to submit reporting each quarter. Competitive grant funding operated on a cash reimbursement basis, awarded through an application process. The detoxification grants are provided to six counties for social detoxification programs and alcohol treatment.

Chart 1. Total LDWI Funding FY09-FY14
(in thousands)



Source: DFA

House Bill 16, passed and signed into law in 2014, increases the distribution to the Local DWI Grant Fund to 46 percent for FY16-FY18 only, reverting back to 41.5 percent in FY19. The bill reduces distribution to the general fund by 4.5 percent. Forecasted impact of HB16 is noted in Table 1.

Table 1. Liquor Excise Tax Distributions to Local DWI Grant Program FY15-FY21
(in millions)

Fiscal Year	Current Distribution Percentage	HB16 Distribution
FY15	$19.6	$19.6
FY16	$19.9	$22.1
FY17	$20.3	$24.7
FY18	$20.6	$27.3
FY19	$21	$30.1
FY20	$21.3	$32.9
FY21	$21.7	$35.8

Source: LFC Files

Program Requirements.
The New Mexico DWI Grant Council approves funding, regulations, and guidelines for LDWI programs. Each county is required to have a DWI planning council and a DWI coordinator responsible for budgeting, planning, developing funding requests, and complying with reporting requirements.

Funding is approved and distributed based on each county's DWI plan, which should include an assessment of each county's individual service gaps and needs, and how LDWI funding will meet those needs. By statute, county DWI plans are required to be approved by the Human Services Department.

Program Structure.
The LDWI program defines eight components which may be employed in any combination by a local DWI program and are eligible for LDWI funds:

- **Screening –** Assessment, reporting, and monitoring of convicted DWI offenders;
- **Treatment** – Prescribed programs designed to modify the alcohol behaviors of DWI offenders;
- **Enforcement** – Activities by law enforcement agencies to prevent and deter incidents of DWI;
- **Prevention** – Community awareness programs directed at youth, the community, and local businesses;
- **Compliance Monitoring** – Programs designed to enhance probation efforts that will assist courts with monitoring sanctioned DWI offenders;
- **Alternative Sentencing** – Programs designed to be alternatives to the traditional sanctions levied on DWI offenders such as Teen Court programs and intervention services;
- **Alcohol-related Domestic Violence** – LDWI funds may support county Court-Ordered Domestic Violence Offender Treatment or Intervention Programs overseen by CYFD.
- **Coordination, Planning and Evaluation** – Coordinating, reporting and evaluating all local program activities, numbers of persons served and the success of the program by the program coordinator.

Historical funding data for all LDWI program components is located in **Appendix G**.

Performance and Accountability.
LGD requires counties submit quarterly financial reports detailing spending by program component. Furthermore, LGD audits about one-third of county LDWI programs each year. Although the audits contain some analysis regarding county programming and county DWI plans, the focus is on adequacy of financial accounting and whether basic reporting requirements are met. Nevertheless, LGD has denied county applications for grant funding and redistribution of reverted funds based on audit findings.

Previous Evaluation.
In 2003, LFC staff conducted a performance audit of the LDWI program, which included findings noted in Table 2.

Table 2. 2003 LFC LDWI Performance Audit Key Findings

A strategic plan which clearly and comprehensively describes the implementation and expected progress of the LDWI Grant Fund Program has not been implemented.
A formula driven methodology that can support and document allocations determined by DFA/LGD does not exist. The grant review process is highly subjective and funding recommendations do not correspond with application review scores.
Training and technical assistance to build capacity at the local level has been inadequate.
The quality and quantity of data that is collected by the local programs is not sufficient to enable adequate assessment of the LDWI Grant Fund Program. In fiscal year 2000, screenings of only 58 percent of convicted DWI offenders were reported by the local programs.
Most LDWI Grant Fund Programs do not adequately monitor contractors, sub-grantees or other recipients of local DWI Grant Fund monies.
Despite the many problems that have plagued the statewide DWI Grant Fund Programs, some local governments have implemented effective DWI Grant Programs in their communities.
Recommendations reported in a DWI Grant Program Evaluation Report by the University of New Mexico (UNM) Institute of Social Research (ISR) include: increasing DFA/LGD staffing and funding; continuing standardization of some program aspects; designing and monitoring standards for Local DWI Program supervision; and standardizing and expanding data collection procedures.
Little progress has been made toward addressing issues identified in the New Mexico County Local DWI Grant Program Evaluation report issued by the Rocky Mountain Group, Inc. (RMG) in December 1996. Then, as now, the data collection process in each county vary significantly and often does not lend itself to in-depth comparison across counties; tracking and data collection are inconsistent and inadequate; and Local DWI Grant Programs are not able to demonstrate program impact.
The San Juan County Treatment Program is very expensive, although it appears to have some positive impact on re-arrest rates for first and second time offenders. A comprehensive cost/benefit analysis has not been performed.

Source: LFC Files

The report also provided a series of recommendations including:

- Establish a long-term strategic plan that clearly identifies milestones and timelines.
- Develop an effective grant proposal scoring mechanism that objectively rates and ranks each proposal.
- Strengthen the Administrative Handbook to provide better guidance to local DWI Coordinators and establish orientation and on-going training curricula for DFA/LGD program managers and local program coordinators.
- More closely monitor program expenditures; develop a formal process for approving budget adjustments; and implement a standard file management system.
- Increase funding to DFA/LGD for program management and oversight.
- Develop guidelines that establish standardized written policies and controls of administrative and fiscal procedures.
- Develop a training curriculum for local program coordinators that covers a broad spectrum of issues related to program management.
- Perform a cost-benefit analysis on San Juan County Treatment Facility to determine efficiency and economy of program.

In 2014, the DWI Affiliate of the New Mexico Association of Counties released a strategic plan for county DWI programs in response to the LFC recommendation. The plan prioritizes prevention, treatment, and compliance monitoring, and places an emphasis on program evaluation. The plan also identifies program goals and timelines for completion. For example, by looking to make treatment mandatory for all offenders, counties aim to reduce DWI recidivism statewide by 5 percent by 2016.

NEW MEXICO HAS A DIMINISHING NEED FOR ROBUST COUNTY OPERATED INDIGENT PROGRAMS

In 2011, a Legislative Finance Committee program evaluation found the state had a complex patchwork of locally-financed indigent health care. Since this report, New Mexico has chosen options under federal health care reform to expand Medicaid to previously ineligible individuals, and new health care purchasing exchanges are in the implementation process, though enrollment remains low.

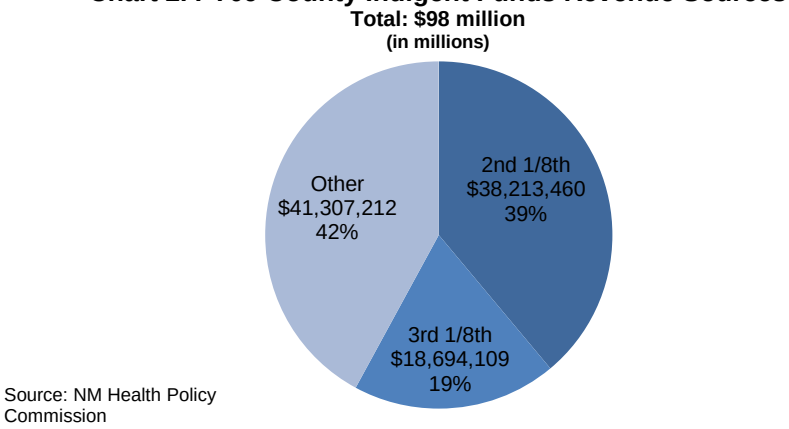
The report found New Mexico needs to re-evaluate the use of local taxes to see if they are adequately addressing healthcare goals or if they need to be repurposed to better leverage federal matching funds. The report found local programs were disjointed with insufficient accountability, unclearly defined goals, and had a diminished ongoing need after the implementation of Affordable Care Act (ACA). Key findings from the report included:

- County indigent programs varied in scope, populations, and services funded, creating a disjointed approach to indigent care statewide.
- Program administration caused concern related to duplication of effort and missed opportunities to leverage federal Medicaid funds.
- The report also found the state's elimination of gross receipts taxes on medical services had a double impact on the state general fund with both the loss of revenue and increased spending on providing local governments "hold harmless" funding. The report found this combined impact totaled an estimated $86 million in FY11.

Historically, county spending from local indigent funds far exceeded revenue from locally-imposed 2nd 1/8th gross receipts tax increments, indicating counties have used other revenue sources for indigent care. Overall, county indigent fund revenues increased over 200 percent between FY03 and FY09, from almost $33 million to over $98 million, according to the New Mexico Health Policy Commission. County indigent fund expenditures during that same time period increased by 150 percent, from $35 million to over $87 million.

Counties have not relied solely on the 2nd 1/8th GRT increment to fully cover all indigent fund expenses, which is allowed. In 2009, this revenue source accounted for less than 40 percent of revenue for indigent funds. Many counties reported supporting the indigent fund with revenue from the 2nd 1/8th GRT increment, which is dedicated to indigent care, as well as with other revenue. Other revenue sources included the 1/16th GRT increment for County-Supported Medicaid (for counties who enacted this increment), grants, penalties, reimbursements, and interest, according the New Mexico Health Policy Commission report. For example, Doña Ana County reported $2 million of revenue from the 2nd 1/8th, with $6.5 million from the 3rd 1/8th, and another $6.6 million from other revenue sources, including grants. Santa Fe County reported $4.9 million in 2nd 1/8th revenue and $4.5 million from other sources. Similar trends existed in other counties. Lea County reported $4.1 million from the 2nd 1/8th and $2.6 million from other sources; San Juan County reported $5.5 million and $5.1 million from these two revenue sources; and Guadalupe County reported $131 thousand.

Chart 2. FY09 County Indigent Funds Revenue Sources

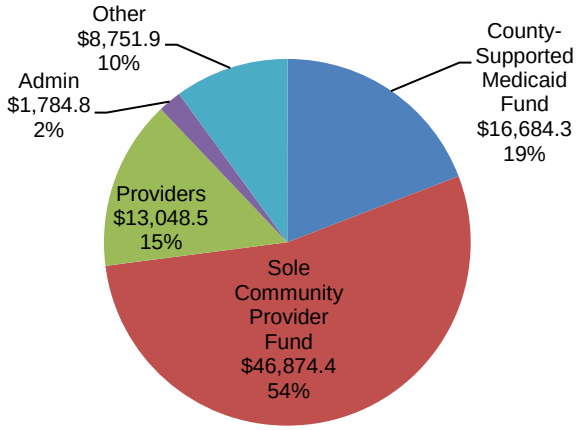


Source: NM Health Policy Commission

In FY13, counties budgeted over $68 million in revenue for their indigent funds. Again, counties appear to use other revenues for indigent funds as the 2nd 1/8th for that year generated an estimated $36 million. These figures exclude Bernalillo and Socorro counties.

Because of these multiple funding streams, counties managed to support indigent care spending, contribute to Medicaid statewide, and subsidize rural hospitals all from indigent care funds. For example, many counties have not imposed the authorized 1/16th County Supported Medicaid GRT increment, and instead use indigent funds to meet this obligation. In FY09, counties reported spending $16.6 million of indigent funds for the County-Supported Medicaid transfer. The biggest expenditure from indigent funds was transfers for the Sole Community Provider program (SCP), totaling almost $47 million in FY09. Counties transferred about $47 million for SCP in FY11, and $56 million in FY12. Both years, contributions exceeded revenue generated by the 2nd 1/8th gross receipts tax increment, indicating counties turned to other revenue sources for indigent funds.

Chart 3. FY09 County Indigent Fund Spending



Source: NM Health Poliicy Commission

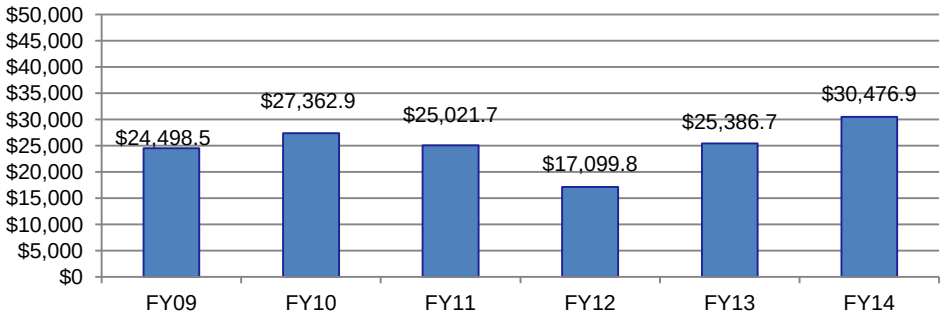
Indigent claims and other spending on health care providers comprised about $13 million in FY09. The New Mexico Association of Counties conducted a survey of how counties spent revenue from only the 2nd 1/8th GRT increment for FY13. Counties reported similar levels of spending, $14.3 million on these types of community services for indigent patients. Counties reported spending $5 million for community-based providers, $3.5 million for out-of-county hospital claims, and $2.6 million for behavioral health services. Lea, San Juan, and Santa Fe counties accounted for $3.3 million of spending on community-based providers alone. San Juan County accounted for over half ($1.4 million) of all spending on behavioral health services, while Lea and Santa Fe counties accounted for 26 percent ($669 thousand) and 22 percent ($254 thousand) respectively.

Some counties use indigent funds for local jail health care costs. Based on FY09 data, only ten counties reported using indigent funds for inmate health care. However of the nearly $1.1 million spent, Lea County accounted for almost $800 thousand. The other counties reported spending between $219 dollars and $92 thousand.

Increasing costs put constraints on the ability of counties to fund other indigent care priorities such as Sole Community Provider (now the Safety Net Care Pool) and community health initiatives. Lea County does not leverage two available 1/16th GRT increments available for county correctional facilities. In contrast, Santa Fe County leverages correctional GRT increments along with fee revenue and general fund to pay for inmate expenses including health care. In a third example, San Juan County does pay for inmate health care with indigent funds and also leverages both correctional GRT increments, paying almost $1.1 million for inmate health care out of their indigent fund in FY13. Chaves and McKinley counties also noted that county inmates were eligible under their indigent care programs.

Between FY09 and FY14, county indigent fund balances increased over 24 percent to over $30 million. Most of the fund balances are located in a few counties, including Eddy, Lea, San Juan, and Sandoval counties. San Juan County reported a large swing in fund balance and accounts for most of the decline in FY12, but has since rebounded. Reported fund balances more than doubled between FY03 and FY08, and rose from $7.3 million to over $18 million, as noted in **Appendix C**.

Chart 4. Statewide County Indigent Fund Balances FY09-FY14
(in thousands)



Source: County Budgets submitted to DFA (Unaudited)

Since 2011, the state has made a number of changes impacting county indigent funds, which in some cases have caused significant financial competition for funding for the first time. The state has made three key policy changes that have a near-term financial impact: increased restrictions on source of county revenue that can be used for leveraging Medicaid funds for local hospitals, enactment of statutory changes impacting county indigent funds and required Medicaid matching contributions for rural hospitals, and enactment of a phase-out of medical GRT hold harmless payments along with additional county taxing authority.

HSD tightened up requirements on the county revenue used to draw down federal Medicaid funds for rural hospitals to ensure compliance with federal regulations. Between 2011 and 2014, HSD sought better assurances that counties were transferring public funding from local indigent funds to the state Medicaid program for SCP, as opposed to funds that could have been grants to county indigent funds from hospitals. HSD overhauled the SCP program as part of its comprehensive federal waiver, and sought dedicated local tax revenue to continue county support for local hospitals in the 2014 legislative session. The reasons for these requested changes are discussed further below.

At the time of the 2011 LFC report, the federal Centers for Medicare and Medicaid Services (CMS) was scrutinizing how county matching funds were acquired to ensure compliance with federal regulations. Federal regulations prohibit use of funds as the non-federal share where the state or county had received donations from private healthcare providers that are related to the amount of Medicaid reimbursement paid to the provider. A preliminary CMS report concluded that in certain instances, the non-federal share of Sole Community Provider hospital payments in FFY09 were based on improper provider donations. HSD had historically required counties to

certify they were transferring public money to draw down federal Medicaid funds. However, CMS asserted that in nine instances counties had received donations from private SCP hospitals, either via direct payments to the county or, in one case, through in-kind services, that were related to the amounts transferred by the counties to the state to fund SCP payments. HSD was negotiating with CMS to resolve issues raised and eliminate state exposure for previous payments. Initially the liability was estimated to range from $11.6 to $53 million. The final amount was $7.9 million and paid by counties, which also resulted in lower payments to hospitals.

Also at the time of the 2011 report, five New Mexico private hospitals had been named in a whistleblower lawsuit alleging that they violated the False Claims Act by making improper donations to New Mexico counties that were correlated to the amounts transferred by those counties to the state to fund SCP payments to these hospitals. The federal Department of Justice had intervened in the lawsuit with regard to three of the hospitals. Hearings could be possible soon.

Through Senate Bill 268, the state enacted changes impacting county indigent funds and how rural hospitals are financed through Medicaid. Senate bill 268 sought to amend state law to comply with new changes made by HSD to ensure compliance with federal Medicaid regulations, replace the Sole Community Provider program for rural hospitals, and better align law with how counties were administering their indigent care programs. The legislation converted what was formally known as the County Indigent Fund into a Health Care Assistance Fund. Counties can continue to leverage the 2nd and 3rd 1/8th gross receipts tax increment and/or mill levy revenues already enacted into this new fund. The act states revenues from other sources may be transferred into the fund, but no transfers can be made from the fund for any purpose other than those stipulated in the Indigent Hospital and County Health Care Act. The legislation goes on to state indigent hospitalizations cannot be paid for through any other county fund. Counties continue to have flexibility to use the fund to make payments to meet obligations for the County-Supported Medicaid fund.

The legislation also created the Safety Net Care Pool Fund, replacing the SCP fund, and requires counties to transfer the "equivalent" of 1/12th of one percent gross receipts tax revenues into the fund managed by HSD. Counties have flexibility to transfer revenue from any public source, including the new health care assistance fund. This means counties do not have to rely solely on one taxing increment to meet obligations to support rural hospitals. One major change under this program is counties no longer have the flexibility to determine how much annually to dedicate to their own local hospitals, in part due to issues raised in the previous section of this report. Further, there is no longer a direct relationship to how much a county transfers and how much in federal Medicaid a hospital will receive since local funds go into a state pool and are distributed according to a new federally-approved formula and rates paid based on use of services. This issue of county control has caused, and continues to cause concern among counties. A line-item veto of the sunset clause on the required transfer of funds has also caused concern for counties.

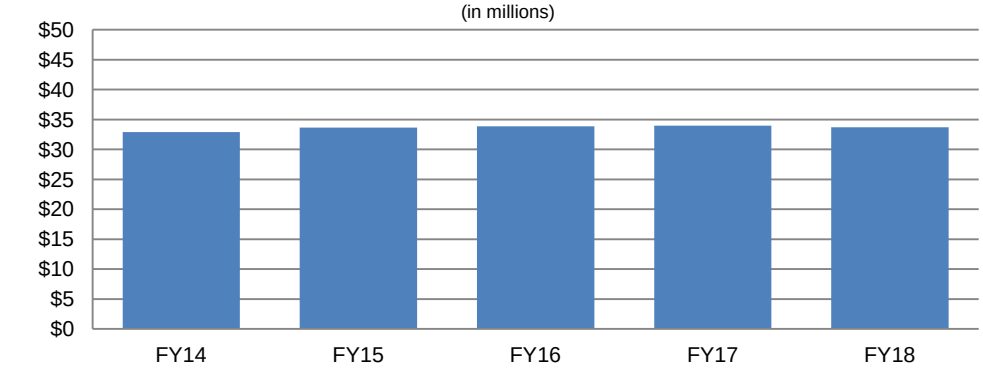
The legislation also provided counties with additional gross receipts taxing authority for general purposes of one-sixteenth of one percent or one-twelfth of one percent.

The state enacted legislation to phase out hold harmless payments for exempting medical services from gross receipts taxes, however projections show payments will remain relatively flat through FY18. Between FY05 and FY13, the state made over $264 million in payments to local governments, including counties, to hold them harmless from elimination of medical services from gross receipts taxes. In 2013, the state enacted House Bill 641 as part of a comprehensive tax package, which includes provisions to phase out these payments over a 15-year period.

However, actual payments are not projected to decline at the schedule rate according to the legislation because projected medical inflation and increases in the economic base (e.g. potential lost revenue) exceed those amounts. As a result, local governments do not face much, if any, decline in state support through FY18, according to projections by TRD. Counties typically account for about 19 percent of hold harmless payments for medical

services. Projections show payments to counties will hover between $6.2 and $6.5 million during the next four fiscal years. The legislation provided counties three general purpose 1/8th GRT increments to provide flexibility to deal with the scheduled phase-out, which would raise far in excess of reduced revenue from loss of hold harmless payments for both medical services and food.

Chart 5. Projected Medical Hold Harmless Payments to Local Governments FY14-FY18



Source: TRD, LFC Files

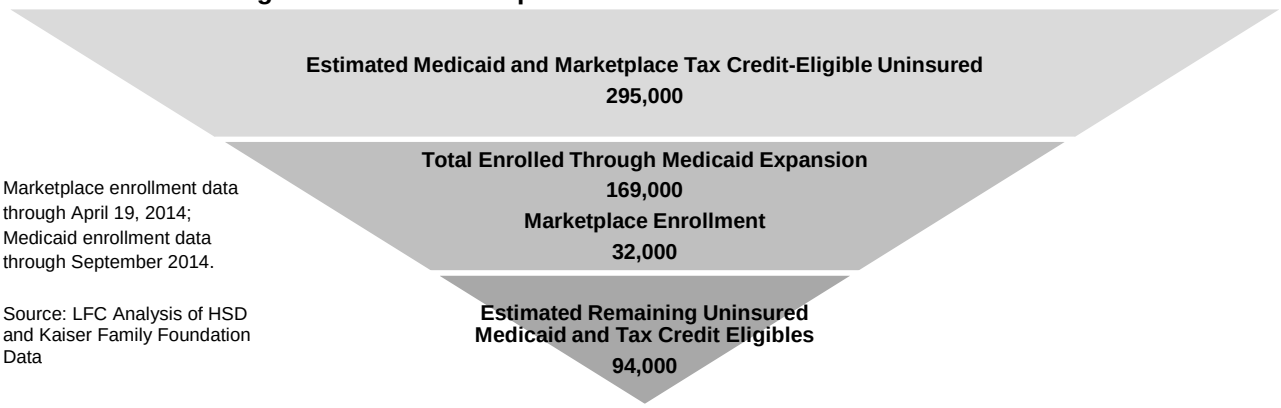
Some counties have enacted new tax increments to bolster health care spending. San Juan County has enacted tax increments that more than offset reduced indigent fund revenue due to no longer receiving payments from its local hospital. The new tax increments will allow the county to continue funding many of its indigent programs, jail health care, and fulfill payments to Medicaid and the Safety Net Care Pool. The county is projected to generate surplus funds of $3.3 million in FY16. The newly enacted GRT increments have a sunset clause, with the 1/8th increment expiring at the end of calendar year 2017, and the 1/16th increment expiring at the end of CY16. Impact of the additional revenues is shown in **Appendix D**. With the newly-passed GRT revenues and the 53 percent reduction in indigent care provider payments also enacted in 2014, the county will yield a funding surplus in its health care assistance fund.

In August 2014, the Curry County Commission passed a 1/4th GRT tax increment to fund indigent care obligations as well as other priorities such as the county's detention center. If the county took 30 percent of the revenues generated from this new tax increment and directed it to indigent care, the county would meet all indigent care obligations, as noted in **Appendix D**.

With Medicaid expansion and new health insurance options for New Mexicans, the need for county indigent programs will diminish significantly. As the ACA and Medicaid expansion reduce the uninsured population, the legislative mandate and funding of county indigent care should be revisited. Senate bill 268 stipulates that hospitals cannot seek reimbursement from counties for claims for Medicaid-enrolled individuals. However, Medicaid will only reimburse claims as old as 90 days prior to enrollment. Therefore, a focus on enrolling all Medicaid-eligible individuals is paramount in reducing costs to hospitals and counties, and ensuring the state is leveraging increased Medicaid reimbursement rates.

The Kaiser Family Foundation estimated 295 thousand uninsured New Mexicans would be eligible for Medicaid under expansion or for enrollment into a marketplace health plan with tax credit subsidies. HSD confirmed 169 thousand Medicaid expansion enrollees as of June 2014 and Kaiser reports 32 thousand people have purchased a plan on the health exchange as of April 2014. This leaves an estimated 94 thousand eligible people not enrolled in Medicaid or a health plan on the exchange with tax credits. It will be vital to reach this population to maximize increased Medicaid funding through the ACA and reduce direct county indigent care expenditures.

Figure 2. Estimated Impact of the ACA on New Mexico Uninsured

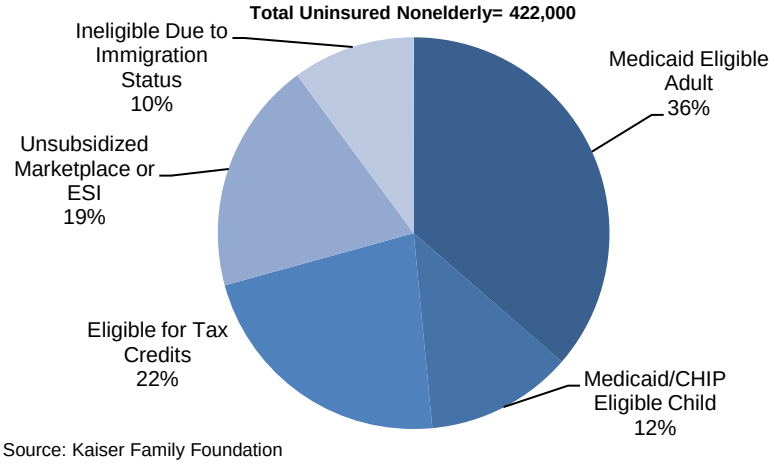


Marketplace enrollment data through April 19, 2014; Medicaid enrollment data through September 2014.

Source: LFC Analysis of HSD and Kaiser Family Foundation Data

Gaps in coverage will likely continue, primarily for immigrants not eligible for Medicaid or subsidized insurance, and for individuals opting not to sign up for available coverage. While many uninsured individuals who access county indigent care funding will gain coverage through Medicaid expansion and access to insurance plans in the health care exchange, there are segments of the population that will continue to need other sources of care. Beyond county inmates, the ACA stipulates only citizens can access care through Medicaid or the health care exchange. Therefore, resident aliens, authorized day labor, foreign students and undocumented persons would still be categorized as uncompensated care. The Kaiser Family Foundation estimates approximately 42 thousand New Mexicans may fall into this ACA-ineligible category, remaining the responsibility of other programs such as county indigent care and hospital uncompensated care. Furthermore, Native Americans are not required to obtain coverage under the Affordable Care Act, meaning services obtained outside of the federal Indian Health Services system will continue to impact hospital uncompensated care and county indigent care programs.

Chart 6. Coverage Eligibility Among Uninsured New Mexicans as of 2014



Source: Kaiser Family Foundation

Other local public bodies are rethinking how to provide safety net health care in light of the Affordable Care Act. Counties and other regions are using various models from nonprofits to consortiums of hospitals to reduce costs and better manage health care in the post-ACA environment. These programs operate as plans, as opposed to paying claims post-service, as New Mexico counties do. One example is the Healthy San Francisco program, which caters to individuals up to 500 percent of the federal poverty level (FPL) who are not eligible for any other public health insurance program. Enrollees are assigned to a medical home, annual renewal is required, and those with income above 100 percent are subject to quarterly fees, plus co-pays may also apply. The San Francisco Department of Public Health administers the program and it is funded through the city and county of San Francisco

(72 percent), federal funding (15 percent), local employers (11 percent), and participant fees (2 percent). The county estimates that 80 percent of 60,000 uninsured persons have enrolled in the program.

A nonprofit operates the Nevada Access to Healthcare Network, which offers a discounted medical plan available to anyone not legally required to seek coverage under the ACA and who meets an income requirement between 100 percent and 250 percent of federal poverty level. Every patient is assigned a primary care physician and a personal care coordinator and is provided access to discounted care from a network of over 2,000 providers in a variety of service categories. Patients pay a monthly fee ($35-40 for adults and $10 for children) and fees for service directly to providers based on income. Public funding pays to administer the program. Other models for health care programs are located in **Appendix E**.

Increased oversight at the state level is needed to ensure proper implementation of SB 268 and accounting for county indigent fund spending. The lack of comprehensive information on county indigent funds, previously provided by the Health Policy Commission (HPC), hampers state oversight and health care planning. Statute requires HPC to collect and report on county indigent programs, however this agency is no longer operational and has not been able to report this information since FY09. Other duties of were transferred to DOH and UNM, however this responsibility was not. As a result, the Legislature lacked critical information during deliberations over changes to county-financed indigent care and support for rural hospitals during the 2014 legislative session. Critical information included comprehensive data on sources of revenue used for indigent funds, fund balances, and how counties were using these resources.

The Department of Finance and Administration is best positioned to monitor indigent fund spending through its budget approval process of county budgets. County budget information currently is not detailed enough to collect the type of needed information on indigent spending, and neither are financial audits. But a simple reporting schedule similar to what was used by HPC could be submitted by counties along with their budgets to DFA for review. Having this information will be critical for the state to monitor the implementation of SB 268 and any future needed changes to financing indigent care and rural hospitals as Medicaid and health care expansion rolls out over the next few years.

Given the risk to the state, financial audits of counties should ensure compliance with federal regulations prohibiting improper donations for drawing federal Medicaid funds. HSD had originally sought to have a tax revenue, at county choice, to be directed to the Safety Net Care Pool to prevent the possibility of improper funds being used for this program as allegedly been done in the past. SB 268 still allows counties significant flexibility to deposit a variety of revenue sources into its indigent fund (Health Care Assistance Fund) and transfer to the Safety Net Care Pool fund. HSD still requires county certification that transferred funds are in fact public. However, financial auditors could provide some additional assurance though targeted compliance testing as part of annual financial audits at the direction of the State Auditor.

Recommendations

The Legislature should consider:

Amending statute to sunset the Indigent Hospital and County Health Care Act including county indigent care obligations and the authority for imposing the 2nd 1/8th GRT increment in 2020. The legislature would need to review and take action on any changes during the 2019 legislative session. If discontinued, counties could continue to support indigent programs through general purpose tax revenues;

Amending statute to increase the rate of phasing out medical hold harmless payments from 5 to 10 percent a year avoid a financial cliff for local governments; and

Refining parameters around the Health Care Assistance Fund to establish a maximum fund balance and revert excess funds to the County-Supported Medicaid Fund or the Safety Net Care Pool to ensure public funding supports low income New Mexicans.

The Office of the State Auditor should:

Direct financial auditors to review counties' spending and transfers for the Safety Net Care Pool comply with state and federal law and regulations as part of annual county financial audits.

The Department of Finance and Administration:

Require counties, as part of the budget review process, to include a schedule of detailed revenue and expenditures of the Health Care Assistance Fund and report annually to the Legislature in a similar format as the previous Health Policy Commission reports.

HSD HAS MADE SIGNIFICANT CHANGES AND IMPROVEMENTS IN MEDICAID FUNDING FOR RURAL HOSPITALS, BUT PROGRAM COSTS NEED MONITORING

In 2011, a LFC program evaluation found problems with Medicaid administration and financing for rural sole community hospitals. When LFC last reviewed the Sole Community Provider and county indigent care programs, the Affordable Care Act had not been fully implemented, and the state had not elected to expand Medicaid. Even with the uncertainty around the federal law, and the status of the Sole Community Provider Program, counties' ability to fund indigent health care faced challenges. SCP was growing at an unsustainable rate and health care costs were also increasing, while GRT revenues were decreasing. The report found total spending on the Sole Community Provider Program, which supported mostly rural hospitals or those outside the Albuquerque metro area, was projected to reach $267 million in FY12. The program had grown exponentially over the years, with insufficient accountability and uncertainty as to its impact on increasing access to care or reducing uncompensated care costs.

SCP program costs had increased significantly, in part due to how available funding was calculated. The report found the SCP funding formula contributed to average annual increased spending of about 20 percent between FY03 and FY10. The total program had increased in cost from $55 million in FY01 to an estimated $255 million in FY11. Counties were able to fully fund this entire program, and the state had never contributed financially. For many years, counties did not draw down all available funds according to the funding formula. For example, total program funding was projected at $267 million based on county contributions, but a total of $340 could have been available with sufficient matching funds. Although not a mandatory program, the funding formula put pressure on counties to provide the full match to available federal SCP funds.

County contributions were typically more than revenue generated by the equivalent of a 1/8th GRT increment. For example, in FY12, counties transferred $57 million for the Sole Community Provider Program. The tax equivalent was less than $35 million.

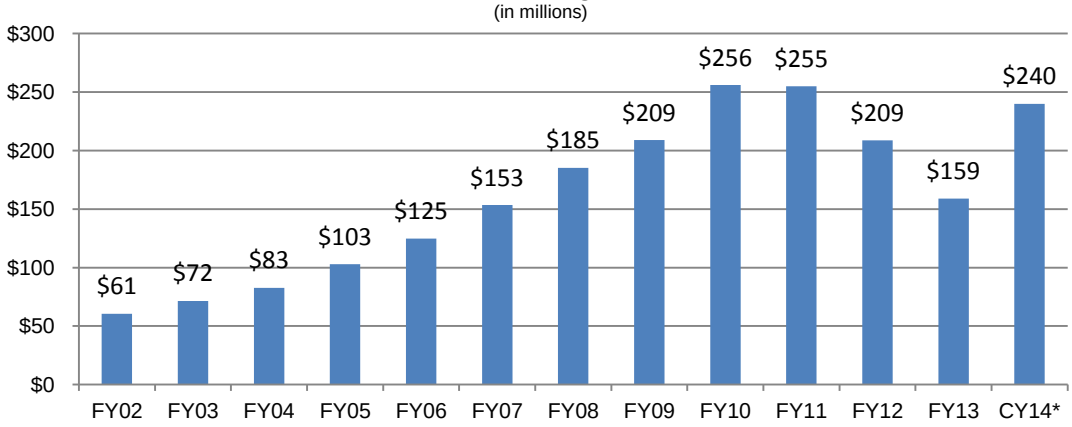
Some hospitals appeared to be overcompensated, receiving payments that exceeded costs of Medicaid and uninsured uncompensated care. The report found SCP reporting from hospitals to counties and HSD was often inadequate and lacked standardization statewide. The program did not specify how funds would be used by hospitals, a concern for counties, and lacked an assessment of whether Medicaid and indigent uncompensated care costs were reduced. Many hospitals appeared to receive total Medicaid payments, including from SCP that exceeded the cost of providing care to Medicaid patients, and the cost of uninsured care as well. As a result, some hospitals appeared to have had all Medicaid unreimbursed and uninsured uncompensated care not only eliminated, but result in a net financial gain above the cost to provide care.

The program faced an unclear future with expansion of health care and reduced numbers of New Mexicans without a payment source. Nationally, supplemental payment programs, such as Disproportionate Share Hospital Program (DSH), are scheduled to have funding declines in recognition of the anticipated improved payer mix. New Mexico has one of the highest uninsured rates in the nation, and as more people have a source of payment for care, the continued need for SCP, particularly at current levels, was anticipated to diminish beginning in 2014. The report noted that resources used for SCP could be redirected toward picking up the eventual state share of newly-eligible Medicaid recipients. However, the report noted that should the state choose to use Medicaid to help finance uncompensated care from residual gaps in coverage, then a smaller SCP program may continue to be needed. For example, some communities may have significant numbers of uninsured immigrants that seek care in local emergency rooms that result in uncompensated care costs.

Finally, the 2011 report noted problematic arrangements for county financing of the SCP program, as detailed in the first section of this report.

HSD implemented a new program for supporting rural hospitals that would provide supplemental payments and rate increases, and prevents overcompensation. In 2013, HSD reviewed and revised the formula used to calculate county-supported hospital funding to ensure compliance with federal regulations. This resulted in a significant reduction in the amount of funding HSD could pay directly to hospitals using county matching dollars. For example, the original formula showed that for FY13 more than $310 million was available. County commitments for that year would have drawn down about $246 million. However, "after [the] formula correction, only $69 million was available, a 71 percent drop from the $246 million anticipated by hospitals and counties." HSD then proposed a new payment structure to the federal government. Between FY12 and FY13, the state started to transition to a new program and hospital funding decreased to $159 million, almost entirely among private hospitals and unneeded county matching funds were returned. Counties with public hospitals appeared to continue the practice of using money from those hospitals for Medicaid federal match funding.

Chart 7. Total Sole Community Provider/Safety Net Care Pool Funding
(in millions)

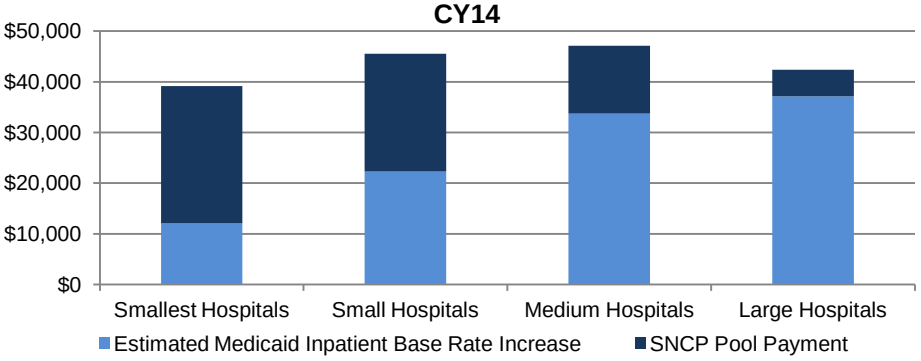


Note: Totals include UPL Supplemental Payments*2014 Estimated based on full funding.
Source: HSD

The new approach for supporting rural hospitals is divided into three key parts: a supplemental payment pool of funds, a rate increase, and a quality improvement component. The new program allocates $69 million to supplemental payments, primarily targeting small hospitals called the uncompensated care pool. Each former sole community hospital has to apply for the pool of funds and demonstrate Medicaid uncompensated and uninsured costs. Ninety percent of the allocation of the pool is designated for hospitals with less than 100 beds, with 10 percent for hospitals with 100-200 beds. If smaller hospitals cannot demonstrate need, funding would become available for larger hospitals, including those over 200 beds.

The second part of the approach includes rate increases for inpatient care, which primarily benefits larger hospitals given higher patient volume than very small hospitals. HSD estimates larger hospitals that treat more clients would benefit from approximately $171 million in Medicaid rate increases. HSD needs a consistent source of revenue for this new program, and coupled with the complexity in how rates get paid to hospitals through Medicaid and a history of improper county payments, sought to redirect county tax revenue to achieve this.

Chart 8. Total Estimated Safety Net Care Pool Financial Impact CY14



Source: HSD

While UNM Hospital (UNMH) is part of the program, its funding is separate from the rest of the hospitals. This hospital has always received supplemental funding through separate parts of Medicaid and would continue under this new program. UNM Hospital puts up the state share ($14 million) for drawing down federal Medicaid funds which is allowed as UNMH is a constitutionally created and publicly funded entity.

Finally, the new program also includes a quality of care component, with potential pay for performance awards of $29 million over four years. Hospitals will collect baseline performance data during 2015 and then earn incentive payments for reaching certain targets in subsequent years.

The new program is designed to prevent overcompensation, and adds much needed transparency and reporting, as previously recommended by LFC. HSD has implemented an application process for hospitals to demonstrate estimated Medicaid unreimbursed and uninsured costs. This reporting format and application process allows the state to assess the gap in reported hospital costs to deliver care to Medicaid and uninsured clients, against payments received from Medicaid. HSD will use this to monitor the payment amounts hospitals receive so that Medicaid payments do not exceed costs of delivering services to Medicaid and uninsured clients.

For almost all hospitals in the Safety Net Care Pool, uncompensated Medicaid and uninsured care would be significantly reduced. Based on full funding, the program would cover all Medicaid services at cost, and cover costs of uninsured care at all hospitals in the program except for three large hospitals. For hospitals under 200 beds, the program would eliminate over $100 million in uncompensated care. For example, Cibola General Hospital reported $10 million in the cost of caring for Medicaid and uninsured clients in its application to the state for funding. The hospital received $7.9 million in payments from Medicaid and uninsured individuals, leaving a gap of $2.1 million. Under the new and fully funded program, this hospital would receive about $800 thousand in supplemental uncompensated care pool payments, and estimated $1.3 million in higher rates.

The program is estimated to reduce Medicaid uncompensated care between 42 to 69 percent at large hospitals. The program would reduce uncompensated care by an estimated $42 million at the three hospitals with 200 beds (Memorial Medical Center, San Juan Regional, and Christus St. Vincent). The remaining gap between total Medicaid payments and cost of care for Medicaid clients and uninsured would be about $35 million. UNM hospital would have uncompensated care reduced by $66 million leaving unreimbursed costs at over $75 million.

HSD has insufficient funding to fully implement the program, due in part to high cost and lack of revenue from the counties. Going forward, the program has a total funding gap of over $36 million, including $11 million needed to match federal funds. HSD is currently in discussions about how to apply reductions to hospital payments due to lack of funds for FY16. HSD did not request funding to close the gap in its FY16 budget request and at the time of this report does not intend to seek state support from the general fund to fully fund the program.

This funding gap is due to lower than needed contributions from counties. HSD's proposal had assumed a county funding level of $36 million, which is the equivalent of a 1/8th GRT increment. However, SB 268 provided for a required county funding level of about $24 million.

The program initially was estimated to cost $192 million, but has increased to $240 million due to new estimates from Medicaid expansion. The original projection assumed about $133 million in federal matching funds, but that grew to $182 million without a corresponding increased need in local matching funds because the federal government will pay 100 percent of the cost initially, and eventually stepping down to 90 percent. All of the projected increased costs of the program would go into the rate increase, which would rise from $123 million to $171 million.

Of the $48 million in increased rates, UNM Hospital would gain an additional $21 million under the latest estimates. Other hospitals in the program would receive the remaining estimated $27 million in increased rates. Absent full funding, hospitals' total estimated payments would go back down to levels similar to HSD's original proposal.

HSD's original proposal assumed insufficient county revenue, and required a state appropriation from the general fund to support this local program for the first time. Originally, HSD estimated $60 million in state matching money would be funded approximately as follows: a $36 million transfer from counties from the equivalent of a 1/8th gross receipts tax increment, $9 million in state general fund contributions, and $14 million from a University of New Mexico Hospital inter-governmental transfer.

Table 3. Hospital Payment Plan Revenues and Expenditures

Revenues	**HSD Original Projection**	**Current HSD Projection****
Counties	$36,000,000	$24,000,000
SB 313 GAA	$9,000,000	$9,000,000
Federal	$133,000,000	$182,000,000
UNM	$14,000,000	$14,000,000
Gap in Needed Matching Funds		$ 11,000,000
Total	**$192,000,000**	**$240,000,000**
Expenditures	**HSD Original Projection**	**Current HSD Projection**
SNC Pool	$69,000,000	$69,000,000
Rate Increase	$123,000,000	$171,000,000
Total	**$192,000,000**	**$240,000,000**

Source: HSD

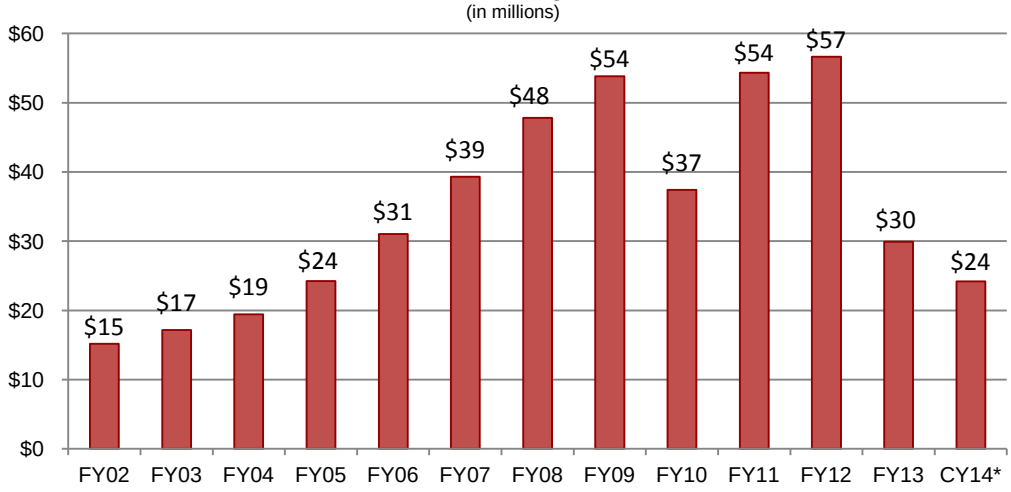
The state has assumed a larger and more uncertain liability with this program given federal matching rates will decline for newly-eligible Medicaid clients, and managing the cost of the rate increase may prove difficult. For example, initially the state will not bear the cost for the additional $49 million built into this new program for rate increases attributable to newly-eligible clients. If that amount holds into the future, the state share will increase to about $4.9 million. In effect the state has already committed at least $14 million from the general fund for a program it has never had responsibility to fund before.

This new program assumes a rate increase of over $171 million, most of which will flow through managed care contractors. Monitoring and managing the rate increase separate from other negotiated payments between managed care and these hospitals may prove difficult for the state. Hospitals will not be guaranteed the estimates provided by HSD for the program, because payments under the rate increase will be dependent on patient volume and types of inpatient services provided. Revenues from the Medicaid rate increase will only be generated for Medicaid-enrolled patients. Medicaid-eligible but unenrolled patients, as well as Medicaid-ineligible inpatient care costs will still fall either to the hospital as uncompensated care, or to counties through their indigent care programs. Furthermore, Medicaid will only reimburse costs retroactively for 90 days for patients who are enrolled after they receive care. This creates an added incentive to ensure all Medicaid-eligible persons presenting themselves for care at SNCP hospitals are enrolled in a timely fashion.

Finally, some risk exists since program revenues are now directly tied to GRT equivalents that could result in over or underfunding from county contributions.

County contributions to rural hospitals will decline from previous levels with enactment of SB 268, causing an $11 million shortfall. Counties historically had been contributing over $50 million, however some of those contributions appear, whether proper or not, to have come from local hospitals.

Chart 9. County Sole Community Provider/Safety Net Care Pool Funding
(in millions)



Note: Totals include UPL Supplemental Payments.
Source: HSD

<u>The state should continue to monitor this program and rural hospitals' financial health.</u> The new program effectively pays full cost for Medicaid and uninsured clients, but HSD should ensure this does not result in excessive profitability. A 2010 study by the Human Services Department (HSD) found New Mexico hospital profit margins were generally higher than the regional, state, and national averages. The net national average in 2008 was 2.64 percent, with the New Mexico average at 9.86 percent. In FY13, hospitals statewide reported almost $242 million in net income, or 5.4 percent, and Safety Net Care Pool hospitals reported net income of $122 million, or 4.6 percent, according to cost reports compiled by the New Mexico Hospital Association. This type of information should be regularly collected and analyzed to have more current information on hospital fiscal health.

The new program subsidizes other state's low hospital payments to rural hospitals caring for out-of-state individuals. For example, some hospitals reported other state's paid between 20 to 50 percent of their cost for out-of-state Medicaid clients. With New Mexico's new program, this funding gap will be paid by New Mexico taxpayers.

Estimated rate increases would rise to cover 80 percent of hospital costs for inpatient services, but many had already negotiated favorable rates with Medicaid managed care companies. For example, one hospital reported that Medicaid managed care paid 17 percent more than reported cost for inpatient care, others reported near 80 percent before the scheduled rate increase. Some hospitals, particularly smaller ones, appear to be paid by Medicaid managed care far below reported costs, indicating either high cost to deliver care or low negotiated rates. Either way, for these hospitals, the funding gap will be fully subsidized by uncompensated care pool payments that may cause market pricing distortions.

Recommendations

The Legislature should consider:

Authorizing counties the option to opt-in to fully fund rural hospitals and provide the equivalent of 1/8th of one percent gross receipts tax revenue, and for those that do, de-earmark the increment required for health care;

Amending statute to sunset the Safety Net Care Pool and associated rate increases in 2020. The legislature would need to review and take action on any changes during the 2019 legislative session; and

Not providing additional support from state funds for the Safety Net Care Pool program or rate increases. Other revenue options besides county contributions could be revisited, including exemptions from gross receipts taxes for for-profit hospitals, and leveraging community benefit requirements for non-profit hospitals.

The Human Services Department should:

Provide, as part of the department's budget request, an annual report on the effectiveness of this program at reducing uncompensated care, the cost of the program, associated revenues, and financial health of each participating hospital;

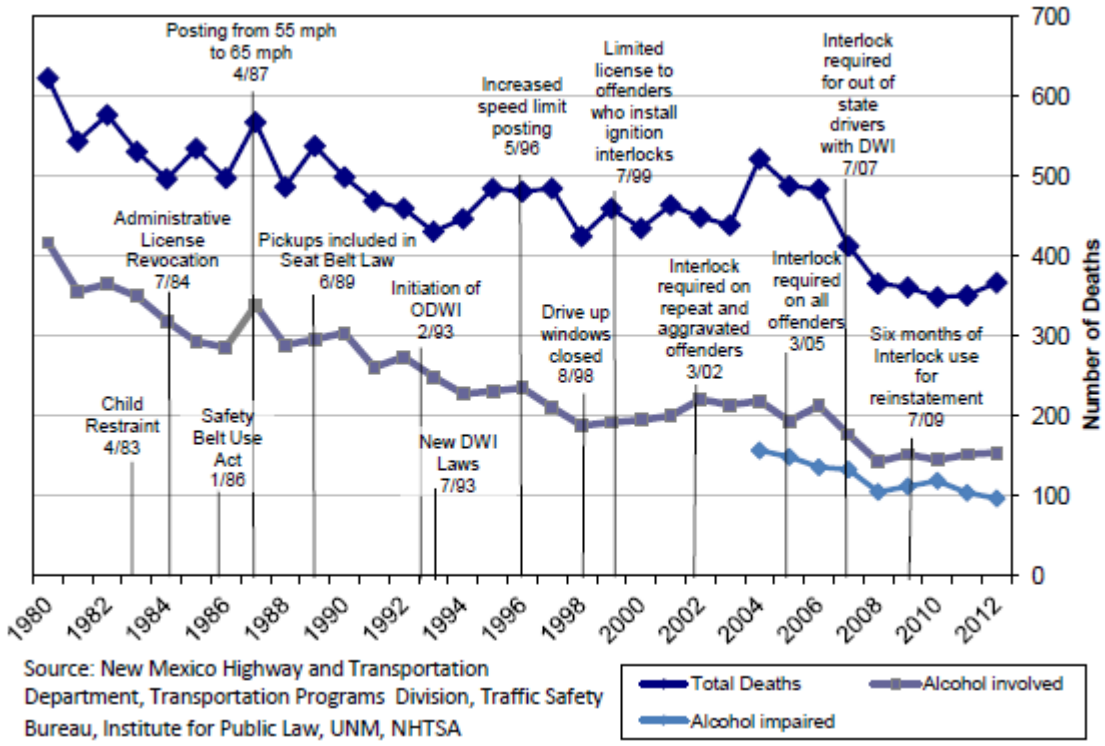
Establish a fixed methodology going forward to fund hospital Safety Net Care Pool applications that incorporates a uniform set of data and methodology to forecast future uncompensated care costs; and

Require hospitals applying for Safety Net Care Pool funding establish and maintain a mechanism for enrolling incoming patients into Medicaid when eligible and report on enrollment numbers annually to maintain status as a program-eligible hospital.

THE LDWI PROGRAM DOES NOT TARGET FUNDING TO HIGH-NEED AREAS EFFECTIVELY, EMPHASIZE BEST SERVICES, NOR ALIGN FUNDING TO OUTCOMES

Alcohol-related crash deaths dropped steadily in New Mexico between 1980 and 2012, following the implementation of various statutory interventions. As noted in Figure 3., over a twenty-year timeframe various legal changes may have contributed to reduced overall automobile crash deaths as well as alcohol-related crash deaths. Some of these interventions included laws increasing safety belt requirements, the closure of drive-up liquor windows, and a requirement for ignition interlocks. However, most recent crash data suggests results of DWI interventions have plateaued.

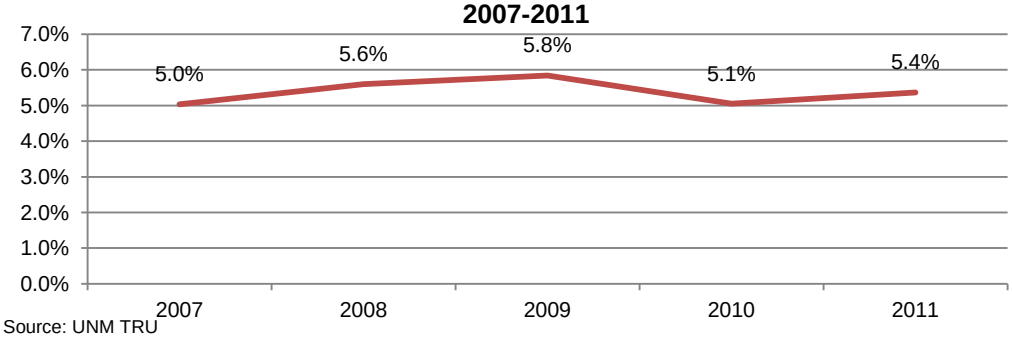
Figure 3. Total and Alcohol-Involved Crash Deaths, Legislative and Administrative Actions in New Mexico, 1980-2012



Source: New Mexico Highway and Transportation Department, Transportation Programs Division, Traffic Safety Bureau, Institute for Public Law, UNM, NHTSA

Between 2007 and 2011, while overall automobile crashes and fatalities have dropped, alcohol-related crashes continue to be approximately 5 percent of total crashes in New Mexico. According to most recent data available, 5.4 percent of total crashes in 2011 was attributable to alcohol. Eighteen of thirty-three counties were above this average, ranging as high as 10.4 percent in both McKinley and Rio Arriba counties.

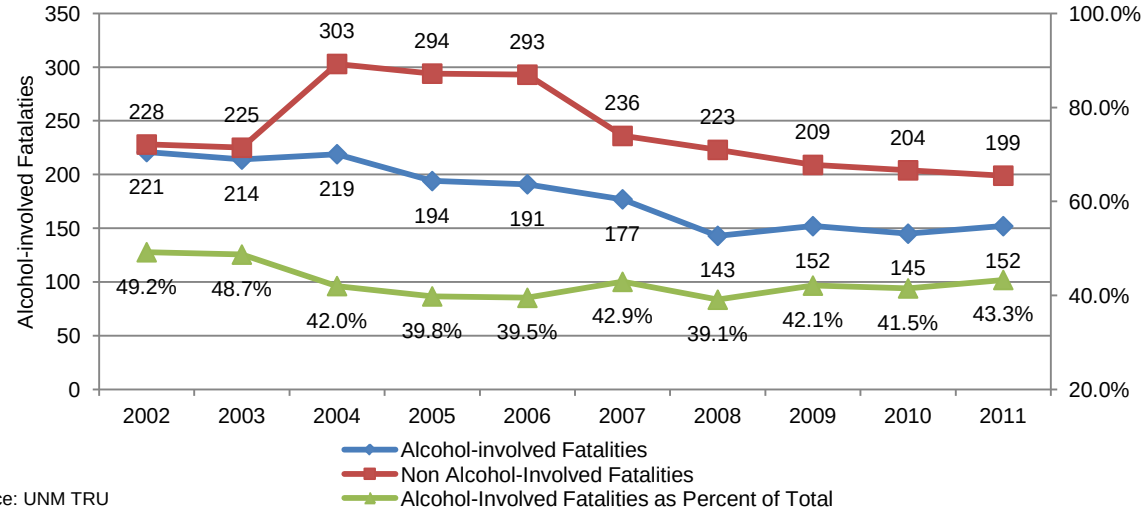
Chart 10. New Mexico Alcohol-involved Crashes as a Percentage of Total Crashes 2007-2011



Source: UNM TRU

Furthermore, while all traffic fatalities dropped between 2007 and 2011, alcohol-involved fatalities as a percentage of total traffic fatalities remained relatively constant around 40 percent. One could infer that while crashes are resulting in less fatalities overall, targeted DWI efforts have not made significant progress in reducing the percentage of DWI fatalities.

Chart 11. New Mexico Traffic Fatalities 2002-2011



Source: UNM TRU

While alcohol-related fatalities remain virtually unchanged, DWI arrests and convictions are dropping. Between 2010 and 2013, the number of statewide DWI arrests decreased by 27 percent, as noted in Table 4. The number of DWI arrests due to automobile crashes also decreased from 2,314 in 2010 to 2,052 in 2013 or 11 percent. Moreover, DWI conviction rates dropped by almost half from 2003 to 2013. The reduction in DWI arrests and convictions coupled with DWI fatality rates may speak to challenges in enforcing current DWI laws.

Table 4. New Mexico DWI Arrests and Convictions 2003-2013

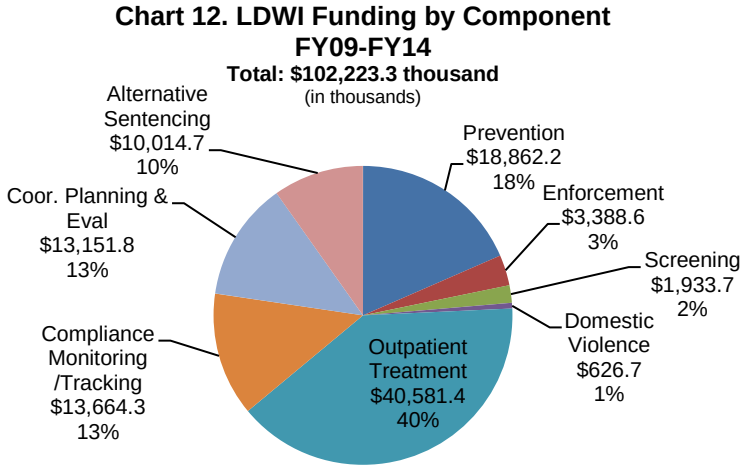
Year	Arrests	Convictions	Percent of Arrests Leading to Convictions*
2003	20,541	13,264	65%
2004	20,272	13,515	67%
2005	18,718	12,989	69%
2006	18,679	13,260	71%
2007	19,977	14,021	70%
2008	19,881	13,713	69%
2009	19,100	12,921	68%
2010	16,741	11,099	66%
2011	14,684	9,856	67%
2012	13,669	8,672	63%
2013	12,249	4,359	36%

*The arrest and conviction of an individual may not occur in the same year.

Source: UNM Division of Government Research

The state allocates approximately $18 million annually though the LDWI program, with most going to county-based programs. Between FY09 and FY14, over half of all LDWI funding went into two program components: treatment (40 percent) and prevention (18 percent), followed by compliance monitoring and tracking (13 percent), coordination, evaluation, and planning (13 percent), and alternative sentencing (10 percent). Treatment funding goes to intensive outpatient treatment as well as jail-based or other facility-based treatment programs. However, in the case of prevention, counties utilize a wide variety of strategies from pamphlets and health fairs to school-based alcohol education programs.

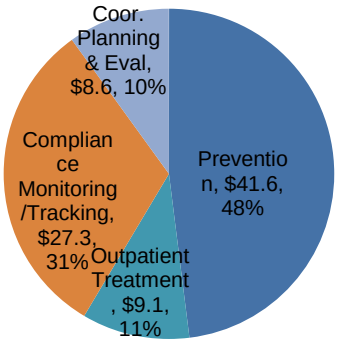
Chart 12. LDWI Funding by Component FY09-FY14



Source: DFA

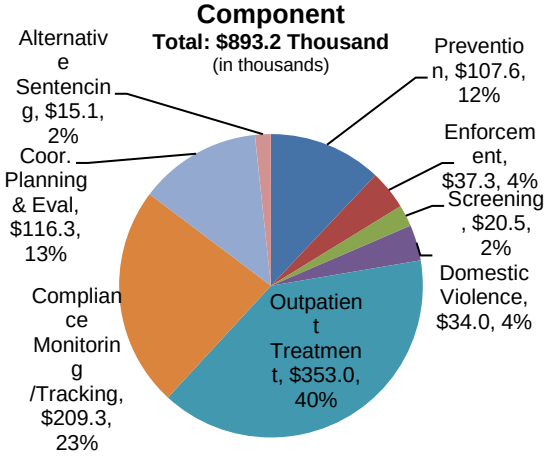
Counties have flexibility to prioritize funding of their LDWI program. There are three funding mechanisms for the LDWI program: distributions, competitive grants, and detoxification grants. By statute, 65 percent of LDWI competitive grant funds have to be directed to treatment. Beyond this requirement, counties apply for LDWI funding based on their county's priorities among the eight available program components. For example, Mora County focused on four program components in FY13, while Sandoval County requested funding for all eight LDWI program components.

Chart 13. FY13 Mora County LDWI Expenditures by Component
Total: $86.7 Thousand
(in thousands)



Source: DFA

Chart 14. FY13 Sandoval County LDWI Expenditures by Component
Total: $893.2 Thousand
(in thousands)



Source: DFA

Various factors contribute to how counties use LDWI funds, including need, availability of service providers, and access to other funding sources. For example, many counties either do not fund or request less funding for enforcement, as the Department of Transportation offers CDWI grants, which focus on enforcement activities. Least populated counties, for the most part, focused on the fewest LDWI program components, which may speak to a lack of access to services.

In 2014, the Legislature passed Section 7-1-6.40 NMSA 1978 (House Bill 16) which increases the distribution of liquor excise tax revenues into the LDWI grant fund from 41.5 percent to 46 percent for FY16 through FY18. After FY18, the LDWI distribution reverts back to 41.5 percent as shown in Table 5.

Table 5. Liquor Excise Tax Revenue Distribution
FY15-FY19

			Previous Law		Current Law (HB16)		Difference	
			In Thousands					
	Estimated Total Liquor Excise Tax Collection (in thousands)	**LDWI Distribution Percentage**	**General Fund**	**LDWI**	**General Fund**	**LDWI**	**General Fund**	**LDWI**
FY15	**$46,900**	**41.5%**	**$27,437**	**$19,464**	**$27,437**	**$19,464**	**$0**	**$0**
FY16	$47,750	46.0%	$27,934	$19,816	$25,785	$21,965	($2,149)	$2,149
FY17	$48,750	46.0%	$28,519	$20,231	$26,325	$22,425	($2,194)	$2,194
FY18	$49,750	46.0%	$29,104	$20,646	$26,865	$22,885	($2,239)	$2,239
FY19	$50,700	41.5%	$29,660	$21,041	$29,660	$21,041	$0	$0

Source: August 2014 Consensus Revenue Forecast

At their October 2014 meeting, the DWI Grant Council passed a motion whereas using FY15 liquor excise tax revenue as a baseline, any additional revenues occurring in FY16-FY18 would be made available to counties through an application process addressing strategic priorities as follows:

1. Treatment
2. Prevention
3. Compliance Monitoring
4. New and Innovative Programming

Funding will be prioritized to the first three components as stated in the DWI Affiliate's newly-created strategic plan, with any remaining funds available for new or innovative interventions. As of the printing of this report, the DWI Grant Council has not determined criteria for how these funds will be awarded.

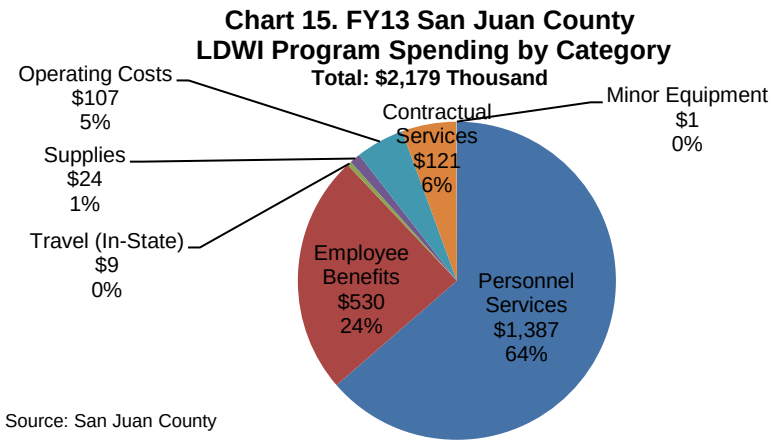
Increased LDWI funding offers an opportunity to make targeted investments in programs proven to work. For FY16, DFA estimates that $1.2 million in new revenues will be available for the LDWI program. The sunset provision around these increased revenues creates an opportunity for targeted funding in finite projects. The LDWI program could invest in pilot projects and measure the effectiveness of these projects with new revenues available for FY16-FY18. Many counties invest in evidence-based practices for DWI treatment and prevention, however, the LDWI program has not evaluated these interventions for effectiveness. Fiscal year 2015 could be used as a baseline to inventory county programs and obtain information on how much counties are investing in evidence-based programs. With this information, the DWI Grant Council could design criteria to identify good pilot opportunities and track the results through defined measures, such as DWI recidivism, over the three-year period. Whether the additional funding continued beyond FY18, the LDWI program would obtain good data on what has proven effective in reducing DWI incidents and could better target funding going forward.

State allocation of LDWI funding is overly complicated, leads to fragmentation of funding and does not prioritize high-need areas of the state. Counties applying for LDWI funding complete extensive annual applications providing a case study supporting the county's funding request. However, DFA does not require counties report similar data points in applications to perform comparative analysis of need. LDWI funding is split into three funding mechanisms: distributions, grants and detoxification grants. Counties can apply for any of the three sources of funding, but each source requires a separate application and differing requirements. Furthermore, funding has gone primarily to larger counties ahead of counties with highest need.

On average, all but six county DWI programs have not funded treatment at the statutorily-required 65 percent for LDWI grants. Between FY09 and FY14, counties overall spent an average of 48 percent of their LDWI grant funds for treatment, falling below the statutory mandate. However, the six counties that also received detoxification grants through LDWI spent 93 percent of grant funds on treatment, surpassing the statutory mandate. DFA's reporting from counties does not assess where counties are in meeting this requirement throughout the year, nor is this issue addressed when new LDWI applications are vetted through the DWI Grant Council. This is the one programmatic requirement for counties to meet in delivery of their DWI programs. It would be valuable to identify what prevented counties from meeting this requirement to ensure program requirements are attainable and address any challenges counties have in meeting them.

For FY15, DFA has created a new methodology to award LDWI funding to counties, which eliminates the competitive grant funding and increased distribution funding to all counties by 1.4 percent. DFA changed this funding requirement to allow counties to have more consistent funding for planning purposes. However, it is unclear whether or not treatment services must be maintained at the 65 percent level as in previous years for any portion of LDWI program funding. Removing the competitive grant component creates a hold harmless scenario where program funding could continue to grow without reassessment of how funds are distributed across the state.

The LDWI program does not have controls to ensure reasonable administrative costs. DFA-required reporting may not give sufficient data to adequately monitor LDWI program overhead costs. Counties report program expenses quarterly to DFA. For example, San Juan County's FY13 LDWI expenses were reported FY13 as shown in Chart 15.



Counties report program expenses by revenue source (distribution or grant funds). While reporting this data is helpful in understanding how counties are spending LDWI funds overall, it does not sufficiently quantify administative versus direct program costs. Therefore, DFA is unable to determine what percentage of LDWI funds go to programming versus overhead costs. In contrast, managed care contracts for Medicaid require that no more than 15 percent of revenues be directed to administrative costs and managed care organizations are required to report on this requirement. This stipulation ensures that maximum funding goes to direct patient care.

While counties may be effectively managing overhead costs in their DWI programs, DFA is unable to observe this through current reporting. Moreover, since DFA changed how funding is distributed, effectively making all funds similar, it would be beneficial to require reporting of expenses by program component and by administrative versus direct program costs. This would allow DFA to perform more effective cost-benefit analysis and monitor indirect program spending.

The LDWI program does not sufficiently emphasize evidence-based practices, nor does it use program outcome data to ensure accountability or inform funding decisions. While there is a requirement to use 65 percent of the smaller grant funding source for treatment programs, the LDWI program does not prioritize evidence-based programs. Moreover, while counties do provide extensive reporting, the data is focused on accountability around spending, and does not incorporate outcomes in measuring program performance.

The LDWI program does not require programs be evidence-based. Many counties voluntarily integrate evidence-based practices into their DWI programming, mostly in prevention and treatment, however DFA does not require that counties disclose which programs meet this standard, nor is there an incentive to focus on evidence-based practices.

Counties are not required to report program outcomes, a continuing problem identified by LFC in 2003. All LDWI-related reporting counties provide to DFA focuses on financial accountability. However, counties are not required to submit data related to outcomes. While fiscal oversight is important to strong program management, how funded services are impacting DWI issues in the state is also an area of concern. Many counties track epidemiological data such as DWI crashes, but not all counties track the same data points. Therefore, it is difficult to assess LDWI program success county to county or statewide, and outcomes are not linked to how the program is funded.

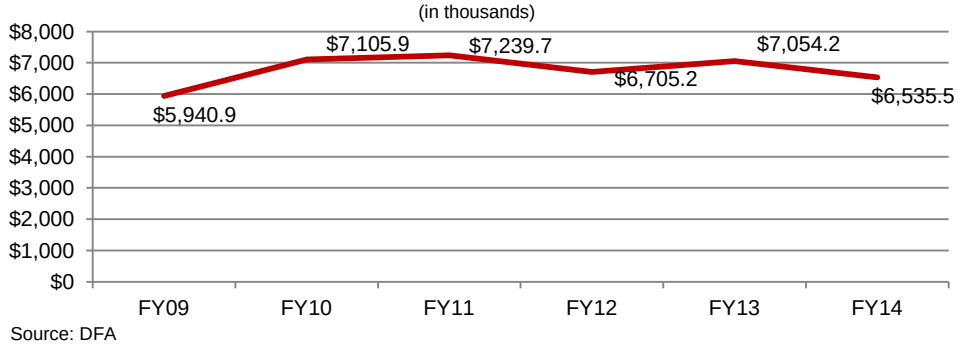
Lack of consistent outcome data prevents the DWI Grant Council from allocating funds based on greatest need. LFC staff compiled various data points including population, poverty rates, alcohol-related crashes and deaths, DWI arrests and convictions, and LDWI program funding to identify counties with the highest need for DWI intervention as detailed in **Appendix H**. Staff then compared this data, most of which was from 2011, to 2012 LDWI program funding. When looking at 2012 LDWI program dollars per DWI incident (combined DWI crashes

and arrests), the average was $1,015 of LDWI funding per DWI incident. However, various counties fell below this average, including Doña Ana ($611), McKinley ($765), and San Miguel ($653). All three of these counties had concerning indicators related to DWI such as DWI crashes, arrests, or deaths.

On the other side of the scale, various counties had high levels of LDWI funding compared to previous DWI incidents including Harding ($73,127), Mora ($2,950) and Union ($2,833). These counties did not have a high number of DWI incidents. This wide disparity in funding compared to DWI incidents speaks to the need to right-size funding to match need statewide as well as an opportunity to consolidate programs across various counties to better leverage funding and reduce duplication of effort.

Treatment programs and access to providers vary statewide, but counties generally lack evidence of effectiveness and specific program costs. According to local DWI program reporting, 64 percent of DWI offenders screened were referred to treatment. Most counties refer offenders to treatment whether the treatment is funded by LDWI or other funding sources. Treatment accounted for 40 percent of LDWI funding between FY09 and FY14 for a total of $41 million.

Chart 16. LDWI Treatment Funding FY09-FY14



Source: DFA

Counties primarily fund intensive outpatient and jail-based treatment for DWI offenders, with varying levels of success. In FY13, Bernalillo County received the highest amount of LDWI treatment funding ($4.3 million), followed by San Juan ($771 thousand) and Sandoval counties ($353 thousand).

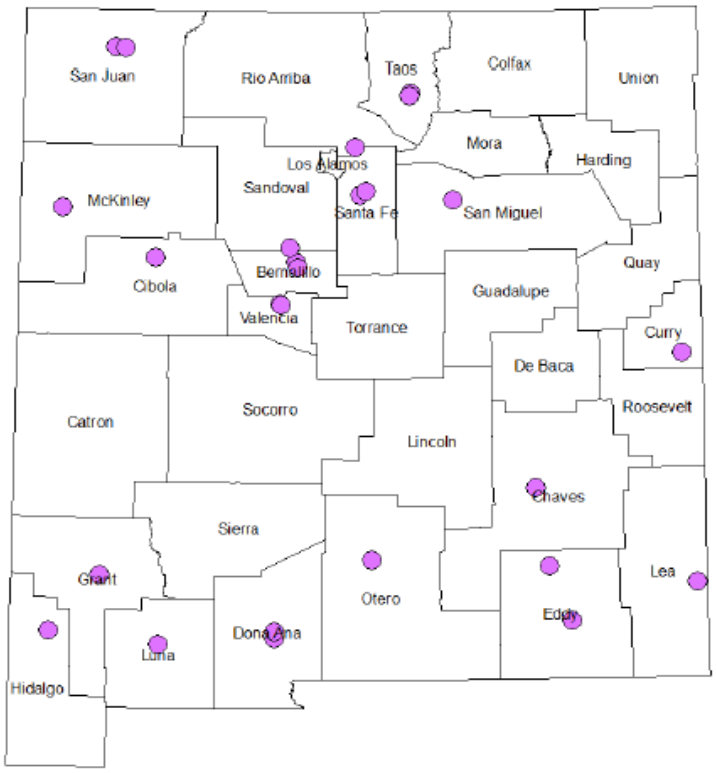
Counties are using various evidence-based treatment models through their DWI programs, however impact and costs of these programs are not being tracked. Counties have implemented different treatment modalities such as cognitive behavioral therapy, SBIRT (Screening, Brief Intervention, and Referral to Treatment), functional family therapy, and the matrix model into their inpatient, outpatient, and jail-based treatment programs. A more complete list of treatments being used and definitions is located in **Appendix I**. While many of these services have been evaluated for their effectiveness through research studies and many are endorsed by SAMHSA or other leading organizations, consistent outcome measurement and evaluation has not been performed as a requirement of the LDWI program. First, not all counties fund evaluation through LDWI. Second, evaluation of different treatments and their impact on recidivism could be benchmarked against other studies to test if treatment is being delivered with fidelity and if results warrant investment in a specific type of treatment.

Furthermore, counties report treatment costs overall, and not by treatment type, making analyzing costs and associated benefits of programs difficult. In a 2014 Results First report on adult behavioral health services in New Mexico, LFC staff noted the state needs a better inventory of how it currently spends money on behavioral health services. The LDWI program faces a similar challenge in identifying how counties invest in substance abuse treatment.

Access to treatment is an area of concern for LDWI programs. Various counties struggle with access to treatment providers for their DWI programs. In fact, for FY13, ten counties did not spend any LDWI funding for treatment, with various counties reporting that substance abuse treatment services were not available in their counties and offenders were referred to other counties for treatment. For example, Catron County has two treatment providers for a county covering 7 thousand square miles. However, the county noted that one provider did not have a counselor assigned to the county. The county's other contracted treatment provider had one counselor in the county. Therefore, the county has to also refer offenders to either Grant or Socorro counties for services. At this time, Catron County does not have access to intensive outpatient treatment services for DWI offenders. Colfax County also expressed concerned with DWI offenders being able to come into Raton for treatment due to being out of county or out of state residents. The county is addressing this issue by referring to treatment providers closer to where offenders reside and using web-based technologies.

As of 2012, HSD reports there were 27 Medicaid-eligible intensive outpatient substace abuse treatment providers (IOP) in New Mexico as noted in Figure 4. A current list of all intensive outpatient treatment providers in the state is not available. Nineteen of 33 counties had an IOP provider who could bill Medicaid for services. Counties use LDWI funds to directly fund treatment, with no correlation to Medicaid eligibility.

Figure 4. Medicaid-Eligible Adult Intensive Outpatient Substance Abuse Treatment Providers as of October 2012



Source: HSD

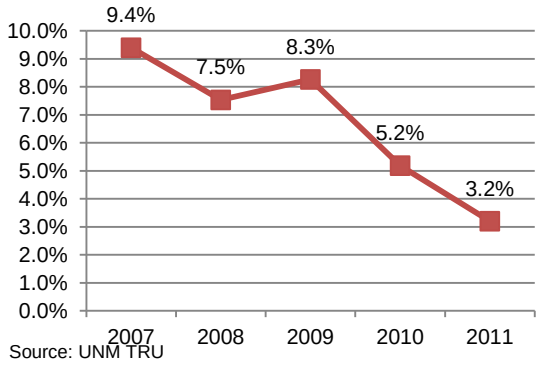
However, Figure 4 speaks to where providers are located and where potential need for more providers exists. It is important to note that this map does not consider any changes in available services after various behavioral health organizations were taken over by Arizona providers in 2013. Fifty-six percent of Medicaid-eligible IOP treatment providers were affected by this management change, and the status of these locations is unknown at this time.

Counties struggle with completion of jail-based treatment programs. Bernalillo County's jail-based treatment program has produced mixed results related to program completion and continuity of care. A 2011 University of New Mexico study reviewed the county's Addiction Treatment Program (ATP), a 28-day jail-based treatment program with an after-care component targeted at DWI offenders or those with a DWI in their history. The program is housed in a separate area of the Metropolitan Detention Center where clients participate in an evidence-based program known as Moral Reconation Therapy (MRT).

The study showed that of a sample of 428 clients, only 11 percent received both the jail-based and after-care program components, of which less than half completed the after-care component. For clients who participated in the full program (treatment and after-care), 43.5 percent received an administrative discharge from detention before completing the 28-day program, proceeding into after-care participation. The study recommended the program require participants to complete the 28-day jail-based component before proceeding into after-care. The study did not look at recidivism, but noted that some clients in their sample did previously participate in ATP.

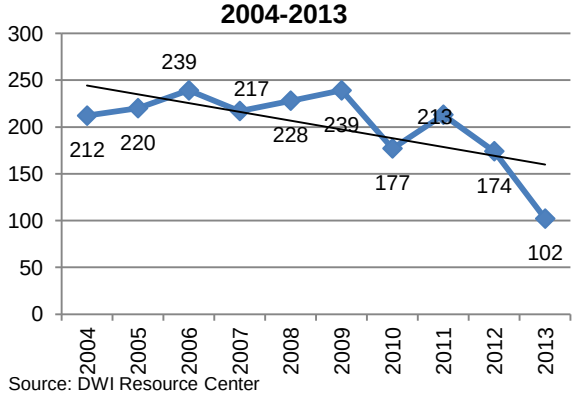
Counties achieve varying results in their DWI programs. Socorro County has shown significant reductions in DWI crashes and arrests. According to a DOH report on substance abuse, between 2007 and 2012, Socorro County had one of the highest alcohol-related death rates in the state at 76.2 per 100,000 in population. During that same timeframe, DWI crashes as a percent of total crashes decreased two-thirds from 9.4 percent to 3.2 percent, the second lowest rate in the state. Furthermore, between 2004 and 2013, DWI arrests dropped 52 percent.

Chart 17. Socorro County Alcohol-Involved Crashes/Total Crashes 2007-2011



Source: UNM TRU

Chart 18. Socorro County DWI Arrests 2004-2013

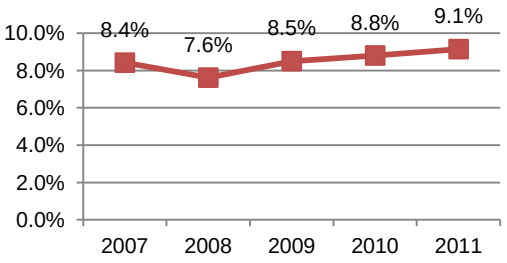


Source: DWI Resource Center

Socorro County focuses over 50 percent of its LDWI funding on treatment. From FY09 to FY13, the county received an annual $150 thousand detoxification grant as part of the LDWI program, targeting this funding completely to jail-based and intensive outpatient treatment. Socorro County also puts a quarter of its LDWI funding into compliance monitoring and tracking and a smaller percentage (6 percent in FY13) into prevention efforts.

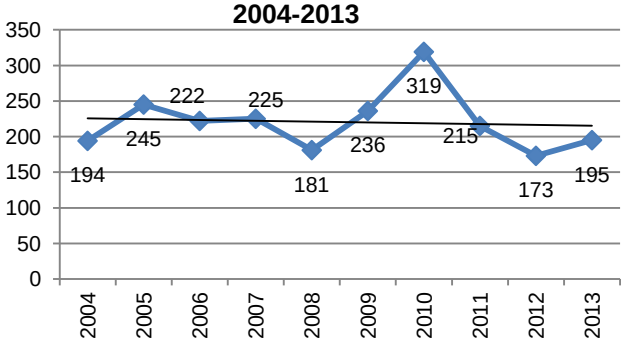
Taos County also had a high alcohol-related death rate of 61.7 per 100,000, but has not made gains in reducing alcohol-related crashes as a percentage of total crashes as noted in Chart 19. Additionally, over the ten-year period of 2004-2013, DWI arrest rates have remained relatively unchanged. Taos County does not fund treatment through the LDWI program, stating there is not enough available funding to do so. Instead the county focuses over half of its funding on compliance monitoring and tracking, followed by coordination, planning and evaluation, then prevention and alternative sentencing programs.

Chart 19. Taos County Alcohol-involved Crashes/Total Crashes 2007-2011



Source: UNM TRU

Chart 20. Taos County DWI Arrests 2004-2013

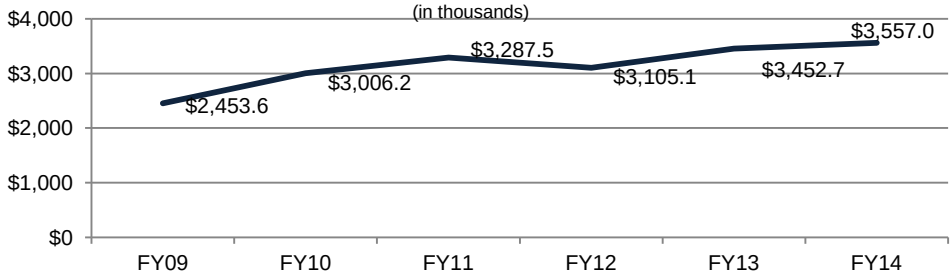


Source: DWI Resource Center

<u>Investments in DWI prevention efforts lack evidence-based support, and proof of effectiveness.</u> As of the end of FY13, counties self-reported providing 39 different prevention programs, 33 of which were education programs for children and adults, with the remainder spent on non-evidence-based programs such as safe rides, alcohol-free social events, public outreach, and media campaigns. In FY13, counties targeting the most LDWI funding to prevention as a percentage of total funding included De Baca (70 percent), Hidalgo (63 percent), Catron (62 percent), and Harding (62 percent).

Chart 21. Prevention LDWI Funding FY09-FY14

(in thousands)



Source: DFA

Counties deploy a variety of prevention programs, but are not required to report which programs they fund and the associated costs. Many counties choose to self-report which prevention programs they operate on their annual LDWI funding application. However, DFA does not ask for detail related to the program implmented, how long the program has been used, whether the program is evidence-based, how outcomes are being measured and the associated results, nor how much programs cost. In reviewing FY14 LDWI applications, LFC staff was able to identify specific prevention programs being used in 30 counties. The remaining counties did not detail how they use prevention dollars in their programs specifically. LFC staff sent a survey to counties asking them to inventory their prevention programs as shown in Table 6.

Table 6. LFC LDWI Program Inventory

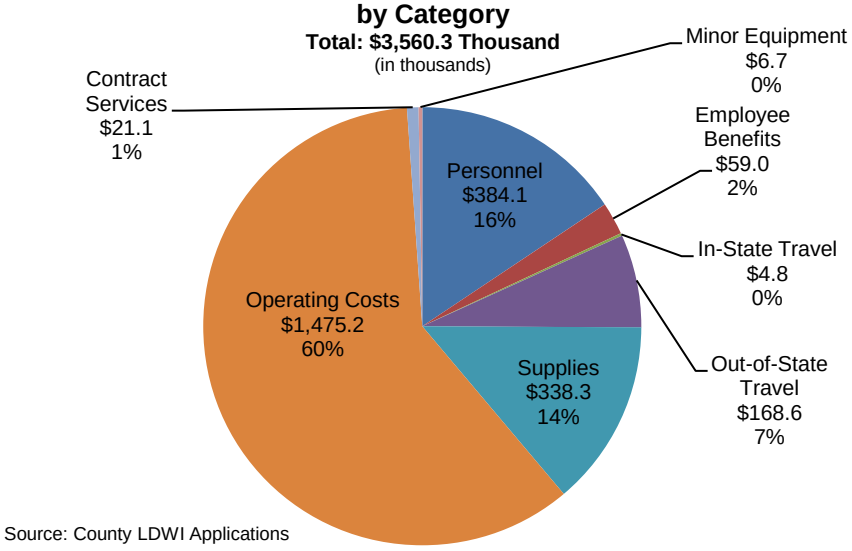
Prevention					
Program Name	Fiscal Year When Implemented	FY14 Funding Amount	Is this an evidence-based program? (Y/N)	Program Description	How are results measured?

Source: LFC

Having information that shows how counties are choosing prevention programs, the cost of programs, how results are measured and how long the programs have been in place could assist DFA and counties to choose the best strategies to fund for DWI prevention.

For FY13, counties budgeted over half of their LDWI prevention funding to operating costs. Almost $1.5 million of prevention funding was targeted to operate prevention programs, as noted in county LDWI applications. The next largest spending categories were personnel ($384.1 thousand) and supplies ($338.3 thousand). LFC staff is presenting budgeted data because counties only report actual expenditures by overall category and not by program component. In FY13, total county prevention expenditures came within 97 percent of budgeted totals.

Chart 19. FY13 LDWI Prevention Budgeted Dollars by Category



Source: County LDWI Applications

Counties organize their prevention program spending in various ways, where some counties hire prevention specialists and/or other permanent program staff, while others rely on contracted services. For example, Bernalillo County funds all prevention services through contracts, which in FY13 totaled $660 thousand. On the other hand, Grant County retains 2 full-time employees for prevention programs for a cost of $51 thousand for salary and benefits. Santa Fe County combined both elements, maintaining a staff of three prevention specialists and using contracted services for education and safe ride programs for a combined total of $477 thousand.

Almost half of New Mexico counties are using the same school-based prevention program, offering an opportunity for cost-sharing to maximize funding effectiveness. Fourteen counties are using an alcohol prevention program called Protecting You, Protecting Me, which was developed by Mothers Against Drunk Driving (MADD). The program is geared to grades 1-5, addressing areas such as brain function and the impact of

alcohol, as well as building safety skills in children. The program is deemed evidence-based by the Substance Abuse and Mental Health Services Administration (SAMSHA). Each county has the ability to purchase the curriculum at a cost of $525, and does not need to replace materials unless there is an update. Previously, online training was available to assist prevention specialists and instructors on how to deploy the program to maintain fidelity, but this method of training has been discontinued. While counties would still need to individually purchase the program materials, counties could pool resources to purchase on-site training for program facilitators, not only ensuring uniformity in program deployment, but also creating a cost savings to their individual DWI programs.

Counties experience challenges in providing prevention programs in school districts. Various counties noted struggles with deploying alcohol prevention programs in schools due to competing educational priorities. Colfax County stated they struggled with obtaining permission to offer programs in the five school districts in the county. Sierra County stated that schools with failing grades chose to focus on academic performance, and completely withdrew participation from the county's DWI prevention programs. Valencia County noted that while there are state and federal requirements to provide substance abuse education in schools, the county faced balancing prevention curriculums with the academic requirements of meeting Annual Yearly Progress (AYP) and No Child Left Behind standards. Currently, there is no PED representation on the DWI Grant Council, but it may be beneficial for the LDWI program to work with PED to integrate county-provided DWI prevention programs into school districts more uniformly.

Counties also use LDWI prevention funding for non-evidence-based strategies such as media campaigns, public outreach and safe ride programs. Many counties referenced following the federal Center for Substance Abuse Prevention's (CSAP) six strategies in designing their prevention programs:

1. Information Dissemination
2. Prevention Education
3. Alternative Activities
4. Problem Identification and Referral
5. Community-Based Processes
6. Environmental Approaches

These strategies help guide how counties operate their DWI prevention programs. Beyond funding school and community-based prevention education programs, counties incorporate other prevention strategies that are funded through the LDWI prevention component. For example, counties disseminate information through media campaigns including print, radio and television ads. All counties have a local DWI Grant Council, which fosters community involvement. Moreover, many counties offer alternatives through alcohol-free events as well as safe ride or designated driver programs. While all of these programs can be impactful, they are not considered evidence-based strategies and there is no way to directly measure their effectiveness in reducing DWI. It is important to note that counties do not have to detail spending (education programs versus safe ride programs, for example) in their quarterly LDWI reporting, so the percentage of funding directed to these strategies is unknown.

LDWI treatment programs are not fully integrated into the state's overall substance abuse treatment plan, creating potential service overlaps and opportunities to leverage Medicaid funding. Counties are providing similar treatment programs as are offered through HSD through Medicaid or other grant programs. Additionally, all publicly-funded substance abuse treatment programs in New Mexico face similar challenges, such as an insufficient supply of providers. However, the LDWI program is not currently a part of statewide planning around behavioral health and substance abuse initiatives.

Potential overlaps may exist between the LDWI program and other funding sources such as Medicaid. Many counties employ intensive outpatient treatment programs. Medicaid lists intensive outpatient care as a service eligible for billing, so it is reasonable to assume that intensive outpatient LDWI treatment services could be eligible for Medicaid reimbursement if clients were enrolled and providers set up for billing. However, there are services

counties are providing DWI offenders that are not currently covered under Medicaid, such as SBIRT. If Medicaid dollars could be better leveraged to fund DWI treatment programs, LDWI dollars could then be redirected to other program components such as alternative sentencing or compliance monitoring. It is important to note that jail-based treatment programs are not eligible for Medicaid reimbursement, as services delivered to incarcerated persons are not Medicaid-eligible.

Furthermore, the Behavioral Health Services Division of HSD (BHSD) administers federal and state (non-Medicaid) dollars related to behavioral health and substance abuse. For FY15, two counties (Rio Arriba and Sandoval) received funding for alcohol-related programming through BHSD. In the case of Sandoval County, BHSD granted $114 thousand in federal dollars, which included funding for a school-based alcohol education program also being funded through LDWI. The county could be using the federal funds towards the 10 percent in-kind/matching requirement for the LDWI program, however, currently required reporting to DFA does not include disclosing the source of matching funds. This makes identifying funding duplications difficult.

HSD's only LDWI program involvement is to approve county DWI prevention and treatment plans. Counties are statutorily-required to submit their LDWI plans to HSD for approval as related to the statewide substance abuse plan. The Behavioral Health Services Division of HSD (BHSD) approves the plans for a period of three years at a time. BHSD also tracks related LDWI funding as part of the overall funding of substance abuse treatment in the state. However, the agency could play a more active role in the LDWI program in areas such as monitoring client outcomes, benchmarking outcome and cost data against other publicly-funded substance abuse programs, or looking for overlap or duplication between programs. All of these functions would assist in creating a more cohesive and cost-effective substance abuse treatment system.

Increased LDWI funding offers an opportunity to make targeted investments in programs proven to work. Speciality courts, such as drug and DWI courts, are evidence-based practices that have been studied extensively and are proven to be a cost-beneficial model to address substance abuse. The state has 46 total drug or DWI courts operated by district and magistrate courts, as well as Bernalillo Metropolitan Court. While drug and DWI courts differ in their target population, both systems have shown positive results in reducing recidivism while being cost-effective.

DWI courts are an evidence-based practice proven to reduce DWI recidivism, but these courts are not being funded by counties through the LDWI program. Similar in format to traditional drug courts, DWI courts serve a DWI offender population. Currently, there are seven DWI courts in New Mexico located in Doña Ana, Bernalillo, Valencia, Torrance, Santa Fe, San Miguel and Eddy counties. All are operated through the magistrate court, except for one under Bernalillo Metropolitan Court. Additionally, a second felony DWI court pilot is being conducted in Albuquerque. DWI courts follow the drug court model and various studies have spoken to their effectiveness in reducing recidivism. For example, a Georgia study showed that DWI court graduates were 65 percent less likely to be re-arrested for DWI, while all DWI court participants, whether they graduated or not, had a 15 percent recidivism rate when compared to 35 percent for non-participants. For FY14, New Mexico DWI courts had an average recidivism rate of 7 percent, with an average cost per day of $22.49 as shown in Table 7.

Table 7. FY14 DWI Court Performance

Court	Graduate Recidivism	Daily Cost per Client	Program Capacity	Active Participants as of 6/30/14
Dona Ana Magistrate	8.82%	$15.90	40	23
Bernalillo County Metro Court	7.67%	$10.79	227	209
Valencia Magistrate	2.70%	$21.02	30	26
Torrance Magistrate	0.00%	$21.45	10	5
Santa Fe Magistrate	22.50%	$21.65	30	12
San Miguel Magistrate	0.00%	$38.60	10	9
Eddy Magistrate	7.69%	$28.00	10	11
DWI Court Averages	**7.05%**	**$22.49**	**51**	**42**

Source: LFC Analysis of AOC Data

Counties are able to fund DWI courts in their counties specifically as an alternative sentencing option through the LDWI program. For FY14, not one county that has a DWI court requested funding to support this program. The General Appropriation Act authorizes a fund transfer from the LDWI fund to the Administrative Office of the Courts (AOC) for drug courts. For FY14, $500 thousand was transferred from the LDWI fund to AOC, and $426 thousand was distributed by AOC to the state's DWI courts. The remainder of the total $1.5 million grant fund went to the state's drug courts.

Recommendations

The Legislature should consider:

Amending statute to add the director of the Behavioral Health Services Division at HSD as a member of the DWI Grant Council with the ability to vote on council initiatives with the requirement that BHSD review prevention and treatment plans as well as outcome reporting on an annual basis and integrate LDWI substance abuse programs into the statewide substance abuse plan.

The DWI Grant Council should:

Pass a resolution requiring LDWI fund recipients for prevention and treatment invest a minimum of 50 percent of funds in evidence-based programs and report this spending in quarterly and annual financial reports;

Require LDWI fund recipients report outcome-oriented performance measures related to recidivism by intervention type (detention, community supervision, DWI court, inpatient or outpatient treatment, etc.);

Pass a resolution allowing DWI courts to independently present applications for funding similar to counties; and

Establish a maximum of LDWI funds that counties can expend for administrative functions and require counties to report on administrative versus direct service expenditures on quarterly and annual reports.

The Department of Finance and Administration should:

Establish a model for assessing DWI risk in conjunction with the Department of Health to identify high-risk counties and include this data when scoring LDWI fund applications to ensure funding is addressing need;

Streamline annual LDWI applications to request common output and outcome data points to allow for comparative analysis of applications;

Require counties to annually report program level data on prevention and treatment programs including program cost, whether the program is evidence-based, number of years a program has been used, and total persons served. Reason for discontinuing programs should also be reported annually.

The Human Services Department should:

Work with the DWI Affiliate through the New Mexico Association of Counties to inventory treatment services and providers funded through the LDWI program to eliminate duplications with Medicaid, as well as work to get LDWI treatment providers registered to bill through Medicaid.

Counties should:

Coordinate with neighboring counties, especially in areas of the state where providers are not readily available, to maximize available treatment resources, implement common prevention programs when applicable and coordinate evaluation of programs and

Partner with the Administrative Office of the Courts to align jail sentences with assignment to jail-based treatment programs to maximize effectiveness through program completion, as well coordinate continuation of treatment with terms of probation when detainees exit detention before treatment is complete.

October 27, 2014

Representative Luciano "Lucky" Varela
Chairman, Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87501

Dear Chairman Varela:

Please accept this letter as the Human Services Department's response to the draft LFC evaluation report entitled "County Health Care and the Local DWI Grant Program." We appreciate the efforts of your staff to understand these complex programs and make useful recommendations for their improvement. Our response focuses primarily on the sections and recommendations related to the implementation of the Safety Net Care Pool.

As noted in the report, in addition to the expansion of Medicaid eligibility to more lower-income adults, there has been a substantial amount of change in the payment programs that support local hospitals. The Sole Community Provider program was replaced with the Safety Net Care Pool (SNCP) program to comply with the state's federal agreement for operation of the Medicaid program, and new legislation (Senate Bill 268) was enacted to, among other things, fund these hospitals payments. As expected, these changes are impacting County Indigent Health Care programs. We appreciate the report's acknowledgement that these changes offer many improvements over the old program, including additional transparency, clarity in requirements, and equity among participants.

In the 2014 legislative session, following more than a year of discussion and negotiation among counties, hospitals and the Human Services Department, the Legislature passed and the Governor signed Senate Bill 268, which provides funding and reporting requirements for payments to our safety net hospitals. The SNCP program includes new payments for uncompensated care and hospital quality improvements, and there is a related increase to inpatient Medicaid reimbursement rates. Counties continue to play a critical role in supporting these safety net hospitals, and Senate Bill 268 and this report reflect that commitment.

Since enactment, HSD has made progress to implement the new programs, including making payments for Uncompensated Care and higher Medicaid reimbursements, establishing the framework for hospital quality improvement programs, and planning the second year of the SNCP program. This work has required collaboration with counties and hospitals, and those efforts will continue in the years ahead.

Our responses to specific recommendations for HSD are included below.

RECOMMENDATIONS

The HSD should provide, as part of the department's budget request, an annual report on the effectiveness of this program at reducing uncompensated care, the cost of the program, associated revenues, and financial health of each participating hospital.

> **HSD Response:** Senate Bill 268 includes new reporting requirements by HSD to counties about payments to local hospitals from the Safety Net Care Pool and payments due to higher reimbursement rates. The UC pool and county revenues are already separately identified in our budget request, and the UC pool applications by individual hospital are available for review at any time. These new reports provide details about Medicaid payments and hospital financing that have not been widely available before, which is one of the key benefits of the Safety Net Care Pool program that was developed through the Centennial Care Medicaid waiver. The financial health of each participating hospital is more difficult to measure. In the past, HSD has entered into a contract for a review of the profitability of New Mexico hospitals. While HSD does not plan to establish this as an annual report, the department is committed to ensuring reasonable Medicaid reimbursement rates.

Establish a fixed methodology going forward to fund hospital Safety Net Care Pool applications that incorporates a uniform set of data and methodology to forecast future uncompensated care costs.

> **HSD Response:** Hospitals participating in the Safety Net Care Pool must submit an application for UC Pool payments, which details their Medicaid payments and costs. This standard application, for the first time, provides an estimate of uncompensated care for the upcoming year for each participating hospital. Never before has such information been available. Hospital applications for payments in calendar year 2015 are due December 31, 2014. This will be the second set of applications, which will help build a history of uncompensated care payments.

Require hospitals applying for Safety Net Care Pool funding establish and maintain a mechanism for enrolling incoming patients into Medicaid when eligible and report on enrollment numbers annually to maintain status as a program-eligible hospital.

> **HSD Response:** Effective January 1, 2014, HSD received new authority from the Center for Medicare and Medicaid Services (CMS) to allow hospitals, Indian Health Service (IHS) facilities, jails, and prisons to perform presumptive eligibility determinations for the newly created Medicaid eligibility categories.[1] We have established presumptive eligibility training, and 45 hospitals, including IHS hospitals, are currently participating. There are currently 322 active presumptive eligibility determiners helping individuals apply for Medicaid coverage. Only three Safety Net Care Pool hospitals are not participating, and we will continue to offer this opportunity to them.

[1] These are generally known as the Modified Adjusted Gross Income (MAGI)-related eligibility categories that were created as a result of the federal Patient Protection and Affordable Care Act. These are four broad categories: New adult (expansion), parents and caretakers, pregnant women, and children.

The evaluation report also reviews the Local DWI grant program, and while this section focuses primarily on administration by counties and oversight by the Department of Finance and Administration, the HSD's Behavioral Health Services Division (BHSD) plays a small role in these programs. In particular, NM's Strategic Prevention Plan Framework can be a useful resource for local DWI prevention efforts. Using this framework would help coordinate local and state efforts to prevent and treat substance abuse. BHSD, as noted in the report, also reviews and approves local DWI plans as part of the statewide substance abuse plan. The additional work recommended for BHSD to track outcomes of local programs and benchmark data across counties would require additional resources currently not available in the department.

With regard to the specific recommendations for the Legislature and HSD's BHSD, we offer the following response:

RECOMMENDATIONS

The Legislature should consider amending statute to add the director of the Behavioral Health Services Division at HSD as a member of the DWI Grant Council with the ability to vote on council initiatives with the requirement that BHSD review prevention and treatment plans as well as outcome reporting on an annual basis and integrate LDWI substance abuse programs into the statewide substance abuse plan.

> **HSD Response:** BHSD would be a willing participant on the DWI Grant Council, and the department, generally, agrees with this recommendation. It should be noted, however, that standardized local outcome reporting is not currently available, and the department would require additional resources for the research and evaluation suggested here. The state already maintains the NM Prevention Strategic Plan Framework, and adoption by local programs would help achieve the recommendations in this report.

Work with the DWI Affiliate through the New Mexico Association of Counties to inventory treatment services and providers funded through the LDWI program to eliminate duplications with Medicaid, as well as work to get LDWI treatment providers registered to bill through Medicaid.

> **HSD Response:** HSD is willing to work with individual providers should they want to become Medicaid approved providers. HSD/BHSD has inventoried treatments services and will make that available to the DWI Affiliate of NM Association of Counties.

In closing, we reiterate our appreciation for the staff's efforts on this report. HSD is committed to continued collaboration with the LFC, and we thank you for the opportunity to respond to this report.

Sincerely,

Sidonie Squier
Secretary

Cc: Julie Weinberg, Director, Medical Assistance Division
Wayne Lindstrom, Director, BHSD, and CEO, BH Purchasing Collaborative
Ellen Costilla, Health Care Operations Manager, MAD

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Susana Martinez
GOVERNOR

Thomas E. Clifford, Ph.D.
Cabinet Secretary

TO: Representative Luciano "Lucky" Varela, LFC Chairman
FROM: Thomas Clifford, PhD, Cabinet Secretary
COPY: Keith Gardner, Chief of Staff, Governor Susana Martinez
SUBJECT: Legislative Finance Committee Evaluation of the Local DWI Program
DATE: October 27, 2014

The Department of Finance and Administration (DFA) appreciates the opportunity to provide information in response to the County Financed Healthcare and Local DWI Program report prepared by staff of the Legislative Finance Committee (LFC). This response will provide general comments on the program, as well as responses to the principle findings and recommendations of the draft study. Although we have not had time to provide feedback on all of the detailed information in the report, we will continue to work with LFC staff in the future to monitor and improve this important program.

General Comments

1. **LDWI Program is making a significant contribution to reducing DWI in New Mexico**

The draft LFC report does not describe the intended scope, the methodology or the performance criteria applied in the review. Thus, it is difficult to determine which aspects of the program have been reviewed and determined to be functioning as intended. Although, like all programs, there is always room for improvement, DFA believes the program is functioning well as documented by the following information.

In FY13 LDWI Programs provided:

a. 8,521 offenders were screened;
b. 4,248 offenders were referred to treatment;
c. 7,933 offenders were tracked or monitored;
d. 481 saturation patrols, checkpoints and other enforcement activities were conducted;
e. 432 DWI arrests, continuing a two-year decline;
f. 121 under 21 possession or consumption citations, continuing a two-year decline;
g. Prevention activities were provided at 352 schools which produced 240,082 student contacts through 12,276 prevention activities;
h. 426 offenders were referred to a domestic violence treatment programs;
i. 241 local DWI Planning Council meetings were conducted.

New Mexico has made substantial progress in reducing DWI with the assistance of the LDWI Programs. The total number of alcohol-involved fatalities in 2013 was down by 40 percent to 132 fatalities from the recent peak of 225 in 2002.

2. **Recommendations to increase reporting and evaluation will increase administrative costs of the program, and may not improve on current methods of evaluation.**

LFC recommends that DFA collect a significant amount of additional information concerning which types of programs are funded and their effectiveness. LFC also expresses concerns over the administrative costs of the program. Adding research and reporting requirements will increase the administrative costs of the program. This will be particularly burdensome on smaller counties that lack program evaluation expertise. Added requirements should be implemented only if they can be justified on a cost-benefit basis.

DFA will continue to refine the Managerial Data Set (MDS) database system which is collecting detailed information on convicted DWI Offenders along with Prevention and Law Enforcement activities funded through the LDWI program. In addition, using information already collected by the LDWI program, the Epidemiology and Response Division (ERD) of the State Department of Health (DOH) prepares an annual New Mexico DWI Offender Characteristics and Recidivism Report. This report contains detailed information on DWI offenders and the types of programs that are most likely to prevent recidivism. The ERD is uniquely qualified to perform such analysis because, to be accurate, an evaluation must statistically control for factors other than the program itself that affect the state's DWI problem. DFA suggests that a coordinated effort between LFC, DFA and the ERD could be implemented to increase the informational value of the annual reports, but that, in the absence of the expertise provided by ERD, added informational reports and evaluations conducted by counties may be of limited usefulness.

3. **State/Local partnership allows counties to develop innovative initiatives that can improve program effectiveness.**

LFC seems to be advocating a model whereby a more limited range of services would be funded by the LDWI program. However, the nature of the program is for the State to fund programs that are administered at the local level. Although there may not be academic research estimating the direct benefits of each of these programs, there may be real advantages in allowing the counties to develop new, innovative and model programs utilizing local knowledge to prevent DWI in their communities.

DFA comments on LFC Findings:

1. **State allocation of LDWI funding is overly complicated, leads to fragmentation of funding and does not prioritize high-need areas of the state.**

LFC argues that LDWI funds are not being targeted as required in statute. Specifically, LFC states "65 percent of LDWI competitive grant funds have to be directed to treatment." However, Section 11-6A-3 G requires that a minimum of 65 percent of grant funding go to "treatment and detoxification." The LDWI program has consistently exceeded this statutory requirement on a statewide basis, although in some counties the ratio has been below 65 percent.

LDWI does make an effort to target high needs. County program applications include the gaps and needs in the community; description of DWI trends and the extent of the DWI problem in the county by using statistical data provided by the Epidemiology and Response Division (ERD) of DOH including the

Recidivism Report, YRRS and data from the Administrative Office of the Courts (AOC). The application also includes a discussion of how the LDWI Program helps to reduce death and injury related to DWI.

LFC argues that the program does not have enough controls to ensure reasonable administrative costs. Currently, quarterly financial reports required of the counties break out costs by line item and component. LDWI funds cannot be used to pay administrative costs unrelated to the program. For example, the guidelines require that only 15 percent of the coordinator's salary may be allocated to administrative functions, the rest of their time is for direct program services. Indirect administrative costs are reported as in kind contributions by the counties. DFA agrees that monitoring and controlling administrative costs is a worthwhile goal, although there may be some uncertainty in assigning some costs. DFA will undertake a study to determine how administrative costs can be separately reported and monitored.

2. **The LDWI program does not sufficiently emphasize evidenced-based practices, nor does it have program outcome information to ensure accountability or inform funding decisions.**

Most LDWI funding is allocated according to formulas established in statute. Thus, to change targeting of these funds would require statutory changes. The *distribution* portion of the LDWI funds is awarded by formula established in statute, which includes the alcohol-related injury crashes average of 2000-2002 and the most recent fiscal year retail trade gross receipts available. The *grant* funds are awarded based on information from the application that is ranked and rated using criteria established by rule. While the report does not define the terms "evidence-based practices," current LDWI guidelines require prevention activities to be evidence-based or promising practice activities. All LDWI funded prevention activities are part of the six Center for Substance Abuse Prevention (CSAP) strategies. These activities are recorded in the Managerial Data Set (MDS) database, hosted by ADE, Inc.

Measuring program outcomes is a challenge for the LDWI Programs as many prevention and treatment activities may not have an immediate outcome, but are part of an overall strategy to change behavior. With the FY14 annual report, DFA will be asking counties to report on effectiveness and outcomes of their funded components. At their October 2014 meeting, the LDWI Grant Council created new program evaluation requirements for competitive grant funds in FY16. County programs will be required to work with evaluators in their communities to assist with measuring effectiveness for their prevention and/or treatment programing. They will then use this information as they formulate their grant applications.

3. **Potential overlaps may exist between the LDWI programs and other funding sources such as Medicaid.**

DFA defers to the Human Services Department (HSD) on whether programming currently funded through the LDWI program might be better funded through the Medicaid program. Currently, DFA staff collaborate with HSD staff on the prevention component of LDWI.

4. **Increased LDWI funding offers an opportunity to make targeted investments in programs proven to work.**

DFA agrees that programs funded by the LDWI should be evaluated and priority given to those identified as most effective. To this end, the LDWI Grant Council passed a motion at the October 2014 meeting which requires counties to provide for an evaluation of the prevention, treatment or compliance monitoring components to be eligible for competitive grant funding.

DFA Response to LFC Recommendations

DFA should:

1. **Establish a model for assessing DWI risk in conjunction with the Department of Health to identify high-risk counties and include this data when scoring LDWI fund applications to ensure funding is addressing need.**

DFA agrees that more work can be done with DOH to identify high-risk counties and this information can be used when scoring applications. Such data can be added to that currently provided by DOH and already included in current and past years' applications.

2. **Streamline annual LDWI applications to request common output and outcome data points to allow for comparative analysis of applications.**

DFA agrees that the applications can be improved by requesting common output and outcome data points. However, work is needed to determine what outcome/output measures are most appropriate and how they will be measured.

3. **Require counties to annually report program level data on prevention and treatment programs including program cost, whether the program is evidence-based, number of years a program has been used, and total persons served. Reason for discontinuing programs should also be reported annually.**

DFA does require counties to report annually on prevention and treatment programs. The inclusion of program costs could require significantly more administrative costs to calculate.

The DWI Grant Council should:

1. **Pass a resolution requiring LDWI fund recipients for prevention and treatment invest a minimum of 50 percent of funds in evidence-based programs and report this spending in quarterly and annual financial reports.**

DWI Grant Council believes that the LDWI Program guidelines already address the concerns regarding evidenced based practices for prevention and treatment components. The lack of a specific definition of "evidence-based practices" makes it difficult to establish a quantitative standard such as the one recommended by LFC.

2. **Require LDWI fund recipients report outcome-oriented performance measures related to recidivism by intervention type (detention, community supervision, DWI court, inpatient or outpatient treatment, etc.).**

DOH prepares a recidivism report annually. The report looks at the sanctions imposed by the courts and draws conclusions related to recidivism and court ordered sanctions that are tracked in the ADE database. County programs refer to this report and others such as the NM Substance Abuse Epidemiology Profile and the YRRS reports as they complete their annual applications.

3. **Pass a resolution allowing DWI courts to independently present applications for funding similar to counties.**

DWI Courts can be funded through the county program application if deemed appropriate by the local planning councils. Because the Legislature, through the general appropriation act, diverts funds to the Drug/DWI Courts before the funds reach the county programs, there does not appear to be a need for additional funding for these programs through the application process.

4. **Establish a maximum of LDWI funds that counties can expend for administrative functions and require counties to report on administrative versus direct service expenditures on quarterly and annual reports.**

The current LDWI Guidelines provides that no more that 15% of a Coordinator's salary be budgeted in the Coordination, Planning and Evaluation component. Coordinators and other program staff do provide direct services to the community members. DFA will research appropriate definitions and measures of administrative costs prior to implementation of any additional guidelines.

NEW MEXICO ASSOCIATION OF COUNTIES

October 27, 2014

David Abbey
Director, Legislative Finance Committee
325 Don Gaspar, Suite 101
Santa Fe, NM 87505

Via Email: david.abbey@nmlegis.gov

Re: **County Health Care and DWI Programs**

Dear Mr. Abbey:

On behalf of the New Mexico Association of Counties (NMAC) staff and the NMAC Health Services and DWI Affiliates, we would like to thank your staff for taking the time to meet and work with us on this LFC study. We appreciate the work of Charles Sallee and Maria Griego, and look forward to continue to ensure that the county indigent and DWI programs are operated efficiently and effectively. The study presents some thoughtful and helpful recommendations on how to improve these programs, and we look forward to continue to strengthen and improve them. We appreciate Maria taking the time to meet with county personnel to gain an understanding of how these programs work, and allowing them to review the draft report and to give input as appropriate. NMAC will work with the Legislature, the Human Services Department, the Department of Health and the New Mexico Hospital Association to continue to provide the highest quality and most effective programs to our neediest residents.

We think it is important to emphasize that the community-based DWI and indigent care programs provide an essential safety net for our most vulnerable New Mexicans. These programs have assisted thousands of people over the years and our county personnel work on a very close and personal level with county residents. Counties' obligations to provide essential services continue to grow and expand, often without a commensurate increase in revenues. Notwithstanding this, we are committed to providing the highest level of services and to being responsive to the needs of our residents.

Our responses to the specific recommendations are included below.

DWI Program

- The DWI Affiliate and NMAC do not oppose having a representative from the HSD Behavioral Health Services Division as a member of the DWI Grant Council. We believe this can be done administratively and does not require a statutory change.
- We believe that the current LDWI guidelines adequately address the concerns raised regarding evidence-based practices. Currently, spending on treatment is above statutory

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requirements with approximately 82% of grant funds being used for treatment in FY13 and FY14.

- While NMAC and the DWI affiliate have always been open to the possibility of adding an additional component to allow for funding DWI courts, we believe that funding state courts should be a state and not a county function.
- Indirect costs to administer the grant or distribution programs are not permitted except as in-kind matches. Necessary safeguards for limiting administrative expenditures are already in place, and we will ensure that these limitations are adhered to.
- We support the recommendations made by LFC staff regarding the Department of Finance and Administration.
- We support the recommendation made regarding continuing collaboration with HSD and the counties.
- NMAC and the DWI Affiliate strongly support having counties continue to coordinate with neighboring counties to provide training, to work collaboratively in sharing compliance and service personnel, to maximize available treatment resources, and to implement common prevention programs. Currently, several counties have agreements with other counties and with Native American communities to work together to support multi-jurisdictional efforts.
- We support the concept of aligning jail sentences with assignment to jail-based treatment programs and to coordinate continuation of treatment with the terms of probation. However, it should be pointed out that local governments have limited authority in this area.

Indigent Health Care Program

- NMAC and the Health Services Affiliate strongly believe that it is premature to recommend eliminating the authority of counties to impose the second 1/8th GRT increment in 2020. There is much uncertainty in health care coverage with Medicaid expansion and the Affordable Care Act, and we do not know how things will look in 2020. NMAC is very concerned that eliminating the indigent health care program will have a devastating impact on many of our most vulnerable and needy residents, and will leave many without any option for health care coverage.
- NMAC opposes increasing the rate of phasing out medical hold harmless payments.
- NMAC opposes establishment of a maximum fund balance and reverting local county tax revenues to state programs. We believe that the information on fund balances may not accurately reflect that many of those funds are already encumbered. In addition, many counties are planning to use these funds to pay for ongoing mandated requirements.
- Ensuring that transfers to the Safety Net Care Pool comply with state and federal law is important and all stakeholders should be involved in this process.
- Counties and DFA should work collaboratively to ensure that accurate information on revenues and expenditures for the health assistance fund is provided and maintained.

Medicaid Funding for Rural Hospitals

- NMAC and the Health Services Affiliate support a discretionary, voluntary program whereby counties could choose to provide additional contributions (in addition to the

1/12th mandatory payments) to fund their community hospitals under the Safety Net Care Pool program. Counties also support de-earmarking GRT increments.

- NMAC and the Health Services Affiliate strongly support amending current statute to sunset the counties' obligation to fund the Safety Net Care Pool by the end of 2018, a date that coincides with the expiration of the state Medicaid waiver for Centennial Care.
- NMAC and the Health Services Affiliate support the recommendations made by LFC staff that apply to HSD.

NMAC respectfully submits this response, and along with our affiliates, is committed to continued collaboration with all the stakeholders to strengthen these important programs. Again, we thank the LFC staff for taking the time to work with New Mexico counties and to take input from our subject matter experts. We look forward to working with LFC staff in the future.

Sincerely,

Steven Kopelman
Executive Director

cc: Charles Sallee
Maria Griego

APPENDIX A: EVALUATION OBJECTIVES, SCOPE AND METHODOLOGY

Evaluation Objectives.

- Analyze spending and outcomes of county indigent programs and the Local DWI Grant Program;
- Assess county DWI program cost effectiveness and accountability; and
- Provide an update to the 2011 LFC evaluation of county indigent programs, rural hospital funding, and medical hold harmless payments to counties.

Scope and Methodology.

- Reviewed state statutes, agency policies, procedures, and internal management documents.
- Analyzed data reports from sources including HPC, HSD, DFA, and counties.
- Conducted structured interviews with staff at DFA, HSD, AOC, selected counties and relevant stakeholders.
- Collected survey data from counties on DWI, indigent care, and Sole Community Provider programs.
- Reviewed county financial audits from FY09-FY13.
- Reviewed published literature on other state practices, press releases, and media reports relevant to the evaluation.

Evaluation Team.

Maria D. Griego, Lead Program Evaluator
Cody Cravens, Program Evaluator
Christine Boerner, Fiscal Analyst
Connor Jorgensen, Fiscal Analyst
Clint Elkins, Fiscal Analyst
Caroline Malone, Fiscal Analyst

Authority for Evaluation. The LFC is authorized under the provisions of Section 2-5-3 NMSA 1978 to examine laws governing the finances and operations of departments, agencies, and institutions of New Mexico and all of its political subdivisions; the effects of laws on the proper functioning of these governmental units; and the policies and costs. The LFC is also authorized to make recommendations for change to the Legislature. In furtherance of its statutory responsibility, the LFC may conduct inquiries into specific transactions affecting the operating policies and cost of governmental units and their compliance with state laws.

Exit Conference. The contents of this report were discussed with the Department of Finance and Administration and the Human Services Department during an exit conference on October 17, 2014, and with the New Mexico Association of Counties on October 20, 2014.

Report Distribution. This report is intended for the information of the Office of the Governor, the Department of Finance and Administration, the Human Services Department, the Office of the State Auditor, and the Legislative Finance Committee. This restriction is not intended to limit distribution of this report, which is a matter of public record.

Charles Sallee
Deputy Director for Program Evaluation

APPENDIX B: 2011 LFC EVALUATION RECOMMENDATIONS FOR HSD

Significant Recommendations (Brief Description)	Department Responses (Brief Description)	Implementation (Brief description with who, how and when)	Target Completion Date
HSD should continue to make available on its website a County-Supported Medicaid Fund report showing Medicaid enrollment by county.	HSD will continue to report Medicaid enrollment by county on the Department's website, and while not statutorily required, will post a report containing expenditures by county on the Department's website on a quarterly basis.	HSD posted this information to the website under Public Information at the following URL: http://www.hsd.state.nm.us/mad/RComplianceAudit.html.	January, 2012
HSD should work with counties and hospitals to develop guidelines for standardized SCP reporting by hospitals to counties.	HSD is compliant with the current statute, which directs the counties and hospitals to jointly agree on the report format. The Department is unclear why this recommendation was not directed to county governments and hospitals which are required by statute to develop these reports	HSD is compliant with the current statute, which directs the counties and hospitals to jointly agree on the report format. The Department is unclear why this recommendation was not directed to county governments and hospitals which are required by statute to develop these reports.	N/A
The HSD should post reports on their website that show the full amount of SCP funding, both local and federal, by county, for the SCP program.	available upon request and, although not statutorily required, will post the information on the Department's website.	HSD posted this information to the website under Public Information at the following URL: http://www.hsd.state.nm.us/mad/RPublicInformation.html.	January, 2012
The HSD should develop a training module on locally-funded healthcare and make it available for use by the Association of Counties and individual counties.	HSD has previously developed and currently uses a PowerPoint presentation which will be made available on the Department's website.	HSD has posted this information to the website under the following url: http://www.hsd.state.nm.us/mad/RPublicInformation.html	January, 2012
The SCP funding formula should be revisited and changed to control exponential growth and ensure total Medicaid payments do not exceed the costs of Medicaid and indigent care costs at specific hospitals.	HSD does not disagree that the funding formula should be revisited. However, HSD is concerned about the findings that led to the second part of this recommendation. The data is outdated and inadequate to draw the stated recommendations.	HSD does not disagree that the funding formula should be revisited. (See related response to #7.). However, HSD is concerned about the findings that led to the second part of this recommendation. The data is outdated and inadequate to draw the stated recommendations. Update: In late 2012, HSD reviewed the formula and identified an error that inflated the amount available for supplemental payments. In response, HSD revised the methodology for compensating Sole Community Provider Hospitals. The revision recognizes that MCO membership far exceeds FFS recipients, and additional support for SCP hospitals now comes from both MCO payments and state payments. The state plan is being amended to reflect the state payment amounts through 2013. Under Centennial Care, the program will transform into the Safety Net Care Pool for payments to hospitals. In addition, the hospital fee schedule will be adjusted for former SCP hospitals, to reflect a higher base amount. The SNCP will be composed of a funding pool for Uncompensated Care, mostly at smaller hospitals, and a Hospital Quality Improvement Incentive Pool for all former SCP hospitals and the state teaching hospital. The HQII is available for payments to hospitals that meet certain quality metrics beginning in 2015. Going forward into 2014, the capitation paid to MCO's on a monthly basis will be adjusted to reflect the higher payment rates for the SCH providers and the MCO's will increase their payment rates to the former SCH providers.	January, 2014

Significant Recommendations (Brief Description)	Department Responses (Brief Description)	Implementation (Brief description with who, how and when)	Target Completion Date
The HSD, working with counties, should ensure local funding for SCP complies with federal regulations and provide a status report to the LFC no later than January 31, 2012 on resolution of outstanding issues stemming from the federal review of SCP payments. The HSD should ensure that any possible repayment of funds does not impact the general fund. The Legislature may wish to consider language in the General Appropriations Act of 2012 to ensure that appropriations from the general fund are not used to finance any SCP refunds.	The Department engaged outside counsel to support the Department's efforts to address concerns raised by the Centers for Medicare and Medicaid Services (CMS). The Department is negotiating a resolution with CMS that will put the program on solid footing and allow continued funding for New Mexico's rural and teaching hospitals. The Department will report to the LFC at the time of resolution.	The Department, through its outside counsel, continues to work with CMS in resolving the draft financial management report for FFY09. The only outstanding issue is the pay back for the Community Health Systems, Inc. hospitals (the "CHS Hospitals") Because the CHS Hospitals are involved in a qui tam action (false claims act case) with the Department of Justice, CMS is awaiting DOJ approval on the proposed global settlement. Since the LFC hearing in December 2012, and in accordance with the settlement, HSD has instituted new certification forms for the private hospitals and impacted counties. This new form, which was approved by CMS, went into effect on January 1, 2012.	Completed.
No later than September 1, 2012, the HSD, working with counties and hospitals, should study and make recommendations to the LFC and governor whether SCP should continue in its current form and financing mechanisms, given federal health reform and state Medicaid redesign.	HSD has been studying all Medicaid programs to determine the impact of Medicaid Modernization and the federal health care reform law. This report suggests that the Sole Community Provider program will not be necessary after the implementation of the Patient Protection and Affordable Care Act (PPACA). Given the uncertainties about the implementation and effectiveness of PPACA, the Department would suggest a more cautious outlook for the necessity of this and other programs that support rural hospitals or indigent care. 2013 Update: see item #5 update re: modifications to SCP program.	HSD has been studying all Medicaid programs to determine the impact of Medicaid Modernization and the federal health care reform law. This report suggests that the Sole Community Provider program will not be necessary after the implementation of the Patient Protection and Affordable Care Act (PPACA). Given the uncertainties about the implementation and effectiveness of PPACA, the Department would suggest a more cautious outlook for the necessity of this and other programs that support rural hospitals or indigent care. 2013 Update: see item #5 update re: modifications to SCP Program.	Ongoing

APPENDIX C: COUNTY INDIGENT FUND BALANCES FY09-FY14

Year-End Unaudited County Indigent Fund Balances
FY09-FY14
(in thousands)

County	FY09	FY10	FY11	FY12	FY13	FY14
Bernalillo	$161.8	$245.2	$244.3	$235.8	$205.2	$262.7
Catron	$9.5	$52.9	$9.4	$96.9	$176.9	$218.9
Chaves	$110.2	$21.8	$110.4	$705.0	$705.0	$1,587.4
Cibola	$784.8	$315.7	$372.9	$282.4	$334.6	$260.8
Colfax	$339.7	$365.4	$335.4	$279.2	$193.3	$163.0
Curry	$594.3	$503.7	$261.2	$225.1	$197.9	$711.6
De Baca	$72.5	$87.4	$109.2	$111.6	$113.6	$89.7
Dona Ana	$2,064.3	$3,786.8	$726.7	$59.9	$335.1	$172.3
Eddy	$619.5	$1,003.8	$1,731.5	$2,504.8	$2,943.2	$3,914.3
Grant	$28.4	$146.4	$44.6	$216.9	$910.9	$1,187.4
Guadalupe	$26.4	$14.2	$30.0	$46.9	$77.1	$81.8
Harding	$0.0	N/A	$0.0	$0.0	$0.0	$0.0
Hidalgo	$144.4	$132.3	$100.2	$102.4	$73.6	$65.0
Lea	$1,382.6	$1,248.9	$1,766.0	$2,476.0	$2,468.6	$3,785.3
Lincoln	$101.4	$149.7	$111.5	$237.9	$355.0	$550.2
Los Alamos	$1,464.4	$1,529.2	$1,432.9	$547.2	-$5.6	$482.0
Luna	-$51.3	$71.6	$8.1	$84.1	$17.0	$174.9
McKinley	$1,729.3	$1,245.2	$1,426.5	$1,042.9	$1,547.2	$48.9
Mora	$54.0	$65.4	$73.2	$75.1	$90.5	$104.1
Otero	$991.0	$987.8	$1,031.6	$220.3	$234.8	$457.3
Quay	$105.3	$106.6	$67.7	$77.9	$34.7	$64.9
Rio Arriba	$404.5	$264.9	$0.0	-$2.7	$311.1	$845.3
Roosevelt	$0.0	$10.2	$0.0	$0.0	$0.0	$8.6
San Juan	$8,057.8	$7,752.1	$7,826.5	$326.6	$6,001.0	$5,598.0
San Miguel	$3.1	$26.3	$27.5	$238.0	$364.8	$504.6
Sandoval	$2,111.7	$3,043.3	$3,310.2	$3,419.1	$3,619.0	$3,981.0
Santa Fe	$1,546.3	$1,776.3	$505.2	$752.0	$746.6	$1,921.6
Sierra	$202.8	$280.1	$321.8	$336.0	$295.5	$553.0
Socorro	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Taos	$258.7	$787.0	$694.1	$208.8	$315.6	$797.3
Torrance	$64.2	$20.5	$69.4	$48.8	$19.9	$123.4
Union	$15.3	$0.25	$13.0	$3.7	$46.9	$171.7
Valencia	$1,101.7	$1,322.3	$2,260.4	$2,141.4	$2,657.7	$1,589.8
Total	**$24,498.5**	**$27,362.9**	**$25,021.7**	**$17,099.8**	**$25,386.7**	**$30,476.9**

Source: County Budgets

APPENDIX D: COUNTY INDIGENT FUND BUDGET SCENARIOS

San Juan County FY16 Indigent Fund Budget Scenarios
(in thousands)

No Changes	
2nd 1/8th GRT Revenue (Based on FY14 GRT collections; 4.3% FY15, 4.8% FY16 estimated growth)	$4,702.5
County-Supported Medicaid 1/16th	-$2,351.3
Balance:	**$2,351.3**
Safety Net Care Pool Payment 1/12th	-$2,868.1
Balance:	**-$516.8**
Other Indigent Care Expenses (6.1% 2014; 6.2% 2015 estimated growth)	-$5,813.2
Balance:	**-$6,330.0**
Including New GRT Revenues	
2nd 1/8th GRT Revenue (Based on FY14 GRT collections; 4.3% FY15, 4.8% FY16 estimated growth)	$4,702.5
Additional 1/8th and 1/16th	$7,053.8
County-Supported Medicaid 1/16th	-$2,351.3
Balance:	**$9,405.1**
Safety Net Care Pool Payment 1/12th	-$2,868.1
Balance:	**$6,537.0**
Other Indigent Care Expenses (6.1% 2014; 6.2% 2015 estimated growth)	-$5,813.2
Balance:	**$723.8**
Including New GRT Revenues and Reduction in Indigent Expenses	
2nd 1/8th GRT Revenue (Based on FY14 GRT collections; 4.3% FY15, 4.8% FY16 estimated growth)	$4,702.5
Additional 1/8th and 1/16th	$7,053.8
County-Supported Medicaid 1/16th	-$2,351.3
Balance:	**$9,405.1**
Safety Net Care Pool Payment 1/12th	-$2,868.1
Balance:	**$6,537.0**
Other Indigent Care Expenses (6.1% 2014; 6.2% 2015 estimated growth) and total budget reduced 53 percent	-$2,732.2
Balance:	**$3,804.8**

Note: The newly enacted 1/8th GRT increment expires at the end of CY17, and the 1/16th increment expires at the end of CY16.

Source: LFC Analysis of TRD and County-Provided Data

Curry County FY16 Indigent Fund Budget Scenarios
(in thousands)

No New Revenues	
2nd 1/8th GRT Revenue (Based on FY14 GRT collections; 4.3% FY15, 4.8% FY16 estimated growth)	$1,314.3
County-Supported Medicaid 1/16th	-$657.2
Balance:	**$657.2**
Safety Net Care Pool Payment 1/12th	-$801.6
Balance:	**-$144.5**
Other Indigent Care Expenses (6.1% 2014; 6.2% 2015 estimated growth)	-$470.7
Balance:	**-$615.1**
Including New GRT Revenues	
2nd 1/8th GRT Revenue (Based on FY14 GRT collections; 4.3% FY15, 4.8% FY16 estimated growth)	$1,314.3
30% of Additional 1/4th GRT	$721.4
County-Supported Medicaid 1/16th	-$657.2
Balance:	**$1,378.6**
Safety Net Care Pool Payment 1/12th	-$876.2
Balance:	**$502.4**
Other Indigent Care Expenses (6.1% 2014; 6.2% 2015 estimated growth)	-$470.7
Balance:	**$31.7**

Source: LFC Analysis of TRD and County-Provided Data

APPENDIX E: SAFETY NET HEALTH CARE PROGRAM MODELS

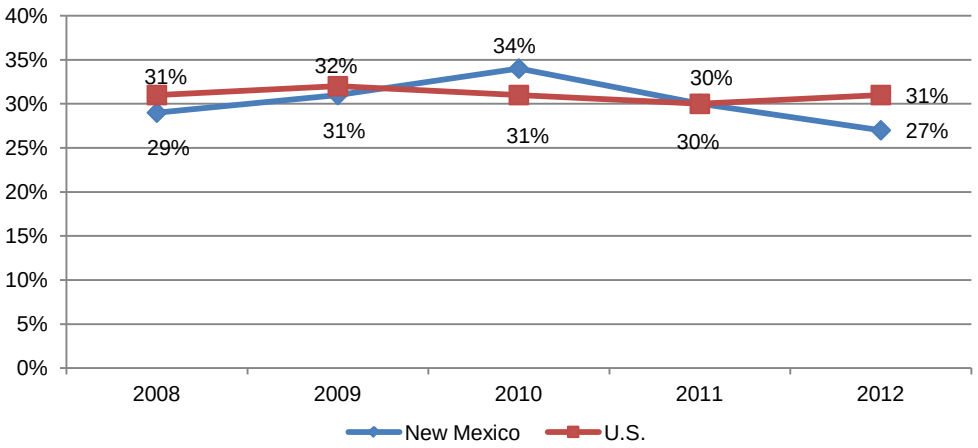
Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
DC Health Alliance *Washington DC*	DC Dept of Healthcare Finance & Human Services	Public insurance progam (similar to Medicaid)	No charges	Income under 200% FPL. Cannot be eligible for Medicaid or enrolled in third party medical.	Comprehensive services, but does not include vision, dental, behavioral health, non-ER transportation, long term care, open heart surgery or transplants.	Each member is assigned to a Managed Care Organization to coordinate care.		$40 million program funded solely by local tax dollars.	24,000 (in 2011)
Harris County Gold Card Program *Harris County, Texas*	Harris Health System (hospital district is a political subdivision that was created by voter referendum that owns all city-county hospitals)	Indigent Care Program	No premiums or member fees. Co-pays apply and are based on income.	Income under 300% FPL. County Residents only. Cannot have other health coverage.	Patients have access to primary care, emergency services, specialist care, pharmacy, & dental provided by the Hospital District (16 health centers, 6 school based centers, dental center, dialysis center, mobile health units, 2 hospitals)	Each member is assigned to a community health clinic for primary care.		Property Tax, DSH payments, and revenue from patient payments.	
New York Health and Hospitals Corp (HHC) *New York City, NY*	Health and Hospitals Corporation (consortium of four hospital systems)	Hospital charity care programs (required by state law)	No fees and $15-$20 copays for most care. "Artists to Access" – if uninsured, can paint or sing for patients and receive credits to pay for care.	Income under 300% FPL. Must be Uninsured and not eligible for Medicaid or Exchange.	Comprehensive network including home health, school based health centers, mobile medical office	Hospitals got waiver through Medicaid to focus on delivery system reform. They found 100 potential partners to focus on healthcare access and care coordination.		Mostly paid by federal DSH funds for hospital ($893M), but hospitals could lose this money due to ACA changes.	

Program & Location	Agency Type	Description	Member Fees & Renewal	Eligibility Criteria	Services	Care Coordination	Provider Payments	Funding Mechanism	# People Enrolled
Portico Health Net *Hennepin, Ramsey and Washington Counties, Minnesota*	Nonprofit	Discount care management program	Each household pays a sliding scale, monthly fee $25-$50. Copays for non-preventive visits. Patient pays 25% coinsurance.	Income under 275% FPL	Prevention-based coverage (primary care, urgent, specialty, mental health, pharmacy), through provider networks aligned with one of the program's nine participating hospital systems	Navigation to help with health management understanding bills, social services, patient advocacy, referrals to specialty care, mental health management, and enrollment in Medicaid and Exchange.	Payment for hospital-based procedures, such as x-rays and MRIs, is at a hospital-negotiated rate (typically 110 % of the Medicaid rate).	Over $2 million of investment by all hospitals, government, health plans, United Way and private and corporate foundations.	1,429 people (in 2013)
Nevada Access to Healthcare Network *Nevada*	Nonprofit	Discount medical plan for the uninsured.	Monthly fee of $35-$40 for adults and $10 for children. Additional fees at the time of service are capped, based on income.	Income from 100-250% FPL. Available to anyone "not legally required" to get covered under ACA.	Greatly discounted care from network of 2,000+ providers including primary care, specialists, behavioral health, clinic, hospitals, dentists, optometrists, radiology, surgery and pharmacy.	Every patient is assigned a PrimaryCare Physician & "personal care coordinator" to call whenever a service is needed, and is told how much the service will cost.	Hospitals & providers give reduced rates. Walmart is contracted to provide drugs at 30% cost. Patients pay providers (plan cannot directly pay providers).	"Shared responsibility": providers offer reduced rate, government funds for plan administration. Patients pay for ½ of operating costs. "Patient Care Fund" helps patients by donations.	26,000 people
MaineHealth Care Partners *Cumberland, Lincoln, Waldo and Kennebec counties, Maine*	Nonprofit that operates over three counties.	Donated health services to uninsured and low-income residents	No fee except providers not affiliated with hospital can charge $10 (most waive fee). Also $10 to $25 copay for pharmacy.	Income under 175% FPL. Cannot be eligible for employer plan (unless it costs more than 5% of income.)	Patients can visit hospital-affiliated physicians, NP, and PA, and receive hospital and home care services.	Patients are assigned to participating providers. Only 2 to 3 patients assigned to any given provider at a time.	A network of over 900 volunteer physicians and 8 hospitals provide care. Over 2/3 of local providers participate.		1,000 people (capped)

APPENDIX F: DWI IN NEW MEXICO

Between 2008 and 2012, New Mexico's percentage of total traffic fatalities that was alcohol-impaired was within a few percentage points of national trend. However, both nationally and in New Mexico, this measurement has flat-lined in the last five years of available data.

Percentage of Alcohol-Impaired Traffic Fatalities Compared to Total Traffic Fatalities 2008-2012



Note: BAC 0.08 or higher
Source: NHTSA

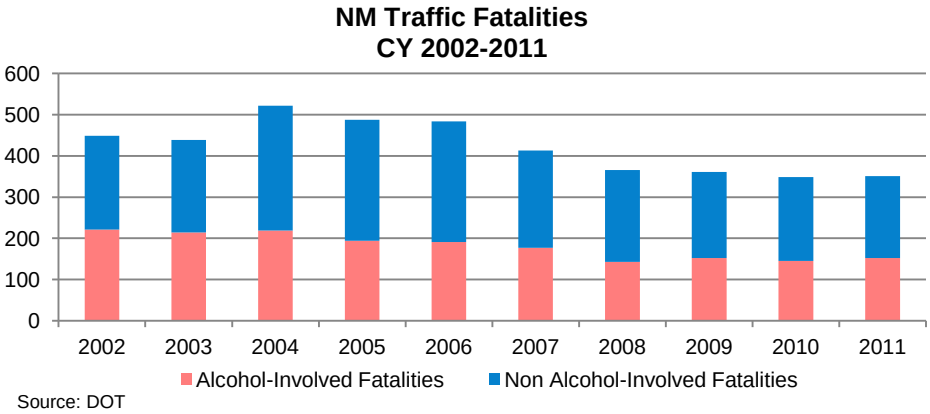
Looking specifically at 2012 data, New Mexico ranked in the middle of states with a 27 percent alcohol-impaired fatality measure, similar to Virginia and the District of Columbia.

National Alcohol-Impaired Traffic Fatalities, 2012

State/Jurisdiction	Total Traffic Fatalities	Alcohol-Impaired Driving Fatalities (BAC greater than or equal to .08)	Percentage Alcohol-Impaired
Montana	205	89	44
North Dakota	170	72	42
Hawaii	126	51	41
South Carolina	863	358	41
Rhode Island	64	24	38
New Mexico	365	97	27
Virginia	777	211	27
District of Columbia	15	4	27
Oregon	336	86	26
Alaska	59	15	25
Georgia	1,192	301	25
Iowa	365	92	25
Kansas	405	98	24
Kentucky	746	168	23
Utah	217	34	16
United States	**33,561**	**10,322**	**31**

Source: NHTSA, 2013

The Department of Transportation (DOT) tracks DWI statistics by county. Between CY02 and CY11, there were 1,808 alcohol-involved traffic fatalities, accounting for 43 percent of total traffic fatalities in the 10-year period. DOT also tracks drug and alcohol-related crashes by age, gender and county.

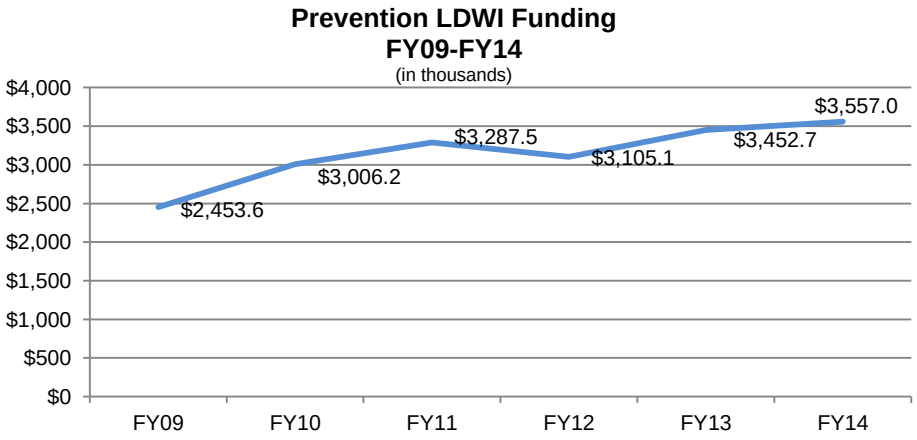


Source: DOT

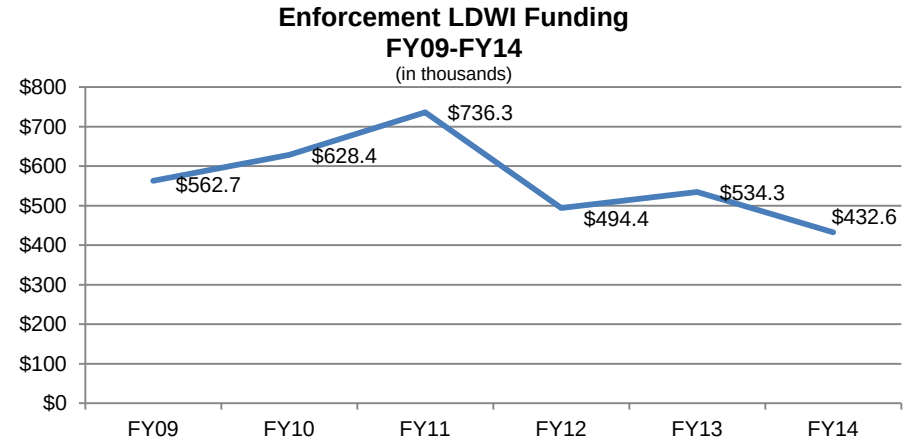
The Department of Health (DOH) tracks epidemiological data related to DWI. In their 2014 *New Mexico DWI Offender Characteristics and Recidivism Report*, DOH noted New Mexico had the highest rate of alcohol-related motor vehicle deaths in the United States prior to 1997. However, by 2012, New Mexico had improved to twelfth in the nation. The report also listed characteristics of DWI offenders according to 2012 data:

- Males were more likely to be DWI offenders than females;
- Hispanics and American Indians were overrepresented among DWI offenders compared to the New Mexico population;
- The largest offender group ranged in ages from 18-24 years old, over representing this age group when compared to the overall New Mexico population. Those aged 25-34 and 35-44 were also overrepresented in the DWI offender population when compared to the general population;
- DWI offenders were less likely to have completed high school than the overall New Mexico population;
- Although DWI offenders were more likely to be unemployed than the general population, 56 percent of DWI offenders were employed; and
- The percent of DWI offenders re-arrested within three years of their first conviction decreased 33 percent between 2002 and 2012, and the percent re-arrested within five years decreased nearly 50 percent.

APPENDIX G: LDWI PROGRAM FUNDING BY COMPONENT



Source: DFA



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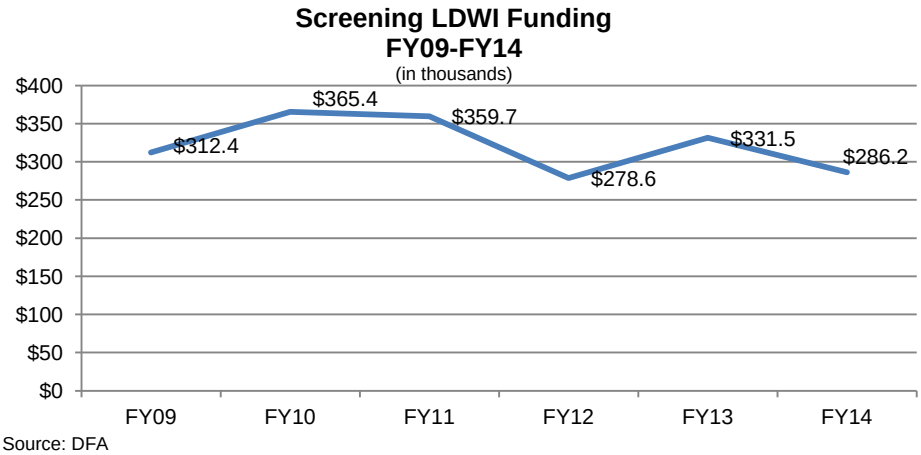

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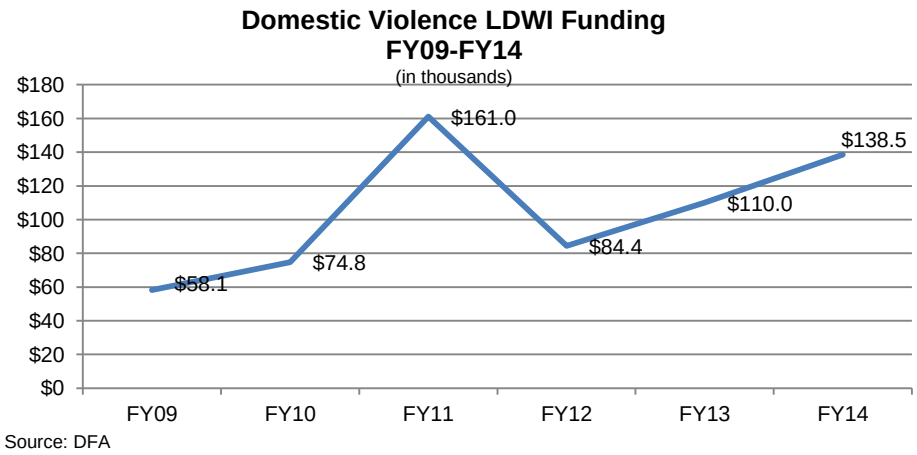

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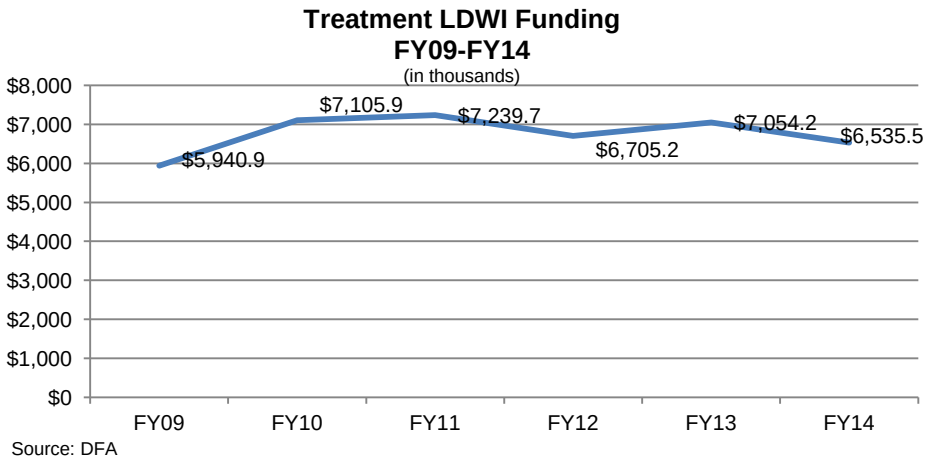

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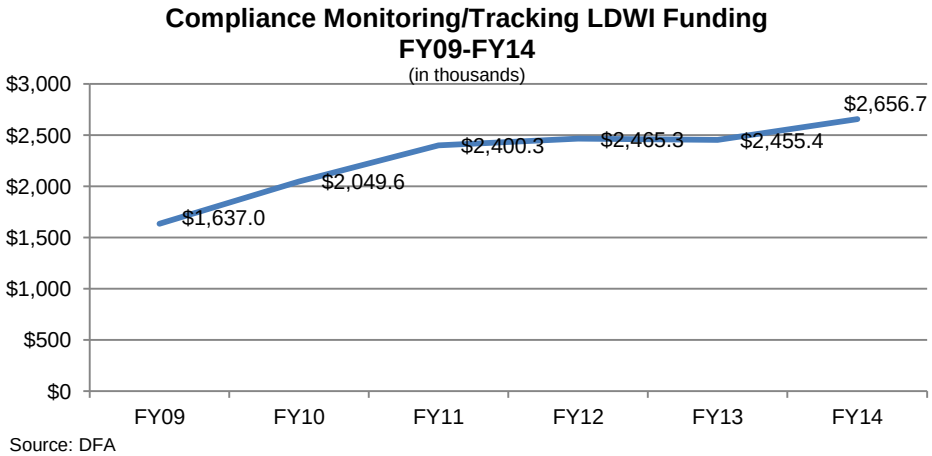


Source: DFA

APPENDIX H: COUNTY DWI INDICATORS

County	2010 Census Population	Percentage of Persons Below Poverty Level 2008-2012	Alcohol-involved Crashes 2011	Alcohol-involved Crashes as a Percent of All 2011 Crashes	Alcohol-Related MVTC Deaths Per 100,000 Population, 2008-2012	Percentage of Drinking and Driving Among Adults (18+), Past 30 Days, 2011	Percentage of Drinking and Driving Among Youth (grades 9-12), Past 30 Days, 2011	Number of DWI Arrests, 2011	Number of DWI Convictions, 2011	2012 LDWI Funding	LDWI Funding per DWI Incident (2012 Funding/2011 DWI Incidents)	LDWI Funding to DWI Incident Ranking
Bernalillo	662,857	17.3	681	29.4	3.3	0.6	5.9	5,004	3,173	$5,570.1	$880	19
Catron	3,725	18.8	1	0	8.3	Excluded due to small sample size	11.4	21	9	$98.5	$4,476	3
Chaves	65,645	20.6	76	3.3	6.4	1.1	14.0	324	261	$373.8	$935	23
Cibola	27,213	28.8	32	1.4	8.9	0	11.9	268	190	$229.9	$678	30
Colfax	13,750	17.6	19	0.8	5.7	0	13.9	103	60	$108.3	$888	25
Curry	48,376	18.0	44	1.9	4.7	0.3	10.9	276	190	$236.8	$888	26
De Baca	2,022	22.3	2	0.1	13.1	Excluded due to small sample size	9.3	10	6	$39.5	$7,456	2
Dona Ana	209,234	25.8	235	10.1	2.8	1.2	10.7	1,322	962	$950.6	$611	32
Eddy	53,829	13.0	35	1.5	8.0	1.0	9.8	337	272	$392.0	$1,054	16
Grant	29,514	18.4	32	1.4	6.3	1.0	16.8	244	166	$236.1	$855	27
Guadalupe	4,687	23.7	8	0.3	5.6	Excluded due to small sample size	11.1	48	30	$114.2	$2,039	7
Harding	695	18.5	0	0	0	Excluded due to small sample size	Excluded due to small sample size	1	1	$73.1	$73,127	1
Hidalgo	4,894	22.5	6	0.3	2.4	Excluded due to small sample size	9.5	44	36	$104.2	$2,084	6
Lea	64,727	16.2	83	3.6	8.7	0.3	15.5	374	264	$458.8	$1,004	17
Lincoln	20,497	14.7	24	1	3.1	1.4	9.4	157	126	$182.5	$898	24
Los Alamos	17,950	4.9	6	0.3	0.9	0	9.6	56	38	$39.6	$962	21
Luna	25,095	29.7	18	0.8	2	0.4	11.3	151	113	$191.3	$1,132	13
McKinley	71,492	33.6	138	5.9	2.9	0.8	8.4	756	432	$684.0	$765	29
Mora	4,881	16.2	7	0.3	12.3	Excluded due to small sample size	17.2	22	13	$35.6	$2,960	4
Otero	63,797	20.7	69	3.0	3.8	0.5	12.2	247	188	$306.1	$975	20
Quay	9,041	18.3	7	0.3	13.2	Excluded due to small sample size	7.9	66	40	$103.5	$1,418	10
Rio Arriba	40,247	19.3	50	2.2	13	0.9	10.3	270	157	$432.0	$1,875	8
Roosevelt	19,846	23.5	15	0.6	6.1	0	12.0	156	123	$182.3	$598	33
San Juan	130,044	20.4	47	2.0	8.2	0.2	6.8	1,438	1,190	$1,586.6	$1,068	14
San Miguel	29,393	26.7	101	4.4	10.0	0.4	10.5	222	151	$210.8	$653	31
Sandoval	131,563	13.2	213	9.2	4.7	0.7	6.7	535	359	$809.2	$1,162	12
Santa Fe	144,171	16.0	214	9.2	4.7	2	12.0	1,112	008	$1,406.3	$1,001	15
Sierra	11,988	25.3	18	0.8	7.8	Excluded due to small sample size	16.9	151	113	$138.5	$819	28
Socorro	17,864	25.0	11	0.5	9.9	0	15.5	213	113	$283.2	$1,264	11
Taos	32,940	23.9	64	2.8	10.0	3.9	10.5	215	103	$279.6	$1,002	18
Torrance	16,383	25.9	10	0.4	9.2	1.2	10.4	79	59	$161.4	$1,813	9
Union	4,549	10.9	6	0.3	7.8	Excluded due to small sample size	22.9	15	10	$50.5	$2,833	5
Valencia	76,574	21.4	48	2.1	6.3	0.9	8.1	316	184	$347.8	$955	22
New Mexico	2,059,183	19.5	2,320	100	5.3	0.9	8.8	14,585	9,790	$17,181.9	$1,015	

Source: United States Census, NM Administrative Office of the Courts, NM Department of Health (IBIS, NM Department of Transportation, DWI Grant Council, UNM Division of Government Research

APPENDIX I: LDWI-FUNDED EVIDENCE-BASED SUBSTANCE ABUSE TREATMENTS

Matrix Model
The Matrix Model is an intensive outpatient treatment approach for stimulant abuse and dependence that was developed through 20 years of experience in real-world treatment settings. The intervention consists of relapse-prevention groups, education groups, social-support groups, individual counseling, and urine and breath testing delivered over a 16-week period. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction. The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and the patient is realistic and direct, but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth.

Moral Reconation Therapy
Moral Reconation Therapy (MRT) is a systematic treatment strategy that seeks to decrease recidivism among juvenile and adult criminal offenders by increasing moral reasoning. Its cognitive-behavioral approach combines elements from a variety of psychological traditions to progressively address ego, social, moral, and positive behavioral growth. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments. The MRT workbook is structured around 16 objectively defined steps (units) focusing on seven basic treatment issues: confrontation of beliefs, attitudes, and behaviors; assessment of current relationships; reinforcement of positive behavior and habits; positive identity formation; enhancement of self-concept; decrease in hedonism and development of frustration tolerance; and development of higher stages of moral reasoning. Participants meet in groups once or twice weekly and can complete all steps of the MRT program in a minimum of 3 to 6 months.

Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric)
Multisystemic Therapy With Psychiatric Supports (MST-Psychiatric) is designed to treat youth who are at risk for out-of-home placement (in some cases, psychiatric hospitalization) due to serious behavioral problems and co-occurring mental health symptoms such as thought disorder, bipolar affective disorder, depression, anxiety, and impulsivity. Youth receiving MST-Psychiatric typically are between the ages of 9 and 17. The goal of MST-Psychiatric is to improve mental health symptoms, suicidal behaviors, and family relations while allowing youth to spend more time in school and in home-based placements. Like standard MST, on which it is based, MST-Psychiatric has its foundation in social-ecological and social learning systems theories. It includes specific clinical and training components for staff designed to address (1) safety risks associated with suicidal, homicidal, or psychotic behaviors in youths, (2) the integration of evidence-based psychiatric interventions, (3) contingency management for adolescent and parent/caregiver substance abuse, and (4) evidence-based assessment and treatment of youth and parent/caregiver mental illness.

MST-Psychiatric teams intervene primarily at the family level, empowering parents and caregivers with the skills and resources to effectively communicate with, monitor, and discipline their children. The intervention assists parents and caregivers in engaging their children in prosocial activities while disengaging them from deviant peers. In addition, it addresses individual and systemic barriers to effective parenting. The intervention is delivered in the family's natural environment (e.g., home, school, community) daily when needed and for approximately 6 months. A MST-Psychiatric team consists of a full-time doctoral-level supervisor, four master's-level therapists, a part-time psychiatrist, and a bachelor's-level crisis caseworker. Teams have an ongoing consultative relationship with an MST expert consultant and an MST expert psychiatrist who provide an initial 5-day training, weekly consultation, and quarterly booster trainings.

Motivational Interviewing

Motivational Interviewing (MI) is a goal-directed, client-centered counseling style for eliciting behavioral change by helping clients to explore and resolve ambivalence. The operational assumption in MI is that ambivalent attitudes or lack of resolve is the primary obstacle to behavioral change, so that the examination and resolution of ambivalence becomes its key goal. MI has been applied to a wide range of problem behaviors related to alcohol and substance abuse as well as health promotion, medical treatment adherence, and mental health issues. Although many variations in technique exist, the MI counseling style generally includes the following elements:

- Establishing rapport with the client and listening reflectively.
- Asking open-ended questions to explore the client's own motivations for change.
- Affirming the client's change-related statements and efforts.
- Eliciting recognition of the gap between current behavior and desired life goals.
- Asking permission before providing information or advice.
- Responding to resistance without direct confrontation. (Resistance is used as a feedback signal to the therapist to adjust the approach.)
- Encouraging the client's self-efficacy for change.
- Developing an action plan to which the client is willing to commit.

Adaptations of the MI counseling approach that are reviewed in this summary include a brief intervention for college-age youth visiting hospital emergency rooms after an alcohol-related event; a brief intervention for adult patients with histories of heavy drinking presenting to primary medical care settings for routine care; and a brief intervention for cocaine and heroin users presenting to urban walk-in medical clinics. Community-based substance abuse treatment clinics also have incorporated an MI counseling style into the initial intake/orientation session to improve program retention (also reviewed below).

Seeking Safety

Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse. The treatment was designed for flexible use: group or individual format, male and female clients, and a variety of settings (e.g., outpatient, inpatient, residential). Seeking Safety focuses on coping skills and psychoeducation and has five key principles: (1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); (2) integrated treatment (working on both posttraumatic stress disorder (PTSD) and substance abuse at the same time); (3) a focus on ideals to counteract the loss of ideals in both PTSD and substance abuse; (4) four content areas: cognitive, behavioral, interpersonal, and case management; and (5) attention to clinician processes (helping clinicians work on countertransference, self-care, and other issues).

Relapse Prevention Therapy (RPT)

Relapse Prevention Therapy (RPT) is a behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. RPT can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment. Coping skills training is the cornerstone of RPT, teaching clients strategies to:

- Understand relapse as a process
- Identify and cope effectively with high-risk situations such as negative emotional states, interpersonal conflict, and social pressure
- Cope with urges and craving
- Implement damage control procedures during a lapse to minimize negative consequences
- Stay engaged in treatment even after a relapse
- Learn how to create a more balanced lifestyle

Coping skills training strategies include both cognitive and behavioral techniques. Cognitive techniques provide clients with ways to reframe the habit change process as a learning experience with errors and setbacks expected as

mastery develops. Behavioral techniques include the use of lifestyle modifications such as meditation, exercise, and spiritual practices to strengthen a client's overall coping capacity.

Twelve Step Facilitation Therapy
Twelve Step Facilitation Therapy (TSF) is a brief, structured, and manual-driven approach to facilitating early recovery from alcohol abuse, alcoholism, and other drug abuse and addiction problems. TSF is implemented with individual clients or groups over 12-15 sessions. The intervention is based on the behavioral, spiritual, and cognitive principles of 12-step fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These principles include acknowledging that willpower alone cannot achieve sustained sobriety, that reaching out to others must replace self-centeredness, and that long-term recovery consists of a process of spiritual renewal. Therapy focuses on two general goals: (1) acceptance of the need for abstinence from alcohol and other drug use and (2) surrender, or the willingness to participate actively in 12-step fellowships as a means of sustaining sobriety. The TSF counselor assesses the client's alcohol or drug use, advocates abstinence, explains the basic 12-step concepts, and actively supports and facilitates initial involvement and ongoing participation in AA. The counselor also discusses specific readings from the AA/NA literature with the client, aids the client in using AA/NA resources in crisis times, and presents more advanced concepts such as moral inventories.

The TSF manual reviewed for this summary incorporates material originally developed for Project MATCH, an 8-year, national clinical trial of alcoholism treatment matching funded by the National Institute on Alcohol Abuse and Alcoholism. Project MATCH included two independent but parallel matching study arms: one with clients recruited from outpatient settings, the other with patients receiving aftercare treatment following inpatient care. Patients were randomly assigned to receive TSF, Cognitive Behavioral Therapy, or Motivational Enhancement Therapy. Findings from Project MATCH are included in this summary. In addition, participants received individual therapy in all research reviewed for this summary.

Community Reinforcement and Family Training (CRAFT)
Community Reinforcement and Family Training (CRAFT) is an intervention designed to help a concerned significant other/family member (CSO) facilitate treatment entry/engagement for a treatment-refusing individual who is abusing drugs or alcohol (the family member). CRAFT was developed with the belief that CSOs, who often have substantial information about their family member's substance abuse behavior patterns, can play a powerful role in helping him/her to enter treatment.

Delivered one on one or in groups of CSOs, CRAFT aims to influence the substance-abusing family member's behavior by changing the way the CSO interacts with him or her. The intervention incorporates the clinical style of motivational interviewing and emphasizes learning new skills to cope with a substance-abusing family member (e.g., using positive reinforcement, letting the loved one face the natural consequences of his or her behavior). CRAFT is also designed to help the CSO become more independent and feel more empowered in his or her relationship with the substance-abusing family member.

The twelve to fourteen 1-hour CRAFT counseling sessions are typically delivered twice weekly for the first 4 weeks and once weekly for the next 6 weeks. However, the CRAFT program moves as fast or as slow as the CSO is able, and the CRAFT therapist may use any procedure at any time. CRAFT therapists are typically counselors with master's degrees who are trained in the intervention. The sessions cover the following topics:

- Handling dangerous situations with the substance-abusing family member
- Remembering the family member's positive attributes that were evident before he or she was abusing substances
- Communicating with the family member using nonjudgmental feedback and reflective listening, and discontinuing communication that is not effective in positively influencing substance abuse
- Using positive reinforcement to support abstinence and increase positive interactions (i.e., scheduling activities the family member enjoys that do not involve substances, participating only when no substances are used that day)

- Practicing nonreinforcement of substance abuse (extinction) by ignoring or avoiding the family member when he or she is abusing substances
- Suggesting and initiating counseling during opportune times
- Developing interests and social supports independent of the family member

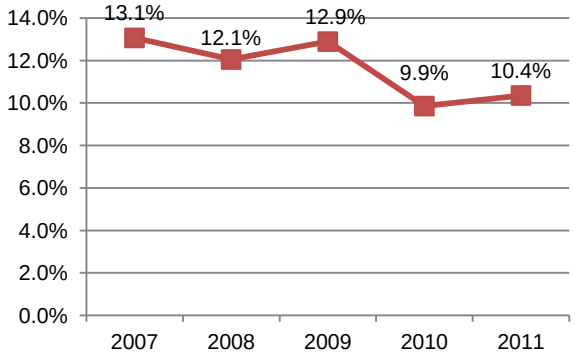
Also during sessions, CSOs discuss problems they have encountered with the substance-abusing family member since the last session. Optional counseling sessions with the substance abusing family member or additional family members can be scheduled as needed. In all the studies reviewed for this summary, the majority of CSOs were women.

APPENDIX J: HIGH-RISK COUNTY CASE STUDY: MCKINLEY, RIO ARRIBA, AND SAN JUAN COUNTIES

Three counties have consistently had high rates of alcohol-related crashes and fatalities, in addition to a high percentage of alcohol-related crashes as a percentage of total crashes:, McKinley, Rio Arriba, and San Juan counties. Below is a look at the current situation in these three counties as well as how the counties are using LDWI funding to address these issues.

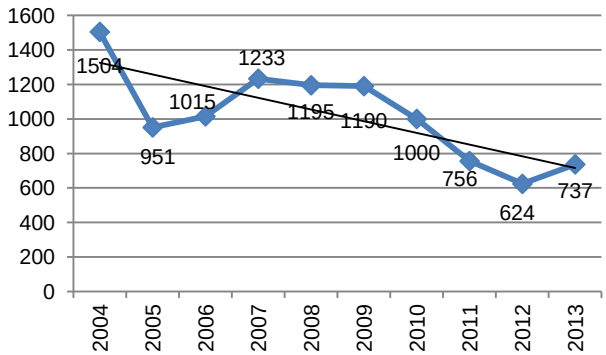
McKinley County. McKinley County's 2010 population was 71,492 and the percentage living below the poverty level was 33.6 percent between 2008 and 2012. DOH reported that between 2008 and 2012, the county had 110.3 alcohol-related deaths per 100,000 and 18.8 alcohol-impaired motor vehicle crash deaths per 100,000. As noted below, the percentage of alcohol-related crashes compared to total crashes in McKinley County were more than double the statewide average for three out of the five years (2007-2011). The University of New Mexico Division of Governmental Research noted that between 2007 and 2011, McKinley County's DWI re-arrest rate was 52 percent, 11 percent higher than the statewide average.

McKinley County Alcohol-involved Crashes/Total Crashes 2007-2011



Source: UNM TRU

McKinley County DWI Arrests 2004-2013



Source: DWI Resource Center

According to the 2011 Youth Risk Resiliency Survey, 31 percent of participating ninth through twelfth grade students self-identified as current alcohol users, with 19 percent identified as binge drinkers (5 or more drinks on one occasion.) Twenty-one percent of survey respondents had taken their first drink before the age of 13.

McKinley County Youth Risk Resiliency Survey Alcohol Results 2003 Versus 2011

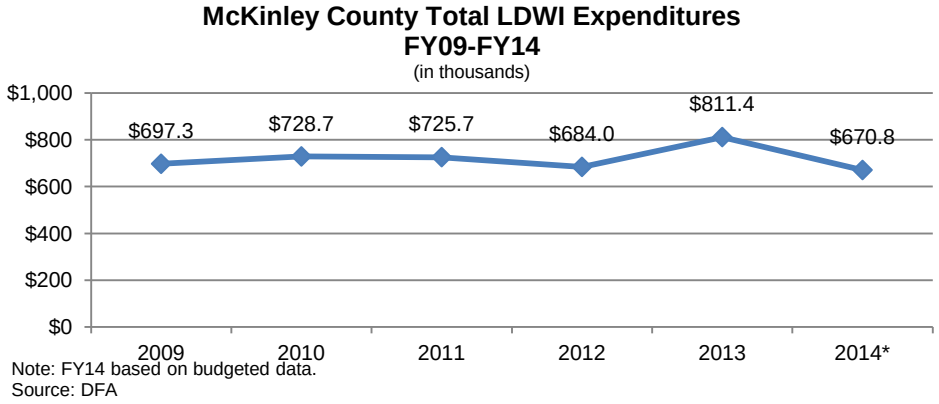
	2003		2011	
	McKinley County	NM	McKinley County	NM
Current Alcohol Use	48%	51%	31%	37%
Binge Drinking (5 or More Drinks on One Occasion)	32%	35%	19%	22%
Drinking and Driving	21%	19%	8%	9%
Rode with a Person Who Drank Alcohol	40%	35%	26%	26%
Consumed First Alcoholic Beverage Before Age 13	36%	36%	21%	27%

Source: DOH

Between 2003 and 2011, McKinley County saw reductions in various youth alcohol-related indicators. The most significant gains were made in current alcohol use (17 percent reduction) and those consuming their first alcoholic beverage before age 13 (15 percent reduction).

Offender screening data from 2011 shows that DWI offenders in McKinley County are predominately Native American (85 percent), male (72 percent) and 33 percent of offenders are between ages 36 and 50. Fifty-eight percent of DWI offenders had completed 12 years of education and 71 percent had an annual income of less than $10 thousand. Over half of offenders were identified as having a severe alcohol problem.

Between FY09 and FY14, McKinley County received $4.4 million from the LDWI program, the sixth highest amount of all 33 counties. For FY14, the county requested LDWI funds for prevention, treatment, screening, compliance monitoring, alternative sentencing, and coordination, planning and evaluation totaling $700 thousand. The county's prevention program includes an evidence-based school curriculum, as well as programs to increase low enforcement of DWI and alcohol laws, reduce easy access to alcohol for minors, increase perceived risk of binge drinking and drunk driving, and address community norms of accepting or encouraging binge drinking or drunk driving. The county employs a prevention specialist and also contracts for media campaigns related to prevention. McKinley County is challenged in serving a high Native American population without any evidence-based prevention programs targeted to this demographic. Instead the county works with programs offering promising practices and also has a cultural competency policy to ensure programs are delivered with fidelity.



Note: FY14 based on budgeted data.
Source: DFA

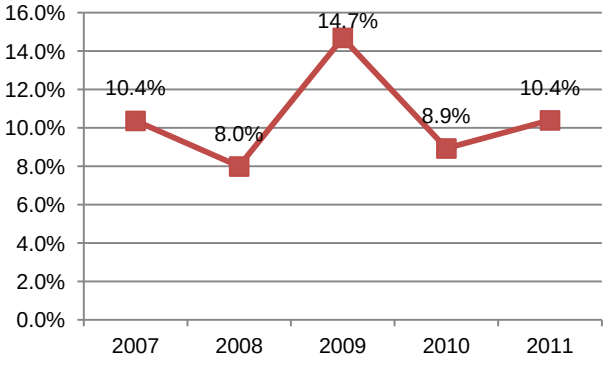
In the treatment arena, McKinley County offers an intensive outpatient treatment program (IOP) and also refers clients to other treatment options based on need. The intensive outpatient program requires clients complete two group counseling sessions, one individual counseling session, and 2 Alcoholics Anonymous meetings per week. The program integrates various practices including Motivational Interviewing, Stages of Change, and Reality Therapy. For FY12, McKinley County's IOP program reported a 68 percent completion rate. In FY14, the county received $63 thousand in LDWI grant funding for treatment, which the county matched with $100 thousand in county liquor excise tax revenues.

McKinley County also conducts compliance monitoring of DWI offenders through supervised probation. Depending on court-ordered sanctions, offenders are required to check in with compliance officers three to four times per week. The county employs a compliance supervisor and five officers, stating they serve over 500 clients per month. Through the alternative sentencing component, McKinley County operates a Teen Court program, as well as electronic and alcohol monitoring devices when court-ordered.

Rio Arriba County. Rio Arriba County's 2010 population was 40,247 and the percentage living below the poverty level was 19.3 percent between 2008 and 2012. DOH reported that between 2008 and 2012, the county had 116 alcohol-related deaths per 100,000 and 16.4 alcohol-impaired motor vehicle crash deaths per 100,000. The percentage of alcohol-related crashes compared to total crashes in Rio Arriba County was virtually double the statewide average for three out of the five years (2007-2011). A study conducted on behalf of the Rio Arriba

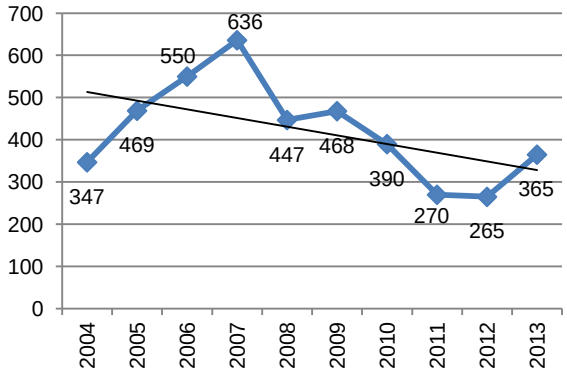
County Commission found that 39 percent of all incarcerations in the county were related to DWI, alcohol, or drug abuse.

Rio Arriba County Alcohol-involved Crashes/Total Crashes 2007-2011



Source: UNM TRU

Rio Arriba County DWI Arrests 2004-2013



Source: DWI Resource Center

According to the 2011 New Mexico Youth Risk and Resiliency Survey, 41 percent of participating ninth through twelfth grade students labeled themselves as current drinkers, of which 28 percent considered themselves binge drinkers (five or more drinks on a single occasion). Thirty-four percent of Rio Arriba high school students reported having their first drink before the age of 13.

Rio Arriba County Youth Risk Resiliency Survey Alcohol Results 2003 Versus 2011

	2003		2011	
	Rio Arriba County	NM	Rio Arriba County	NM
Current Alcohol Use	58%	51%	41%	37%
Binge Drinking (5 or More Drinks on One Occasion)	42%	35%	28%	22%
Drinking and Driving	22%	19%	10%	9%
Rode with a Person Who Drank Alcohol	43%	35%	29%	26%
Consumed First Alcoholic Beverage Before Age 13	43%	36%	34%	27%

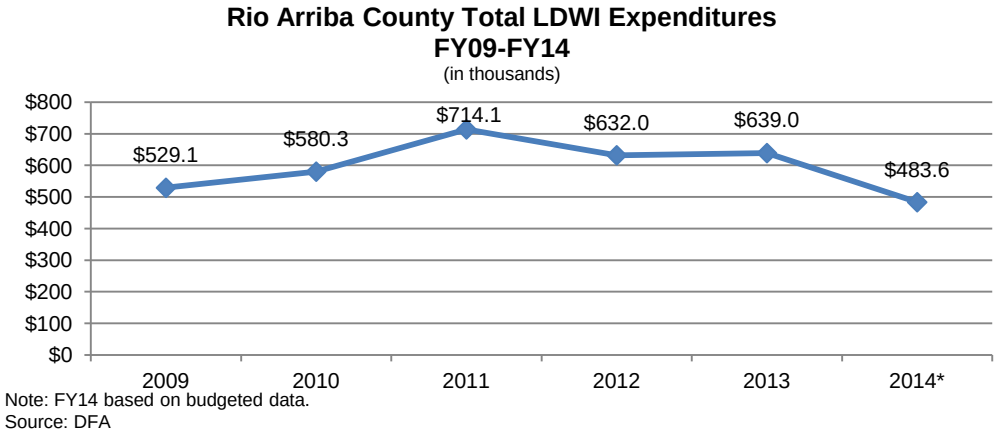
Source: DOH

Between 2003 and 2011, Rio Arriba County saw improvements in various youth alcohol-related indicators. The most significant gains were made in current alcohol use (17 percent reduction), binge drinking (14 percent reduction), and those riding with someone who consumed alcohol (14 percent reduction). However, Rio Arriba County students still reported higher levels of all five activities than the state of New Mexico as a whole.

Convicted DWI offenders are screened by the county's DWI program. Screening data for 2012 found that the majority of offenders were between ages of 26-50 years old, male, Hispanic, with an average educational attainment of 12.35 years. Thirty-four percent showed evidence of a drinking problem and another 32 percent were classified as having middle to late stage alcoholism.

Between FY09 and FY14, Rio Arriba County received $3.7 million from the LDWI program, the seventh highest amount of all 33 counties. For FY14, the county requested LDWI funds for prevention, treatment, compliance monitoring, and coordination, planning and evaluation totaling $630 thousand, including a $200 thousand detoxification grant. The county's prevention program includes evidence-based school curriculums, youth

leadership programs, drug and alcohol-free events, media campaigns, fostering parental involvement, and working with faith-based organizations.

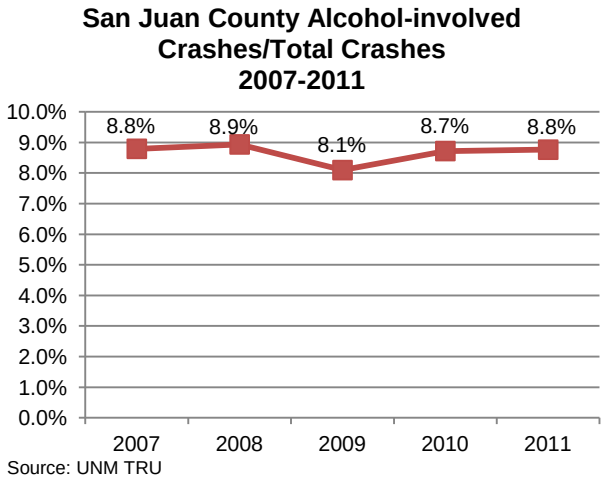


Note: FY14 based on budgeted data.
Source: DFA

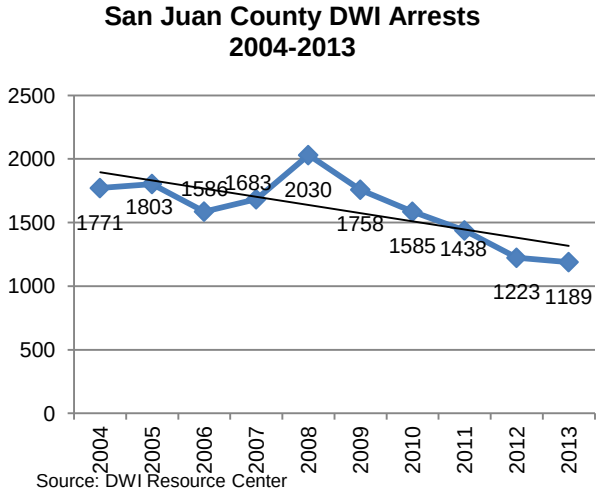
Rio Arriba County funds jail-based and intensive outpatient treatment programs. The jail-based treatment program is 28 days, but can be extended to 90 days for offenders with three or more DWIs. Upon release from the jail-based program, offenders are referred to outpatient services, adding a case management component in FY14. The intensive outpatient program consists of four phrases that also address family involvement, after-care, and relapse prevention for a total of up to 58 weeks of programming. The program uses various evidence-based practices including Motivational Interviewing, Stages of Change, CRAFT, and Mindfulness-Based Cognitive Therapy.

Rio Arriba County employs 1.5 full-time equivalents as compliance officers, who are housed at magistrate court to ensure DWI offenders complete all court-ordered sanctions. Furthermore, the county operates a Teen Court, funded by the county and CYFD.

San Juan County. San Juan County's 2010 population was 130,044 and the percentage living below the poverty level was 20.4 percent between 2008 and 2012. DOH reported that between 2008 and 2012, the county had 68.8 alcohol-related deaths per 100,000 and 2.3 alcohol-impaired motor vehicle crash deaths per 100,000. The percentage of alcohol-related crashes compared to total crashes in San Juan County was consistently 3 percentage points higher than statewide average between 2007 and 2011.



Source: UNM TRU



Source: DWI Resource Center

According to the 2011 New Mexico Youth Risk and Resiliency Survey, 28 percent of participating ninth through twelfth grade students labeled themselves as current drinkers, of which 16.3 percent considered themselves binge drinkers (five or more drinks on a single occasion). Twenty-three percent of San Juan County high school students reported having their first drink before the age of 13.

San Juan County Youth Risk Resiliency Survey Alcohol Results
2003 Versus 2011

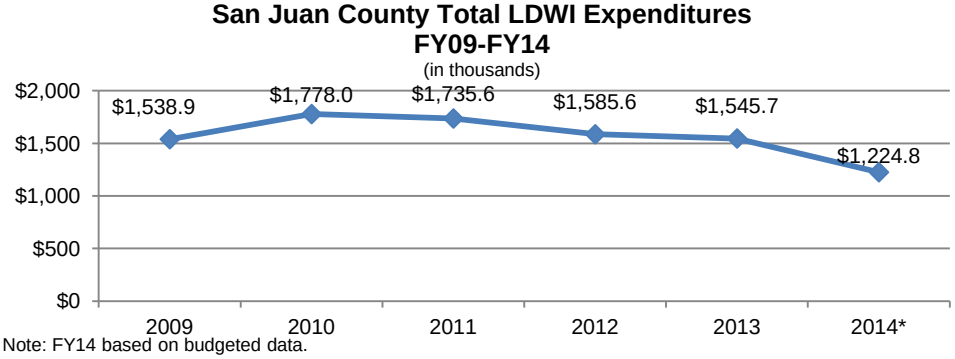
	2003		2011	
	San Juan County	NM	San Juan County	NM
Current Alcohol Use	47%	51%	28%	37%
Binge Drinking (5 or More Drinks on One Occasion)	33%	35%	16%	22%
Drinking and Driving	13%	19%	7%	9%
Rode with a Person Who Drank Alcohol	27%	35%	19%	26%
Consumed First Alcoholic Beverage Before Age 13	32%	36%	23%	27%

Source: DOH

Between 2003 and 2011, San Juan County showed gains in various youth alcohol-related indicators. The most significant gains were made in current alcohol use (19 percent reduction) and binge drinking (17 percent reduction). San Juan County students reported lower levels of all five activities than the state of New Mexico as a whole in both 2003 and 2011.

DWI offender characteristics in San Juan County show 51 percent of offenders make $10 thousand or less annually, 83 percent of offenders make $30 thousand or less per year. Data also shows that 79 percent of 79 percent of offenders report having a severe or established problem with alcohol.

Between FY09 and FY14, San Juan County received $9.8 million from the LDWI program, the second highest amount of all 33 counties. For FY14, the county requested LDWI funds for screening, treatment, compliance monitoring, and alternative sentencing totaling $1.5 million, including a $300 thousand detoxification grant. The county uses compliance monitoring funding for the San Juan County Adult Misdemeanor Compliance Program, which monitored 1,963 offenders in FY12. The program handles all probation services for the county's six magistrate judges. Additionally, the compliance program compiles an approved service provider list for the courts to assist in referring to services in the county.



Note: FY14 based on budgeted data.

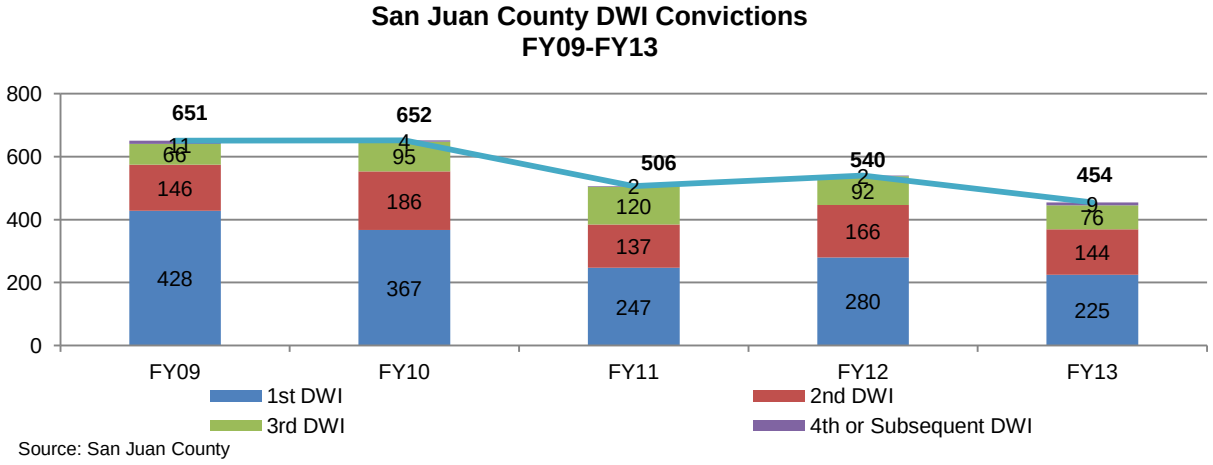
San Juan County's DWI treatment center program reduced recidivism 17 percent when compared to DWI offenders not treated at the center. A federally-funded study found over a five-year period, program participants had a 23.4 percent probability of being rearrested for DWI, while non-program participants had a 40.1 percent

chance of re-arrest. Participants are sentenced to a 28-day program, which focuses primarily on first-time DWI offenders. While it is considered a jail-based treatment program, participants are housed in a separate facility. Upon completion of the program, participants are released and required to attend a 6-month after-care program. Between FY09 and FY13, of participants who completed the 28-day program, an average of 51 percent completed that after-care component.

In FY13, San Juan County targeted over $1.9 million to this structured treatment program, $1 million of which was LDWI funding, and the remainder was county in-kind matching funds. In FY14, the per-client fee for this program is $2,423. The inpatient component of the program costs $264 per day, and when combined with the 6-month after-care program, the total program costs $36 per day. In comparison, New Mexico drug courts have an average per diem rate of $21.84. A 2003 LFC report noted that while the San Juan County program was expensive, it appeared to have a positive impact on re-arrest rates for first and second DWI offenders.

A 2011 New Mexico Drug Policy Task Force report referenced the San Juan alcohol treatment program and recommended it as an alternative to incarceration that counties should consider.

DWI convictions in San Juan County dropped by an average of 8 percent between FY09 and FY13. The greatest driver of this decrease was a reduction in convictions for first-time DWI offenders, dropping by as much as 33 percent in FY11. However, the county did see increases in second, third, and fourth or higher DWI convictions.



Source: San Juan County