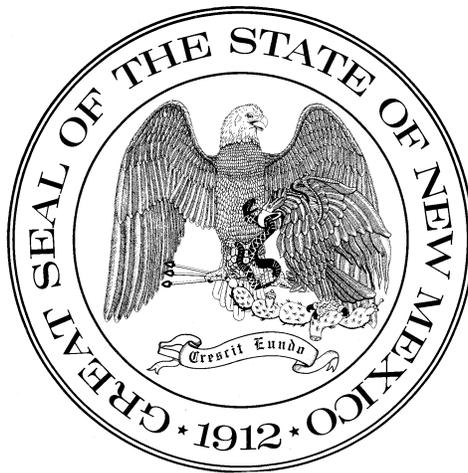


Legislative Health and Human Services Committee

2013 INTERIM REPORT



New Mexico State Legislature
Legislative Council Service
411 State Capitol
Santa Fe, New Mexico

**2013 INTERIM REPORT
LEGISLATIVE HEALTH AND
HUMAN SERVICES COMMITTEE,
INCLUDING
THE DISABILITIES CONCERNS SUBCOMMITTEE AND
THE BEHAVIORAL HEALTH SUBCOMMITTEE**

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EXECUTIVE SUMMARY

SUMMARY

APPOINTMENTS

At its June 18, 2013 meeting, the New Mexico Legislative Council appointed Representative James Roger Madalena as chair and Senator Gerald Ortiz y Pino as vice chair of the Legislative Health and Human Services Committee (LHHS). The New Mexico Legislative Council also appointed members to the LHHS, as well as to the statutory Disabilities Concerns Subcommittee (DCS) of the LHHS. The council created and appointed members to a temporary subcommittee, the Behavioral Health Subcommittee (BHS) of the LHHS. Senator Nancy Rodriguez was appointed chair and Representative Doreen Y. Gallegos was appointed vice chair of the DCS. Senator Benny Shendo, Jr., was appointed chair and Representative Stephen Easley was appointed vice chair of the BHS.

On August 14, 2013, Representative Easley passed away unexpectedly. Representative Phillip M. Archuleta was appointed to replace Representative Easley as vice chair of the BHS.

COMMITTEE AND SUBCOMMITTEE WORK

The LHHS continued its wide-ranging review of health and human services agencies, policies and programming in the state during the 2013 interim. However, one issue overshadowed all other topics this interim: the matter of credible allegation of fraud determinations that the Human Services Department (HSD) made against 15 behavioral health services agencies that had theretofore provided over 80 percent of the state's publicly funded behavioral health services. The credible allegation of fraud determinations led to a referral of these providers to the Attorney General's Office (AGO) for investigation. Pending the outcome of the AGO's investigation, the HSD instituted pay holds against 14 of the 15 agencies, and made provisions for their replacement by five behavioral health services agencies from Arizona. The AGO's investigation, the pay holds against most of the 15 agencies and litigation over this matter continue.

The LHHS and the BHS rearranged much of their interim agendas to accommodate extensive hearings with testimony from representatives of the HSD, the AGO, the Office of the State Auditor, some of the agencies that were the subject of the referrals, individual behavioral health professionals, behavioral health services recipients and their families and advocates and a representative of one of the Arizona replacement agencies.

The LHHS reviewed the progress of the establishment and operation of the New Mexico Health Insurance Exchange (NMHIX), newly created through 2013 legislation to offer health insurance plans to individuals and small businesses. Receiving nearly monthly testimony from NMHIX board members and staff, the LHHS learned that the NMHIX began offering access to enrollment in these plans on October 1, 2013, with the federal government temporarily operating the individual-market portion of the NMHIX until January 1, 2015. At its last meeting, the LHHS heard testimony on the pace of enrollment in both the state's small-business exchange and the federal individual exchange.

The expansion of Medicaid eligibility to previously ineligible adults with incomes below 138 percent of the federal poverty level, regardless of parental status or disability, and the planned rollout of the Centennial Care Medicaid redesign were extensively reviewed by the LHHS, with testimony from the HSD, Legislative Finance Committee staff and Medicaid recipients and advocates on the potential impact of these changes on Medicaid recipients and on the state as a whole.

Health care work force continued to be a focus of the LHHS, which received testimony from experts, universities, agencies, advocates and consumers concerned about the state's capacity to meet the future demand for health care services. The LHHS heard proposals for: health work force data collection and analysis; the establishment of a dental school in the state and better funding for dental education; the potential use of allied dental professionals; licensure for dental therapist-hygienists; the creation of a school of public health; expansion of scopes of practice for several health professions; possibilities for extending graduate medical education beyond academic institutions; allied and community health professionals; and interstate licensure compacts.

The developmental disabilities waiver program jointly administered by the Department of Health (DOH) and the HSD was the focus of several meetings of the LHHS and the DCS. At issue were concerns about the length of delay for those individuals awaiting placement in waiver services; the use of a new tool, the "supports intensity scale", to evaluate the service needs of enrollees and the enrollees' concerns about changes to their service packages; the status of the *Jackson* lawsuit — long-standing litigation between certain enrollees and the state; the regulation of intermediate care facilities for developmentally disabled individuals; the impact of the Medicaid Centennial Care program upon persons waiting for developmental disabilities waiver services and upon those receiving them; and the program's overall sustainability. The committee heard testimony from individuals living with developmental disabilities, developmental disability rights advocates, members of the provider community, the DOH and the HSD.

In addition to its extensive review of services and supports for individuals living with developmental disabilities, the DCS also heard reporting on the State Use Act and on early interventions for children under three years of age.

The committee reviewed matters relating to protective services, including child abuse prevention; elder abuse and exploitation; the state's guardianship program; prescribing of psychotropic drugs to children; and suicide prevention.

The committee heard testimony on public health concerns and disease surveillance, including efforts to address these issues. The committee heard testimony on the pros and cons of creating a liver transplant facility in the state; chronic obstructive pulmonary disease; heart disease among newborns; integrated care models to address complex health conditions; and the continued existence of disparities in the health status and outcomes for New Mexicans on the basis of race, ethnicity and geography.

As noted above, at each of its four meetings this interim, the BHS heard testimony on the matter of credible allegation of fraud determinations that the HSD made against 15 behavioral health services agencies. In addition to these hearings, the BHS examined the status of behavioral health services statewide, including access to services for Native Americans, women, low-income residents and individuals residing in rural areas. It heard testimony on behavioral health in the criminal justice system, medical marijuana and harm reduction, community engagement teams and from the public and advocacy groups on access to behavioral health services during and after the HSD's transition of these services to five Arizona providers.

WORK PLAN AND MEETING SCHEDULE

2013 APPROVED WORK PLAN AND MEETING SCHEDULE
for the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

Members

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos

Sen. Gay G. Kernan
Rep. Terry H. McMillan
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Advisory Members

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote
Rep. Stephen Easley
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff
Sen. Linda M. Lopez

Sen. Cisco McSorley
Sen. Bill B. O'Neill
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson
Sen. Lisa A. Torracco

Behavioral Health Subcommittee

Sen. Benny Shendo, Jr., Chair
Rep. Stephen Easley, Vice Chair
Sen. Sue Wilson Beffort, Member
Sen. Craig W. Brandt, Member
Rep. Sandra D. Jeff, Member
Sen. Howie C. Morales, Member
Sen. Bill B. O'Neill, Member
Sen. Gerald Ortiz y Pino, Member
Rep. Paul A. Pacheco, Member
Sen. Mary Kay Papen, Member
Sen. Sander Rue, Member
Rep. Edward C. Sandoval, Member

Disabilities Concerns Subcommittee

Sen. Nancy Rodriguez, Chair
Rep. Doreen Y. Gallegos, Vice Chair
Sen. Craig W. Brandt, Member
Rep. Nora Espinoza, Member
Rep. Miguel P. Garcia, Advisory Member
Sen. Linda M. Lopez, Member
Rep. James Roger Madalena, Member
Rep. Edward C. Sandoval, Advisory Member
Rep. Elizabeth "Liz" Thomson, Advisory Member

Work Plan

The following is a list of subjects that the statutory Legislative Health and Human Services Committee (LHHS) will review during the 2013 interim. As LHHS membership will consist of many new legislators, the committee will hear an extensive overview of the most important health care matters facing the state. LHHS staff, executive agency staff, community experts and returning LHHS members will offer their expertise on these issues. Topics include an overview of the Medicaid program, the state's response to the federal Patient Protection and

Affordable Care Act of 2010 (PPACA) — including the New Mexico Health Insurance Exchange — and an outline of the state agencies and programs devoted to health and human services.

Medicaid

With the federal approval of the federal waiver under Section 1115 of the federal Social Security Act, the Human Services Department (HSD) will be implementing its new "Centennial Care" program to deliver Medicaid benefits to individuals whose income, disease status or disability qualifies them to receive Medicaid health benefits. The HSD has greatly reduced the list of managed care organizations that will now be offering physical, behavioral and long-term services to Medicaid recipients. The committee will review the implementation of the new, integrated and coordinated care model. The effect of this change in recipients' access to services and on providers will be important.

Pursuant to the PPACA, the state's Medicaid program will expand eligibility as of January 1, 2014 to allow adults whose incomes fall below 138 percent of the federal poverty level to enroll in Medicaid, regardless of disability, disease status or parental status. The committee will track how much outreach and education the HSD is performing pursuant to this expansion and the effect this may have on future health care costs as well as uncompensated care.

The committee will review the HSD's decision to discontinue its policy of providing three months' retroactive eligibility to Medicaid enrollees and the effect this may have on stakeholders and on uncompensated care.

The HSD has recently agreed not to require people who identify as Native American to enroll in managed care. The committee will explore the options that will be available for these fee-for-service Medicaid recipients, including the effect that increased Medicaid enrollment among Native Americans may have upon tribal providers, including independent tribal health enterprises and the Indian Health Service.

Enrollment among children who are currently eligible for Medicaid continues to drop in the Medicaid program, with a reported 40,000 children currently eligible but not enrolled. The impact appears to be particularly felt in Native American communities. Many children reportedly fall off the rolls after newborn coverage expires. The committee will hear the HSD's position on children's enrollment, the possibilities for increasing enrollment through policies such as "fast-track" enrollment and the effect that a continued drop in enrollment among New Mexican children may have on those children's health and development and on providers' uncompensated care burden and the effect on health disparities.

The committee will examine Medicaid dental care benefits, especially those for adults, and consider the adequacy of these benefits in meeting recipients' dental health care needs.

The HSD proposes to cover the expansion of the population of adults with an "alternative benefits package" that provides fewer benefits than the full Medicaid benchmark plan, yet more benefits than are currently provided to adults enrolled in the State Coverage Insurance program for which enrollment has ceased. The committee will seek to learn what benefits will be included and what the effect will be on stakeholders and for uncompensated care costs.

The PPACA provides for stricter Medicaid fraud measures, many of which involve additional electronic claims editing and review. The committee will inquire as to the HSD's progress in implementing Medicaid fraud and error provisions, and the work of the Office of the Attorney General to enforce state and federal anti-fraud law. The committee may review the efforts of states, including Texas and North Carolina, to implement robust anti-fraud programs.

The HSD's new ASPEN system allows for greater data processing and reporting than was previously available under the HSD's outdated ISD2 system. The committee will review ASPEN's potential in affording the legislature greater oversight of the Medicaid program, as the ASPEN system is expected to allow the HSD to compile data to report on utilization, outreach and enrollment and other important indicators of how Medicaid is fulfilling its role.

The federal Indian Health Care Improvement Act of 1976 was permanently reauthorized under the PPACA. One of the provisions that could have an important impact on the state's Medicaid plan is a provision that authorizes exploration of deeming the Navajo Nation as a "state" for Medicaid purposes. The committee will hear testimony from Navajo Nation officials and the HSD on the progress of this exploration.

New Mexico Health Insurance Exchange Act

With the 2013 passage of the New Mexico Health Insurance Exchange Act, the state is moving quickly to establish a state-based health insurance exchange (exchange). The committee will hear testimony from the newly appointed board of directors of the exchange about its plan of operation and the superintendent of insurance about rulemaking related to the exchange. Other important matters for committee review include:

- the viability of the information technology infrastructure of the exchange;
- staffing the exchange;
- the establishment of a navigator program pursuant to the PPACA, as well as the use of in-person assisters, agents and brokers to enroll people and employers in qualified health plans;
- Native American participation in the exchange and the establishment of a Native American advisory council to the exchange pursuant to the New Mexico Health Insurance Exchange Act;
- preparations to study premium growth on and outside of the exchange; and
- the effect of changes to the Health Insurance Alliance Act on approved health plan enrollees and insurer members.

Health Insurance Regulation

With the passage of House Bill 45 (Chapter 74), the Office of Superintendent of Insurance (OSI) is established as of July 1, 2013. The committee will hear testimony from the new or reappointed superintendent of insurance and OSI staff as to the OSI's plans to move forward in the regulation of health insurance.

The committee will also review how the OSI plans to implement the insurance requirements of the PPACA in light of the continued absence of state-level legislation to conform New Mexico statutes to the PPACA health insurance provisions such as guaranteed issue and a ban on preexisting condition exclusions.

The OSI is responsible for creating and implementing a reinsurance program to cover retirees who are younger than 65 years old and thus ineligible for Medicare, as the PPACA requires. The committee will hear testimony from the OSI on reinsurance and may consider the question of whether the reinsurance program would help reduce costs in coverage for public employees and retirees.

The committee will hear testimony from the superintendent of insurance on the superintendent's role as rulemaker and tie-breaking director on the exchange, as well as the OSI's actuarial and policy recommendations regarding exchange viability, including the avoidance of adverse selection and excessive premium growth on the exchange. This information will be important for helping legislators decide whether legislation will be needed to expand the definition of "small employer", whether to later allow large employers to purchase on the exchange or whether legislation is needed to curtail adverse selection.

The New Mexico Medical Insurance Pool's future will be an important consideration for the state in the coming months and years, including its role in providing affordable coverage to high-risk enrollees and the possible effect of including this population on the exchange. The committee will hear testimony on the viability of offering affordable, effective coverage to the pool population, as the rest of the insurance market will be affected by these decisions.

The committee will hear testimony regarding two new sources of coverage to be available through the exchange: a nonprofit "co-op" plan owned by enrollees; and a multistate plan to be offered through the federal Office of Personnel Management.

Large employers in the state have raised concerns regarding the PPACA's requirement that large employers either purchase health coverage for their employees or pay a yearly fine. Large health care provider entities, such as nursing facilities, home health care entities and hospitals, have raised questions about their future viability in light of the PPACA requirement and reimbursement rates that they report to be too low to allow them to provide this coverage. The committee will review the effect of the coverage mandate on health and human service providers and other large employers.

Native American Health

The state continues to face enormous disparities in the health status and access to health care among its ethnic and racial groups. The most glaring of these disparities exists between Native Americans and all other groups. Meanwhile, the PPACA contains a permanent authorization of the Indian Health Care Improvement Act, which sets as federal priorities supports for self-direction and the elimination of health disparities between Native and non-Native Americans. The federal Centers for Disease Control and Prevention reports that Native American rates of chronic disease, suicide, infant mortality and sexually transmitted diseases are much higher than the rates for those health conditions and incidents in other populations. These rates correspond to Native Americans' poverty rates, which are also the highest among racial and ethnic populations in the United States. The committee will continue to explore these disparities and the steps that New Mexico tribes, nations and pueblos, state agencies and the federal government are taking to address these disparities, including specific efforts to provide intergenerational care, control chronic disease and promote wellness.

In its work to examine support for aging populations, the committee will hear testimony on aging in Native American communities, including reports from tribal agencies that provide supports to elders.

Health Care Work Force

One of the greatest health policy challenges facing the state is the lack of trained health care professionals able to serve an increasing population of residents with access to health care services, while a large proportion of health care providers retire or otherwise cease to offer their services in the state.

The PPACA provides for a number of health care and human service work force-related grants. The committee will hear testimony on what grants have been applied for and what opportunities for using these funds to increase work force supply exist.

The committee will hear the program analysis performed by the Legislative Finance Committee staff, as well as the University of New Mexico's recently established Center for Workforce Analysis, on the state's health care work force, as well as an update on the status of the state's supply of health care professionals, and to identify policy solutions to work force supply challenges.

The committee will review best practices in this state and other states regarding health care work force "pipeline" and retention programs. This includes examining work force education, including:

- the bachelor's-to-M.D. and D.D.S. programs;
- solutions to the limit on the number of residencies available to train doctors in the state;

- the role of private educational institutions in meeting the health care work force supply needs; and
- the adequacy of current educational arrangements in supplying the state's dental health care needs.

There are a number of immigrant residents of New Mexico who are health professionals trained in their home countries. Language and licensure barriers prevent many of these professionals from providing licensed health care in New Mexico. The committee will hear a proposal to use these professionals' health care and native-language skills and employ them as "community health specialists", who would offer health education, health literacy and chronic disease management assistance to New Mexicans who share these professionals' languages.

The committee will examine the role of dental health care practitioners, including allied dental health care providers.

The committee also will hear testimony on the value that donated dental and medical services have for patients as well as health care costs in the state.

The committee will review the role of allied or "mid-level" health care practitioners in expanding access to health care. Among other matters, this review would include nurse practitioners' and certified nurse-midwives' potential in addressing some of the unmet need for primary care providers.

The committee will hear testimony on payment parity between primary care providers and physical therapists, occupational therapists and chiropractors.

Aging and Long-Term Care

The committee will hear testimony from the Aging and Long-Term Services Department about its plan for 2013-17 as well as programming related to the federal Older Americans Act of 1965 and the challenges raised by an expected "explosion" in the population of New Mexicans who are over 65 years old.

The committee will hear testimony on best practices in providing the supports necessary to keep elders in their homes to age in place, rather than become dependent or institutionalized. This includes examining legal-medical partnerships to protect seniors' rights, assisting seniors who are raising grandchildren and strategies for self-management, including avoiding falls, managing chronic disease and providing support for community caregivers.

Children and Youth

With the passage of Senate Bill 365 (Chapter 118), the Children, Youth and Families Department (CYFD) is charged with establishing a statewide, evidence-based home visiting program. The LHHS will hear from the CYFD on its plans to implement the program and from LFC staff on the value of early childhood programming.

The Children's Cabinet has offered to apprise the committee of its latest policy priorities and initiatives.

By November 2013, the J. Paul Taylor Early Childhood Task Force is charged with reporting to the LHHS on its recommendations for improving the quality and coordination of early childhood services in the state and improving some of the outcomes for New Mexico, from which the LHHS will hear expert testimony on the work of the CYFD and from the CYFD itself on its work to deliver services and protect children in the state.

The committee will examine best practices in the field of child abuse and neglect prevention. There have also been several calls for the committee to examine the role and capacity of citizen review boards to protect children in foster care.

Staff and students from a medical-legal partnership clinical program at the University of New Mexico will provide the committee with an overview of how their clinic helps to ensure that children receive the legal help they need to maintain access to health care services and to protect them from abuse, neglect and exploitation.

The committee will examine the role of school-based health centers in providing access to health care services in light of an expected increased demand in the need for health care services among those who may be insured pursuant to the PPACA.

The LHHS will study the practice of prescribing psychotropic drugs to children, the potential harm of inappropriate prescribing and best practices in meeting children's needs without overprescribing.

Health Care Delivery

With the passage of Senate Bill 586 (Chapter 151), sole community provider hospitals may now be reimbursed with Medicaid funds pursuant to the 1115 waiver under which the Centennial Care program operates. The committee will examine the effect of this legislation, as well as decreases in Medicare reimbursement pursuant to federal sequestration and sole community provider program changes, while demand is expected to increase pursuant to PPACA provisions such as Medicaid expansion and health coverage mandates.

The committee will examine the effect on the health care system of increased ownership of provider practices by hospitals and the effect that this will have on health care service availability, costs and pricing.

The Department of Health and the University of New Mexico hospitals are expected to conduct a feasibility study regarding the establishment of a liver transplant facility in the state and report their findings to the LHHS.

The committee will hear testimony on the incidence of "never" or "seminal" health care events and efforts to decrease their occurrence.

The committee will hear testimony regarding reports that non-hospital health care facilities and assisted living facilities are largely unregulated in the state, going for long periods without any oversight or inspection. The committee would include in its review the matter of conditions at physician practices where abortions are performed.

The cost of health care in the state corrections system is a matter that the committee will examine, including the cost of laboratory services provided through a third-party contractor.

Population Health, Health Conditions and Well-Being

The committee will review health disparities, including the Racial and Ethnic Disparities Report Card, and the specific concerns from African American community members that their health concerns have been neglected.

The health and well-being of New Mexico's working poor, migrant workers, dairy workers and other agricultural workers are matters the committee will study, including reporting on pesticide exposure and Parkinson's disease.

The committee will examine hunger in the state, including reports relating to food insecurity among children, seniors and low-income residents. The committee will also examine the federal-state Supplemental Nutrition Assistance Program (SNAP), formerly known as "food stamps", and SNAP's role in addressing food insecurity.

The committee will review employment training offered through the federal-state Temporary Assistance for Needy Families (TANF) program and other updates to the TANF program.

The committee will examine the need for and availability of services for homeless people, including services for victims of human trafficking.

The committee will examine the impact of immigration reform on immigrants' access to health care and the possibilities for decreasing uncompensated care. This includes any barriers to health coverage for immigrants, including the ban on Medicaid coverage for new legal permanent residents.

New Mexico is among those states with a centralized public health agency, the Department of Health. Citizens' health councils have been a means of providing local input on public health policy in the state. The committee will look at the work of health councils and the impact of recent years' cuts to these councils.

The Department of Health has recently issued its study on obstructive pulmonary disease, which requests the committee to receive the department's report on the subject.

Patients enrolled in the state's medical marijuana program have raised concerns about the lack of adequate growers and producers in the state. The committee will hear testimony from patients, advocates and the Department of Health on this issue.

Palliative care is health care that is designed to decrease suffering and comfort patients who have foregone therapeutic care. The committee will hear testimony on best practices in palliative care and palliative care's potential in increasing the quality of end-of-life care.

Members of and advocates for individuals with disabilities have requested that the committee hear matters, previously heard by the Disabilities Concerns Subcommittee, related to the developmental disabilities services Medicaid home- and community-based waiver. The committee will hear matters relating to recent changes to the waiver.

BEHAVIORAL HEALTH SUBCOMMITTEE

Behavioral health topics that will be presented before either the full LHHS or the Behavioral Health Subcommittee include the cost to local communities of incarcerating or hospitalizing mentally ill individuals who are unlikely to live safely in the community and the cost-effectiveness of community-based early intervention alternatives for this population, such as community engagement teams, crisis intervention teams, crisis outreach and support teams and harm reduction.

Reports on the status of the Centennial Care carve-in of behavioral health services and details of its implementation with presentations from stakeholders, Medicaid managed care organizations and the Behavioral Health Services Division of the HSD are also of interest to the subcommittee, as is the ongoing role of the Interagency Behavioral Health Purchasing Collaborative.

Other behavioral health topics to be covered this interim include updates on the activities of the statewide and local behavioral health collaboratives, behavioral health needs of veterans suffering from posttraumatic stress disorder and of incarcerated women for successful re-entry into the community, prescription drug dependence and overdose prevention. Relating to prescription drug dependence, the subcommittee will review the availability of and indications for substance abuse services for pregnant women.

The subcommittee will hear recommendations about the state's laws regarding treatment guardians.

The subcommittee will also hear recommendations for improving the way that the state provides outpatient behavioral health services.

DISABILITIES CONCERNS SUBCOMMITTEE

The subcommittee will cover the following topics for its interim work plan: services for individuals with developmental disabilities; the regulation of group homes for individuals with developmental disabilities; protecting the disabled from abuse and exploitation; services for traumatic and non-traumatic brain injury; and funding of programs for the visually impaired.

**Legislative Health and Human Services Committee
2013 Approved Meeting Schedule**

Legislative Health and Human Services Committee

<u>Date</u>	<u>Location</u>
July 1-3	Rio Rancho, Albuquerque
July 25-26	Jemez Pueblo, Santa Fe
September 4-6	Las Cruces, Socorro
October 2-4	Hobbs
November 6-8	Santa Fe
November 25-26	Santa Fe

Behavioral Health Subcommittee

<u>Date</u>	<u>Location</u>
July 9	Roswell
September 3	Las Cruces
September 30	Albuquerque
November 5	Santa Fe

Disabilities Concerns Subcommittee

<u>Date</u>	<u>Location</u>
July 8	Santa Fe
October 1	Albuquerque
November 4	Santa Fe

Revised: May 24, 2013

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

**May 30, 2013
State Capitol, Room 322
Santa Fe**

Thursday, May 30

- 9:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair
—Senator Gerald Ortiz y Pino, Vice Chair
- 9:40 a.m. (1) [Interim Committee Procedures](#)
—Raúl E. Burciaga, Director, Legislative Council Service (LCS)
- 10:00 a.m. (2) [2013 Legislative Highlights](#)
—Michael Hely, Staff Attorney, LCS
- 10:30 a.m. (3) [The Effect of Federal "Sequestration" on New Mexico's Health Care Services and Infrastructure](#)
—Ruby Ann Esquibel, Senior Analyst, Legislative Finance Committee (LFC)
- 11:30 a.m. (4) [Public Comment](#)
- 12:00 noon **Lunch**
- 1:30 p.m. (5) [Early Childhood Services](#)
—Mimi Aledo-Sandoval, Senior Fiscal Analyst, LFC
—Charles Sallee, Deputy Director, LFC
- 2:30 p.m. (6) [New Mexico Health Insurance Exchange: First Steps in Establishment](#)
—Gabriel Parra, Esquire, Member, Board of Directors,
New Mexico Health Insurance Exchange
- 4:00 p.m. (7) [Review and Adoption of Legislative Health and Human Services Committee Interim 2013 Work Plan and Meeting Schedule](#)
—Michael Hely, Staff Attorney, LCS
- 4:30 p.m. **Adjourn**

Revised: June 28, 2013

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

July 1, 2013

**University of New Mexico (UNM) West Campus
Room 2170, 2600 College Boulevard NE
Rio Rancho**

July 2, 2013

**UNM Health Sciences Center (HSC) North Campus
Room 2112, Domenici Center for Health Sciences Education
1001 Stanford NE
Albuquerque**

July 3, 2013

**ABQ Health Partners
Auditorium, 5400 Gibson Blvd. SE
Albuquerque**

Monday, July 1: UNM — West Campus, Room 2170, 2600 College Blvd. NE, Rio Rancho

- 8:30 a.m. **Call to Order**
- 8:35 a.m. **Welcome and Introductions, Approval of May 30 Minutes**
—Representative James Roger Madalena, Chair
—Senator Gerald Ortiz y Pino, Vice Chair
- 8:45 a.m. **Welcome and Introduction to the UNM's West Campus**
—Elizabeth Miller, Ed.D., Interim Executive Director, UNM West Campus
- 9:30 a.m. (1) **Liver Transplant Feasibility Study**
—Dudley Byerley, Citizen Advocate
—Julio C. Sokolich, M.D., New Mexico Surgical Associates
- 10:30 a.m. (2) **Liver Transplant Facility Feasibility — Department of Health Efforts**
—Winona Stoltzfus, M.D., Medical Director, Health Systems Bureau,
Department of Health (DOH)

—Steve McKernan, Chief Executive Officer, UNM Hospital
—Pamela Demarest, Executive Director, Medical Surgical Services, UNM Hospital

- 11:00 a.m. (3) [Health Insurance Cooperative Plan](#)
—Martin Hickey, M.D., Chief Executive Officer, New Mexico Health Connections
- 11:30 a.m (4) [Update from the New Mexico Health Insurance Exchange \(NMHIX\)](#)
—Martin Hickey, M.D., Member, Board of Directors, NMHIX
—Michael Nuñez, Acting Chief Executive Officer, NMHIX
- 12:00 noon **Lunch**
- 1:30 p.m. (5) [Primary Care by Nurse Practitioners and Certified Nurse-Midwives](#)
—Sonda Boulware, M.S.N., A.C.N.P.-B.C., President, New Mexico Nurse Practitioner Council
—Randy McGuire, C.F.N.P., C.W.C.N., McGuire Wound and Ostomy Center, Roswell
—Elaine Brightwater, N.P., D.N.P., Certified Nurse-Midwife
—Nancy Ridenour, Ph.D., A.P.R.N., B.C., F.A.A.N., Dean, School of Nursing, UNM HSC
- 2:30 p.m. (6) [Interstate and Interregional Medical Licensure Compacts](#)
—Lynn S. Hart, Executive Director, New Mexico Medical Board
—C. Grant LaFarge, M.D., Medical Director, New Mexico Medical Board
- 4:00 p.m. (7) [Public Comment](#)
- 4:30 p.m. **Recess**

Tuesday, July 2: UNM HSC — North Campus, Room 2112, Domenici Center for Health Sciences Education, 1001 Stanford NE, Albuquerque

- 8:30 a.m. **Welcome from the UNM HSC**
—Paul B. Roth, M.D., Chancellor for Health Sciences, UNM HSC
- 8:45 a.m. (8) [Vetoed Health and Human Services Legislation from the 2013 Regular Session](#)
—Michael Hely, Staff Attorney, Legislative Council Service

- 9:15 a.m. (9) [Large Employer Health Coverage Mandate — Health and Human Services Providers](#)
—Stephen Byrd, President, Employee Benefits Division, Manuel Lujan Agencies
—Karen Wells, New Mexico Association for Home and Hospice Care
—Anna Otero-Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers
—Linda Sechovec, Executive Director, New Mexico Health Care Association
- 11:00 a.m. (10) [Hidalgo Medical Services \(HMS\) Program Accreditation by the Council for Graduate Medical Education](#)
—Tamera Ahner, Workforce Manager, HMS
- 12:00 noon **Lunch**
- 1:00 p.m. (11) [Dental Education: Dental School, Western Interstate Commission for Higher Education \(WICHE\)](#)
—(via webinar) Howard L. Bailit, D.M.D., Ph.D., Professor Emeritus, University of Connecticut Health Center
—Rudy Blea, Program Director, Office of Oral Health, DOH
—Senator Mark Moores, New Mexico State Senator; Commissioner, WICHE
—Jose Garcia, Commissioner, WICHE
—Patricia Anaya Sullivan, Commissioner, WICHE
- 2:30 p.m. (12) [Center for Health Workforce Analysis](#)
—Arthur Kaufman, M.D., Vice Chancellor for Community Health; Director, Office for Community Health, UNM HSC
—Richard Larson, M.D., Ph.D., Executive Vice Chancellor, Vice Chancellor for Research, UNM HSC
- 3:00 p.m. (13) [Community Health Specialists Program](#)
—Francisco Ronquillo, Health Extension Officer, Office for Community Health, UNM HSC
—Arthur Kaufman, M.D., Vice Chancellor for Community Health; Director, Office for Community Health, UNM HSC
- 3:30 p.m. (14) [UNM HSC Health Care Work Force Education Programs](#)
—Paul B. Roth, M.D., Chancellor for Health Sciences, UNM HSC
- 4:30 p.m. (15) [Public Comment](#)

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

Wednesday, July 3: ABQ Health Partners, Auditorium, 5400 Gibson Blvd. SE, Albuquerque

- 8:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair
—Senator Gerald Ortiz y Pino, Vice Chair
- 8:40 a.m. (16) **ABQ Health Partners — Total Care Model**
—Jill Klar, Chief Operating Officer, ABQ Health Partners
—Robert Mayer, Chief Information Officer, ABQ Health Partners
- 9:30 a.m. (17) **Health Care Provider Covenants Not to Compete**
—David Johnson, Esq., Montgomery & Andrews, P.C.
—James Martinez, M.D., President-Elect, New Mexico Medical Association
- 11:00 a.m. (18) **Donated Dental Services**
—Linda Paul, Executive Director, New Mexico Dental Foundation
—Larry B. Lubar, D.D.S.
- 11:30 a.m. (19) **Public Comment**
- 12:00 noon **Lunch**
- 1:00 p.m. (20) **Medical-Legal Partnerships**
—Yael Cannon, Esq., Assistant Professor of Law, UNM School of Law
—Ellen Leitzer, Esq., Executive Director, Senior Citizens' Law Office (SCLO)
- 2:00 p.m. (21) **Elder Abuse and Exploitation**
—Marsha Shasteen, Staff Attorney, SCLO
—Gregory MacKenzie, Attorney at Law
—Darryl Millet, Attorney at Law
- 3:00 p.m. (22) **Medicaid Fraud and Elder Abuse Unit; Hate Crimes Against Elders**
—Maria Griego, Program Evaluator, Legislative Finance Committee
—Jody Curran, Director, Medicaid Fraud and Elder Abuse Division, Office of the Attorney General (OAG)
—Dave Pederson, General Counsel, OAG
—Joan Gilewski, Nurse Investigator, OAG
—Kathleen Hart, Director, Adult Protective Services Division, Aging and Long-Term Services Department

4:30 p.m. (23) [Alleged Behavioral Health Provider Fraud](#)
—Sidonie Squier, Secretary, Human Services Department
—Diana McWilliams, Executive Director, Interagency Behavioral Health
Purchasing Collaborative

5:00 p.m. **Adjourn**

Revised: January 9, 2014

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

**July 25, 2013
Room 307, State Capitol
Santa Fe**

**July 26, 2013
Community Resource Center
129 Canal Street #B
Pueblo of Jemez**

Thursday, July 25

- 9:00 a.m. **Welcome and Introductions; Approval of Minutes**
—Representative James Roger Madalena, Chair, Legislative Health and
Human Services Committee (LHHS)
—Senator Gerald Ortiz y Pino, Vice Chair, LHHS
- 9:10 a.m. (1) **Update on the Behavioral Health Provider Investigations**
—Shawn Mathis, Staff Attorney, Legislative Council Service
—The Honorable Hector H. Balderas, State Auditor
—Jim Ogle, Co-Chair, Legislative Committee, National Alliance on Mental
Illness-New Mexico
—Barri Roberts, Executive Director, Bernalillo County Forensic
Intervention Consortium
- 10:00 a.m. (2) **Public Comment**
- 10:30 a.m. (3) **New Mexico Health Insurance Exchange**
—Jason Sandel, Vice Chair, New Mexico Health Insurance Exchange
(NMHIX) Board of Directors
—Mike Nuñez, Chief Executive Officer, NMHIX
- 11:30 a.m. **Working Lunch**
- 1:00 p.m. (4) **Health Disparities**
—Carlotta A. Garcia, M.D., Director, Office of Health Equity, Department
of Health
—Yvette Kaufman-Bell, Executive Director, Office on African American
Affairs

3:30 p.m. (5) **Health Insurance Regulation Update**
—David Barton, Chief Counsel, Office of Superintendent of Insurance (OSI)
—Alan Seeley, Chief Actuary, OSI
—Lisa Reed, Patient Protection and Affordable Care Act Implementation
Coordinator, OSI

4:30 p.m. (6) **Public Comment**

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

Friday, July 26

9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS
—Senator Gerald Ortiz y Pino, Vice Chair, LHHS

9:05 a.m. **Governor's Welcome to Pueblo of Jemez**
—The Honorable Vincent A. Toya, Sr., Governor, Pueblo of Jemez

9:30 a.m. (7) **Health and Human Services Program, Tour of Jemez Clinic**
—Maria K. Clark, Director, Pueblo of Jemez Health and Human Services

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

12:30 p.m. (8) **Medicaid Centennial Care Enrollment and Outreach**
—Julie Weinberg, Director, Medical Assistance Division, Human Services
Department

1:30 p.m. (9) **Health Coverage Enrollment and Outreach Roundtable**
—Cathleen Willging, Senior Scientist, Behavioral Health Research Center
of the Southwest
—Sovereign Hager, Staff Attorney, NMCLP
—Erik Lujan, Policy Analyst, New Mexico Indian Council on Aging
—Gabriel Sanchez, Interim Director, Robert Wood Johnson Foundation
Center for Health Policy at the University of New Mexico

3:30 p.m. (10) **2012 SM 57 Working Group Report on Chronic Obstructive
Pulmonary Disease**
—Susan Baum, M.D., M.P.H., Medical Director/Epidemiologist, Chronic
Disease Prevention and Control Bureau, Department of Health
(CDPCB/DOH)
—Laura Tomedi, Ph.D., M.P.H., C.D.C./C.S.T.E. Applied Epidemiology
Fellow, CDPCB/DOH

4:30 p.m. (11) [Public Comment](#)

5:00 p.m. **Adjourn**

Revised: August 30, 2013

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

**September 4-5, 2013
Barbara Hubbard Room, New Mexico State University
1810 E. University, Building 284
Las Cruces**

**September 6, 2013
Skeen Room, New Mexico Institute of Mining and Technology
Socorro**

Wednesday, September 4: Barbara Hubbard Room, New Mexico State University, Las Cruces

- 9:00 a.m. **Welcome and Introductions**
- 9:05 a.m. **Welcome to New Mexico State University (NMSU)**
—Garrey Carruthers, President, NMSU
- 9:15 a.m. (1) **[NMSU Doctor of Nurse Practitioner Program](#)**
—Pamela Schultz, Ph.D., School of Nursing, NMSU
- 10:00 a.m. (2) **[Child Abuse Prevention](#)**
—Shelly A. Bucher, L.M.S.W., Extension Family and Consumer Sciences,
College of Agriculture, Consumer and Environmental Sciences, NMSU
—Esther Devall, Ph.D., Certified Family Life Educator, Family and
Consumer Sciences Department, College of Agricultural, Consumer
and Environmental Sciences, NMSU
—Yolanda Berumen-Deines, Secretary, Children, Youth and Families
Department (CYFD)
—Jared Rounsville, Director, Protective Services Division, CYFD
- 11:00 a.m. (3) **[Public Comment](#)**
- 11:30 a.m. **Depart Barbara Hubbard Room and Transport to Reduced-Gravity
and Biomechanics Lab (Legislators and Staff Only; Transportation in
NMSU Vehicles)**

- 11:45 a.m. (4) [Lunch and College of Engineering Presentation — Jerry Shaw Room, NMSU \(Legislators and Staff\)](#)
—Ricardo Jacquez, Ph.D., P.E., Dean, College of Engineering, NMSU
—Anthony Hyde, Director, Manufacturing Technology and Engineering Center, College of Engineering, NMSU
—Patricia Sullivan, Assistant Dean, College of Engineering, NMSU
—Cynthia Bejarano, Ph.D., Director, College of Arts and Sciences, NMSU
- 12:45 p.m. (5) [Presentation of Reduced-Gravity and Biomechanics Lab \(Legislators and Staff\)](#)
—Ou Ma, Ph.D., P.E., NMSU College of Engineering
—Robert Wood, Ph.D., Professor and Academic Head, Human Performance, Dance and Recreation Department, NMSU
- 1:15 p.m. **Depart for Barbara Hubbard Room**
- 1:30 p.m. (6) [Concerns Regarding Children and Psychotropic Medications — Senate Joint Memorial 44](#)
—Fred A. Baughman, Jr., M.D., Child Neurologist
—Tony Stanton, M.D., Psychiatrist
- 3:30 p.m. (7) [Local Efforts to Examine Pediatric Psychotropic Prescribing](#)
—George Davis, M.D., Psychiatrist, CYFD
—David Mullen, M.D., Medical Director, Child Psychiatric Hospital, University of New Mexico Hospital
- 5:00 p.m. **Recess**

Thursday, September 5: Barbara Hubbard Room, New Mexico State University, Las Cruces

- 9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee
- 9:05 a.m. (8) [Prescription Drug Pricing](#)
—Ken Corazza, Ph.C., Owner, Medicine Chest Pharmacy; Chair, New Mexico Poison Control Board
—Dale Tinker, Executive Director, New Mexico Pharmacists Association
—Jason Parrish, Pharm.D., Director, Retail Pricing, Express Scripts
—David Root, Senior Director, State Government Affairs, Prime Therapeutics

- 10:30 a.m. (9) [Continuing Care Communities](#)
—Linda Sechovec, Executive Director, New Mexico Health Care Association
—DeAnn Eaton, Continuing Care Retiring Community Administrator
- 11:30 a.m. (10) [Public Comment](#)
- 12:00 noon **Lunch**
- 1:00 p.m. (11) [Dental Therapy](#)
—Pamela K. Blackwell, J.D., Project Director, Oral Health Access, Health Action New Mexico
—Terry Batliner, D.D.S., M.B.A., Associate Director, Center for Native Oral Health Research, Colorado School of Public Health
—Frank Alfred Catalanotto, D.M.D., Professor and Chair, Department of Community Dentistry and Behavioral Science, University of Florida
—Sarah Wovcha, Executive Director, Children's Dental Services, Minneapolis, MN
—Kathleen Bettinger, R.D.H., Director, Interim Dental Hygiene Program, Dona Ana Community College
- 2:30 p.m. (12) [Fluoridation and Water Supply](#)
—Rudy Blea, Program Director, Office of Oral Health, Department of Health (DOH)
- 3:30 p.m. (13) [Grant, Luna and Hidalgo Counties Inmate Support Program Pilot Project](#)
—Matthew Elwell, Director, Luna County Detention Center
—Mike Carrillo, Director, Grant County Detention Center
- 4:30 p.m. **Recess**

Friday, September 6: Skeen Library, New Mexico Institute of Mining and Technology, Socorro

- 9:00 a.m. **Welcome and Introductions**
- 9:10 a.m. (14) [Recommendations for Sustainability of Developmental Disabilities Waiver Program](#)
—Ruby Ann Esquibel, Principal Analyst, Legislative Finance Committee (LFC)
—Pamela Galbraith, Program Evaluator, LFC
- 10:00 a.m. (15) [Community Provider Panel on Developmental Disabilities Programs and Services](#)
—Arlene Lindsey, Manager, Developmental Disabilities Program, Tresco, Inc.

—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers

11:00 a.m. (16) **Consumer Perspectives on Supports Intensity Scale (SIS) and Other Issues**

—Doris Husted, Director for Public Policy, the Arc of New Mexico
—Adam Shand and Amira Rasheed, Self-Advocates
—Vicki Galindo, Parent
—Robert Kegel, Parent

12:30 p.m. **Lunch**

1:30 p.m. (17) **Public Comment**

2:30 p.m. (18) **Sustainability of the Developmental Disability System**

—Peter Cubra, Esq., Advocate for People with Developmental Disabilities

3:00 p.m. (19) **Status and Funding of SIS Activities**

—Cathy Stevenson, Director, Developmental Disabilities Supports Division, DOH
—TBD, American Association on Intellectual and Developmental Disabilities

4:00 p.m. (20) **Progress Report on Senate Memorial 20**

—Cathy Stevenson, Director, Developmental Disabilities Supports Division, DOH
—Doris Husted, Director for Public Policy, the Arc of New Mexico

Revised: September 27, 2013

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

**October 2-4, 2013
Bob Moran Hall
New Mexico Junior College
1 Thunderbird Circle
Hobbs**

THIS MEETING WILL BE WEBCAST FROM: www.nmlegis.gov

Wednesday, October 2

- 8:30 a.m. **Welcome and Introductions, Approval of Minutes**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee (LHHS)
- 8:40 a.m. (1) **[Welcome to New Mexico Junior College](#)**
—Steve McCleery, Ph.D., President, New Mexico Junior College
- 9:00 a.m. (2) **[Legislative Finance Committee \(LFC\) Health Care Work Force Report and Department of Health \(DOH\) Perspective](#)**
—Jack Evans, Program Evaluator, LFC
—Rachel Mercer-Smith, Program Evaluator, LFC
—Michael Landen, M.D., State Epidemiologist, DOH
- 10:30 a.m. (3) **[Health Care Work Force Recruitment, Retention and Attrition; Payment Issues and Targeted Delivery Systems](#)**
—David P. Sklar, M.D., Associate Dean for Graduate Medical Education, Professor Emeritus of Emergency Medicine, University of New Mexico (UNM) Health Sciences Center (HSC)
—Jerry Harrison, Ph.D., Executive Director, New Mexico Health Resources, Inc.; Chair, New Mexico Health Policy Commission
- 11:30 a.m. **Lunch**
- 12:30 p.m. (4) **[UNM Work Force Report](#)**
—Richard Larson, M.D., Ph.D., UNM HSC

2:30 p.m. (5) [Grow Your Own Work Force](#)
—Arthur Kaufman, M.D., Vice Chancellor of Community Health; Director,
Office for Community Health, UNM HSC
—Danielle Moffett, M.A., Workforce Program Director, Center for Health
Innovation, Hidalgo Medical Services

3:30 p.m. (6) [Lea County Health Care Plan; Sole Community Provider and Indigent
Funding](#)
—Mike Gallagher, County Manager, Lea County

4:30 p.m. (7) [Public Comment](#)

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

Thursday, October 3

8:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS

8:30 a.m. (8) [Hunger in New Mexico](#)
—Jaron Graham, Pastor, Church of the Nazarene, Lovington
—Ruth Hoffman, Director, Lutheran Advocacy Ministry
—Kathy Komoll, Executive Director, New Mexico Association of Food
Banks

10:00 a.m. (9) [Alzheimer's Task Force Presentation](#)
—Gino Rinaldi, Secretary, Aging and Long-Term Services Department
(ALTSD)
—Myles Copeland, Deputy Secretary, ALTSD
—Agnes Vallejos, Executive Director, Alzheimer's Association, New
Mexico Chapter

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

1:00 p.m. (10) [Ending Homelessness in New Mexico](#)
—Hank Hughes, Executive Director, New Mexico Coalition to End
Homelessness

2:00 p.m. (11) [Services for Victims of Human Trafficking](#)
—Susan Loubet, Executive Director, New Mexico Women's Agenda
—Michael DeBernardi, Psy.D., Director, Behavioral Health Services, The
Life Link at Santa Fe
—Lynn Sanchez, M.A., L.P.C.C., Director, The Life Link at Santa Fe
Human Trafficking Aftercare Program

3:30 p.m. (12) [Post-Natal Screening for Critical Congenital Heart Defect](#)
—Kathy Cooper, R.N., B.S.N., Lovelace Regional Hospital, Roswell
—Sharon T. Phelan, M.D., OB-GYN, UNM Hospital Birthing Unit;
Professor, Department of Obstetrics and Gynecology, UNM School of
Medicine
—Ron Reid, Ph.D., State Director, Program Services and Government
Affairs, March of Dimes, New Mexico Chapter

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

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

Friday, October 4

8:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS

8:40 a.m. (14) [Behavioral Health Services Discussion](#)
—Daniel J. Ranieri, Chief Executive Officer, La Frontera, Inc.

10:30 a.m. (15) [The Role of County and Tribal Health Councils in New Mexico's Public Health Infrastructure](#)
—Ron Hale, Coordinator, New Mexico Alliance of Health Councils
—Jane Batson, Member, Chaves County Health Council
—Patricia Collins, Past Coordinator, Lea County Health Council
—Dick Mason, Co-Chair, Sandoval County Health Council
—Yolanda Cruz, Health Councils and Community Coordinator, New
Mexico Health Equity Partnership

12:00 noon **Lunch**

1:00 p.m. (16) [New Mexico Health Insurance Exchange \(NMHIX\): Open for Business](#)
—Mike Nunez, Chief Executive Officer, NMHIX

2:30 p.m. (17) [Consumer and Advocate Perspectives on the NMHIX and Medicaid Enrollment](#)
—Dick Mason, Health Care for All Coalition
—Erik Lujan, Consumer Advocate
—Pamelya Herndon, Esq., Executive Director, Southwest Women's Law
Center

3:30 p.m. (18) [Centennial Care Concerns](#)
—Ellen Pinnes, J.D., New Mexico Disability Coalition
—Pamelya Herndon, Esq., Executive Director, Southwest Women's Law
Center
—Jim Jackson, Executive Director, Disability Rights New Mexico

4:30 p.m. (19) [Public Comment](#)

5:00 p.m. **Adjourn**

Revised: November 1, 2013

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

**November 6-8, 2013
State Capitol, Room 307
Santa Fe**

Wednesday, November 6

- 8:30 a.m. **Welcome and Introductions**
- 8:40 a.m. (1) **Centennial Care Update**
—Julie Weinberg, Director, Medical Assistance Division, Human Services
Department (HSD)
—Dorianne Mason, Staff Attorney, New Mexico Center on Law and
Poverty
—Jim Jackson, Executive Director, Disability Rights New Mexico
—Ellen Pinnes, J.D., Health Policy Consultant
- 11:30 a.m. (2) **Liver Transplant Facility Update: House Memorial 48**
—Winona Stolfus, M.D., Medical Director, Health Systems Bureau,
Department of Health (DOH)
- 12:00 noon **Lunch**
- 1:00 p.m. (3) **The Tobacco Use and Cost Task Force Report: Senate Memorial 22**
—Heather W. Balas, President and Executive Director, New Mexico First
—Diane Snyder, Executive Director, Greater Albuquerque Medical
Association
—Dona Upson, M.D., Department of Internal Medicine, University of New
Mexico (UNM) Health Sciences Center
- 2:30 p.m. (4) **Adult Falls Task Force Report — Aging and Long-Term Services
Department and DOH**
—Michael Landen, M.D., State Epidemiologist, DOH
—Janet Popp, P.T., M.S., Physical Therapist and Gerontologist, Brookdale
Place and UNM
—Spanda Bhavani Johnson, Wellness Director, Good Samaritan Society,
Manzano del Sol Village

3:30 p.m. (5) [Public Comment](#)

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

Thursday, November 7

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

8:40 a.m. (6) [Health and Working Conditions of New Mexico's Agricultural Workers](#)

—Gail Evans, Esq., Litigation Director, NMCLP

—Maria Martinez Sanchez, Staff Attorney, NMCLP

10:00 a.m. (7) [Parkinson's Disease and Pesticide Exposure \(House Memorial 42\)](#)

—Heidi Krapfl, M.S., Environmental Epidemiology Bureau Chief, DOH

11:00 a.m. (8) [New Mexico Health Insurance Exchange \(NMHIX\) Update](#)

—Mike Nuñez, Chief Executive Officer, NMHIX

—Paige Duhamel, Staff Attorney, Southwest Women's Law Center

12:30 p.m. **Lunch**

1:30 p.m. (9) [Chiropractic Physician Primary Care Delivery](#)

—Steve Perlstein, Chiropractic Physician

—Robert Jones, Chiropractic Physician

2:00 p.m. (10) [Copayment Parity for Chiropractic Physicians, Occupational Therapists and Physical Therapists](#)

—Gretchen Johnson, Physical Therapist

—Johanna Cubra, Occupational Therapist

—Michael Pridham, Chiropractic Physician

2:30 p.m. (11) [Prospects for a School of Public Health](#)

—Robert G. Frank, Ph.D., President, UNM

—Deborah Helitzer, Sc.D., Professor, Family and Community Medicine,
Associate Vice Chancellor of Research Education, UNM

3:30 p.m. (12) [Access to Medical Marijuana](#)

—Jessica Gelay, Policy Coordinator, Drug Policy Alliance

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

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

Friday, November 8

- 8:30 a.m. (14) **Corrections Health Care**
—Eric Chenier, Fiscal Analyst, Legislative Finance Committee (LFC)
—Ruby Ann Esquibel, Principal Analyst, LFC
—Jerry Roark, Director, Adult Prisons Division, Corrections Department (NMCD)
—Rose Bobchak, Acting Director, Adult Probation and Parole Division, NMCD
—Brent Earnest, Deputy Secretary, HSD
- 11:00 a.m. (15) **End-of-Life Choices**
—Barak Wolff, M.P.H., Co-Chair, Executive Council, Compassion and Choices
—Kathryn Tucker, J.D., Director of Legal Affairs and Advocacy, Compassion and Choices
- 12:00 noon **Lunch**
- 1:30 p.m. (16) **Peer-to-Peer Counseling: Report from House Memorial 12 Task Force**
—Toby Rosenblatt, Bureau Chief, Injury and Behavioral Epidemiology Bureau, Epidemiology and Response Division, DOH
- 2:30 p.m. (17) **Economic Development and Health Care Work Force**
—Senator Jacob R. Candelaria
—Dick Mason, Health Action New Mexico
- 3:30 p.m. (18) **J. Paul Taylor Early Childhood Task Force Report**
—Kim Straus, Chair, J. Paul Taylor Early Childhood Task Force; Chair, Children's Trust Fund
—Karen Armitage, M.D., F.A.A.P., Associate Clinical Professor, Family and Community Medicine, UNM
—Susannah Burke, L.I.S.W., Vice Chair, J. Paul Taylor Early Childhood Task Force; Executive Director, PB & J Family Services
- 4:30 p.m. (19) **Public Comment**
- 5:00 p.m. **Adjourn**

Revised: December 19, 2013

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

**December 19-20, 2013
Room 307, State Capitol
Santa Fe**

Thursday, December 19

- 8:30 a.m. **Welcome and Introductions; Approval of Minutes**
—Representative James Roger Madalena, Chair
- 8:35 a.m. (1) **Computer Adaptive Testing — Mental Health Suicide Prevention Solution**
—Steve Trubow, Medical Engineer, Olympic Labs
—Robert Gibbons, Ph.D., Center for Health Statistics, University of Chicago
—Jan Fawcett, M.D., Department of Psychiatry, University of New Mexico (UNM)
- 10:00 a.m. (2) **Native American Suicide Prevention Clearinghouse**
—Sheri Lesansee, Program Manager, UNM Center for Rural and Community Behavioral Health, Native American Behavioral Program
—Doreen Bird, M.P.H., Community-Based Research Specialist, University of New Mexico Center for Rural and Community Behavioral Health
—Kaylee Pesina, Member, Honoring Native Life Youth Council (HNLYC); Student, Native American Community Academy
—Kateri Daw, Member, HNLYC; and Student, Highland High School
—Caroline Bonham, M.D., Director, Center for Rural and Community Behavioral Health, UNM
- 11:30 a.m. (3) **Working Lunch: Health Care Procurement and Transparency Legislation; Brain Injury Services**
—Senator Timothy M. Keller
—Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
—Jerome Mee, President, Mentis El Paso, LLP
—Glenn Ford, Glenn Ford Associates

- 1:00 p.m. (4) [**New Mexico Dental Association \(NMDA\) Update**](#)
—Thomas J. Schripsema, D.D.S., NMDA
—Julius N. Manz, D.D.S., NMDA
- 1:30 p.m. (5) [**Dental Therapists-Hygienist Legislation**](#)
—Pamela Blackwell, Esq., Health Action New Mexico (HANM)
—Mary Altenberg, M.S., C.H.E.S., Executive Director, Community Dental Services, Inc.
—Kristen Christy, Executive Director, Union County Network
—Terry Batliner, D.D.S., M.B.A., Associate Director, Center for Native Oral Health Research, Colorado School of Public Health
- 2:00 p.m. (6) [**Discussion of Dental Health Care Work Force Matters**](#)
—Thomas J. Schripsema, D.D.S., NMDA
—Julius N. Manz, D.D.S., NMDA
—Pamela Blackwell, Esq., HANM
- 3:30 p.m. (7) [**Review and Endorsement of 2014 Legislation**](#)
—Michael Hely, Staff Attorney, LCS
- 4:30 p.m. (8) [**Public Comment**](#)

Friday, December 20

- 8:30 a.m. (9) [**Hospital Funding and County Indigent Fund**](#)
—Brent Earnest, Deputy Secretary, Human Services Department
—Steven Kopelman, Esq., Executive Director, New Mexico Association of Counties
—Jeff Dye, President, New Mexico Hospital Association
- 10:30 a.m. (10) [**Community Health Workers**](#)
—Retta Ward, Secretary of Health
- 11:30 a.m. (11) [**International Community Health Specialists**](#)
—Francisco Ronquillo, P.A., Community Health Advocate
- 12:00 noon (12) [**Working Lunch: New Mexico Health Insurance Exchange — Native American Centers Update**](#)
—Mike Nunez, Chief Executive Officer, New Mexico Health Insurance Exchange
- 1:30 p.m. (13) [**2013 Senate Memorial 94 Report: Guardianships and Decision-Making Authority**](#)
—John Block, Executive Director, Developmental Disabilities Planning Council

—Jim Jackson, Executive Director, Disability Rights New Mexico

2:30 p.m. (14) [Public Comment](#)

3:00 p.m. (15) [Review and Endorsement of 2014 Legislation](#)
—Michael Hely, Staff Attorney, LCS

5:00 p.m. **Adjourn**

BEHAVIORAL HEALTH SUBCOMMITTEE AGENDAS

2013 Interim Report
Legislative Health and Human Services Committee

Revised: July 8, 2013

**TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE**

July 9, 2013

**Eastern New Mexico University, Campus Union Building, Multi-Purpose Room 110
43 University Blvd.
Roswell**

Tuesday, July 9

- 10:00 a.m. **Call to Order and Introductions**
—Senator Benny Shendo, Jr., Chair
- 10:10 a.m. **Welcome**
—Dr. John Madden, President, Eastern New Mexico University (ENMU)
- 10:30 a.m. (1) **Update from New Mexico Rehabilitation Center**
—Janie Davies, Administrative Services Director, New Mexico
Rehabilitation Center
- 11:30 a.m. (2) **Panel: Community-Based Behavioral Health**
—Jane Batson, Interim Assistant Vice President for External Affairs,
ENMU
—Jessie Chavez, Former State Liaison to Local Collaboratives 5, 9, 10
and 12
—Marti Wright Everitt, Chief Executive Officer, Counseling Associates,
Inc.
- 1:00 p.m. **Lunch Provided Onsite for Committee Members**
- 1:15 p.m. (3) **Program Evaluation of Behavioral Health Services 2013**
—Charles Sallee, Deputy Directory, Legislative Finance Committee (LFC)
—Pam Galbraith and Valerie Crespín-Trujillo, Program Evaluators,
LFC
- 2:15 p.m. (4) **Public Comment**

- 4:00 p.m. (5) [Bridges to Accessing Care: Experiences of the DDMI Project](#)
—Alya Reeve, MD, MPH, PI Continuum of Care; Professor of
Psychiatry, Neurology and Pediatrics; University of New Mexico
Health Sciences Center
—Kari Hendra, Family Nurse Practitioner for Student Health, ENMU
—Nathan Padilla, LMSU, Clinical Supervisor for La Familia Mental
Health

5:00 p.m. **Adjourn**

Revised: August 30, 2013

**TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE**

**September 3, 2013
Barbara Hubbard Room, New Mexico State University (NMSU)
1810 E. University, Bldg. 284
Las Cruces**

Tuesday, September 3

- 10:00 a.m. **Call to Order and Introductions**
—Senator Benny Shendo, Jr., Chair
- 10:10 a.m. **Welcome**
—Tilahun Adera, Ph.D., Dean and Professor, College of Health and
Social Services, NMSU
—Pamela Schultz, Ph.D., School of Nursing, NMSU
- 10:30 a.m. (1) **Update on Status of Behavioral Health Services**
—Brent Earnest, Deputy Secretary, Human Services Department (HSD)
—Larry Heyeck, Deputy General Counsel, HSD
—Diana McWilliams, Chief Executive Officer, Interagency Behavioral
Health Purchasing Collaborative; Director, Behavioral Health
Services Division, HSD
- Status of Behavioral Health Services Transitioned to Arizona
Providers
 - Status of Requests for Good Cause Exceptions to Lift the Pay
Suspensions
 - OptumHealth Fraud Detection Activities and Systems
 - OptumHealth's Role and Responsibility for Alleged Overpayments
 - OptumHealth's Future Role in New Mexico's Behavioral Health
System
 - Third-Party Oversight of Behavioral Health Services (June 30, 2013
Through the End of the First Quarter of 2014)
- 12:00 noon **Lunch (Provided)**
- 12:30 p.m. (2) **Public Comment Period #1**

- 1:30 p.m. (3) [North Carolina's Medicaid Audit Experience](#)
—Knicole Emanuel, Partner, Williams Mullen
- 2:30 p.m. (4) [New Mexico Quality Audits of Managed Care Organizations for Medicaid Requirements](#)
—William Boyd Kleefisch, F.A.C.H.E., Executive Director, HealthInsight New Mexico
—Margaret A. White, R.N., B.S.N., M.S.H.A., Director, External Quality Review, HealthInsight New Mexico
—Greg Lújan, L.I.S.W., Project Manager, Behavioral Health, HealthInsight New Mexico
- 3:30 p.m. (5) [Public Comment Period #2](#)
- 5:00 p.m. **Adjourn**

Revised: September 27, 2013

**TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE**

**September 30, 2013
Adelante Development Center
3900 Osuna Road NE
Albuquerque**

Monday, September 30

- 9:00 a.m. **Call to Order and Introductions**
—Senator Benny Shendo, Jr., Chair
- 9:10 a.m. (1) **Native American Behavioral Health Concerns**
—Linda Son-Stone, Chief Executive Officer, First Nations Community HealthSource
—Maria K. Clark, Director, Pueblo of Jemez Health and Human Services Department
—Keahi Kimo Souza, Program Manager, Jemez Behavioral Health Services
—Susy K. Ashcroft, M.A., L.P.C.C./L.A.D.A.C, Co-Occurring Specialist, Manos de Dios Counseling Services
- 10:30 a.m. (2) **Update on Behavioral Health Services**
—Diana McWilliams, Director, Behavioral Health Services Division, Human Services Department, CEO, Interagency Behavioral Health Purchasing Collaborative
- OptumHealth Fraud Detection Activities and Systems
 - OptumHealth's Role and Responsibility for Alleged Overpayments
 - OptumHealth's Future Role in New Mexico's Behavioral Health System
 - Third-Party Oversight of Behavioral Health Services (June 30, 2013 Through the End of the First Quarter of 2014)
- 12:30 p.m. **Lunch (Provided)**
- 1:30 p.m. (3) **Behavioral Health in the Criminal Justice System**
—Nils Rosenbaum, M.D., Crisis Outreach Psychiatrist, Albuquerque Police Department (APD)
—Detective Matt Tinney, Crisis Intervention Unit, APD

- 2:30 p.m. (4) [Update on Community Engagement Team Pilot](#)
—Diana McWilliams, Director, Behavioral Health Services Division,
Human Services Department, CEO, Interagency Behavioral Health
Purchasing Collaborative
- 3:30 p.m. (5) [Public Comment](#)
- 5:00 p.m. **Adjourn**

Revised: November 4, 2013

**TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE**

**November 5, 2013
Room 322, State Capitol
Santa Fe**

Tuesday, November 5

- 8:30 a.m. **Call to Order and Introductions**
—Senator Benny Shendo, Jr., Chair
- 8:40 a.m. (1) **Updates from State Auditor and Attorney General on Behavioral Health Matters**
—Hector H. Balderas, State Auditor
—Albert J. Lama, Chief Deputy Attorney General
- 9:40 a.m. (2) **Public Comment**
- 10:00 p.m. (3) **Mental Health and Community Reentry Issues Among Rural Women Prisoners in New Mexico**
—Cathleen Willging, Ph.D., Behavioral Health Research Center of the Southwest
- 11:00 a.m. (4) **Integration of Behavioral Health and Primary Care for the Seriously Mentally Ill Population**
—Cory Nelson, Deputy Director, Arizona Department of Health Services
- 12:00 noon **Working Lunch**
- 12:15 p.m. (5) **Local Perspectives on Funding for Indigent Behavioral Health**
—Jolene Schneider, B.A., L.A.D.A.C., Executive Director, Four Winds Recovery Center
—Lauren Reichelt, Director of Health and Human Services, Rio Arriba County
—Robert Mitchell, Administrator, San Juan County Alternative Sentencing Division
—Kristine L. Carlson, L.S.W., Program and Clinical Administrator, Totah Behavioral Health Authority

- 1:30 p.m. (6) [County Detention Health Care Costs](#)
—Grace Phillips, Attorney, New Mexico Association of Counties
- 2:15 p.m. (7) [Update on Human Services Department Budget Request for Behavioral Health](#)
—Greg Geisler, Principal Analyst, Legislative Finance Committee
- 2:45 p.m. (8) [Marijuana as Harm Reduction](#)
—Jessica Gelay, Policy Coordinator, Drug Policy Alliance
—Dave Schmidt, Drug Policy Alliance
—Reverend Gerald White, United Methodist Church, and Mrs. Judy White, Parents
- 3:45 p.m. (9) [Public Comment, Continued](#)
- 5:00 p.m. **Adjourn**

DISABILITIES CONCERNS SUBCOMMITTEE AGENDAS

Revised: July 5, 2013

**TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE**

July 8, 2013

**Easter Seals El Mirador, Mark Johnson Building, 10 A Van Nu Po
Santa Fe**

Monday, July 8

- 9:30 a.m. **Call to Order and Introductions**
—Senator Nancy Rodriguez, Chair
- 9:45 a.m. **Welcome**
—Mark Johnson, Chief Executive Officer, Easter Seals El Mirador
- 10:00 a.m. (1) **Update on Jackson Litigation**
—Gabriel Sanchez-Sandoval, General Counsel, Department of Health
 (DOH)
—Cathy Stevenson, Director, Developmental Disabilities Supports Division,
 DOH
—Debbie Hambel, Department of Vocational Rehabilitation, DOH
—Kathleen Kunkel, Esq., Walz & Associates
- 11:00 a.m. (2) **Consumer Perspectives on Jackson Compliance**
—Sally Faubion, Director of Guardianship, The ARC New Mexico
—Doris Husted, Public Policy Director, The ARC New Mexico
—Patsy Romero, Chief Operations Officer, Easter Seals El Mirador
- 12:00 noon **Working Lunch Provided for Legislators**
- 12:10 p.m. (3) **Public Comment**
- 1:30 p.m. (4) **Sustainability of the Developmental Disabilities Waiver and
Continuation of Compliance**
—Anna Otero Hatanaka, Executive Director, Association of
 Developmental Disabilities Community Providers
- 2:30 p.m. (5) **Regulation of Intermediate Care Facilities**
—Mark Johnson, Chief Executive Officer, Easter Seals El Mirador
—Linda Sechovec, Executive Director, New Mexico Health Care
 Association

3:10 p.m.

Adjourn

3:15 p.m.

(6) [**Tour of Intermediate Care Facility Home \(Legislators Only\)**](#)

Revised: September 27, 2013

**TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE**

**October 1, 2013
Adelante Development Center
3900 Osuna Rd. NE
Albuquerque**

Tuesday, October 1

- 9:00 a.m. **Call to Order, Introductions and Approval of Minutes**
—Senator Nancy Rodriguez, Chair
- 9:10 a.m. (1) **[Los Lunas Community Program for the Developmentally Disabled](#)**
—Jon Hellebust, Administrator, LLC, Department of Health (DOH)
- 10:10 a.m. (2) **[Developmental Disabilities Issues](#)**
—Cathy Stevenson, Director, Developmental Disabilities Supports Division,
DOH
- 12:00 noon **Working Lunch Provided for Legislators**
- 12:15 p.m. (3) **[Early Intervention Services from Birth to Age Three](#)**
—Anna Otero Hatanaka, Executive Director, Association of
Developmental Disabilities Community Providers
- 1:15 p.m. (4) **[Public Comment and Response by the DOH and Human Services
Department](#)**
- 5:00 p.m. **Adjourn**

Revised: October 31, 2013

**TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE**

**November 4, 2013
Room 322, State Capitol
Santa Fe**

Monday, November 4

- 8:30 a.m. **Call to Order, Introductions and Approval of Minutes**
—Senator Nancy Rodriguez, Chair
- 8:40 a.m. (1) **Summary of Fiscal Year 2015 Requests**
—Ruby Ann M. Esquibel, Principal Analyst, Legislative Finance Committee
- 9:00 a.m. (2) **Centennial Care for Developmental Disabilities Waiver Recipients and Persons on Wait List**
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department (HSD)
- 10:00 a.m. (3) **Developmental Disabilities Issues, Continued**
—Cathy Stevenson, Director, Developmental Disabilities Supports Division (DDSD), Department of Health (DOH)
- 11:30 a.m. (4) **Final Senate Memorial 20 Report**
—Cathy Stevenson, Director, DDSD, DOH
—Doris Husted, Director of Public Policy, ARC
- 12:30 p.m. **Lunch**
- 1:30 p.m. (5) **Senate Memorial 102 Progress Report**
—Gabrielle Sanchez-Sandoval, General Counsel, DOH
—John Block III, Executive Director, Developmental Disabilities Planning Council
—Michele Lis, ML Consulting, LLC, SM 102 Task Force Facilitator
—Nancy Koenigsberg, Legal Director, Disability Rights New Mexico
- 2:30 p.m. (6) **State Use Act Report**
—Pamela June, Executive Director, Horizons of New Mexico
—Henri Grau, Sole Proprietor, Henri Grau Design and Photography

- John A. Bishop, Jr., Principal, Aging Matters, L.L.C.
- Ellen Driber-Hassall, Principal, Aging Matters, L.L.C.
- Robert Rayner, Principal Architect, R2 Architectural Design & Consulting, L.L.C.
- Cody Unser, Representative, Cody Unser First Step Foundation

3:30 p.m. (7) [Public Comment and Response by the DOH and HSD](#)

5:00 p.m. **Adjourn**

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

**May 30, 2013
Room 322, State Capitol
Santa Fe**

The first meeting of the 2013 interim of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Thursday, May 30, 2013, in Room 322, State Capitol in Santa Fe, New Mexico.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Absent

Rep. Nora Espinoza
Rep. Terry H. McMillan

Advisory Members

Rep. Phillip M. Archuleta
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Stephen Easley
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Sen. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Nancy Rodriguez
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

Sen. Sue Wilson Beffort
Rep. Nathan "Nate" Cote
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Sander Rue
Sen. Lisa A. Torracco

Guest Legislators

Rep. Ernest H. Chavez
Sen. Carlos R. Cisneros
Sen. Stuart Ingle
Rep. W. Ken Martinez

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Rebecca L. Griego, Records Officer, LCS
John M. Butrick, Law School Intern, LCS

Guests

The guest list is in the meeting file.

Handouts

Copies of all handouts are in the meeting file, including those from the public comment period.

Thursday, May 30**Call to Order**

Representative Madalena called the meeting to order at 9:30 a.m.

Introductions

The chair asked the LHHS members and staff to introduce themselves.

Interim Committee Procedures

Upon the request of the chair, John Yaeger, assistant director for legislative affairs, LCS, provided a presentation on interim committee procedures. Mr. Yaeger presented the tentative interim calendar and explained the "blocking provision". A quorum will be five members of the committee. Committees meet in the State Capitol after September 30 unless otherwise agreed upon with the New Mexico Legislative Council. Members were asked to provide their preferred methods of contact and communication with the LCS. Mr. Yaeger also provided the following guidance on procedure:

- advisory members serve as nonvoting members of the committee;
- generally, a good deal of action by a committee can be done by consensus, e.g., a letter requesting information or drafting a letter by LCS staff for committee review;
- however, formal action should be made upon a motion and then a vote of the voting members with a quorum present. Examples of formal actions include endorsement of legislation; issuance of a letter reflecting the committee's opinion, concern or other statement; or the creation of a subcommittee. The vote can be made by voice, by a show of hands or even by the chair asking whether there is any objection to the motion. A formal calling of the roll is not always necessary; and
- if a quorum is not present, the members present cannot act formally as a committee, but they can operate as a subcommittee to take testimony, but not to take formal action, if the number of voting members present plus advisory members present plus legislators attending the meeting as one of their extra days present equals five. (Council Policy No. 3 (B)).

2013 Legislative Highlights

The chair asked the committee lead staff, Mr. Hely, to present the 2013 legislative highlights to the committee. (Please see the "highlights" handout for the legislation endorsed by the LHHS and its subcommittees and passed during the 2013 session.) Funding measures that were incorporated into the budget were also discussed.

Members of the committee voiced several questions and concerns. A member asked whether, and received confirmation that, the secretary of human services is among the governor's appointees to the board of directors of the New Mexico Health Insurance Exchange (HIX). Another member asked that the LCS provide the members with a list of bills that were vetoed last session and, thus, will be germane in the 2014 session. Mr. Hely agreed to present a list of the vetoed legislation related to health and human services at a subsequent committee meeting.

The Effect of Federal "Sequestration" on New Mexico's Health Care Services and Infrastructure

The chair requested Ruby Ann Esquibel of the Legislative Finance Committee (LFC) to present issues related to the federal budgetary cuts known as "sequestration". Sequestration has three parts: national, macro state-level concerns and specific effects to health and human services programs. The economy and health service provisions are stabilized but not robust, according to Ms. Esquibel. Please see the sequestration handout for a more detailed description of sequestration issues, including statistics and exemptions as discussed by Ms. Esquibel.

Ms. Esquibel recommended that the legislature consider many contingencies as discussed in the portion of the handout relating to states' economies. The estimate on page 13 of the handout is a low, conservative number. The committee members had several questions and concerns.

Ms. Esquibel explained that reductions breakdowns were accessible online. The "deal" discussed on page 7 of the handout was still pending as of February 2013.

One member was concerned about leasing revenues and the resulting yet undetermined effects on schools.

Another member asked about transfer authority from page 10 of the handout and requested that these numbers be updated periodically so that the LHHS can provide other members the best recommendations.

One member had a question about the impact on the Supplemental Nutritional Assistance Program, or "SNAP", and the fiscal impact the program would have on the state. The impacts are as yet unknown as there is a lot of variance between the different models provided today.

Another member was concerned about the impact of payroll taxes and how that will affect gross receipts tax and economic spending. This member was also concerned about the effect that sequestration would have on health safety nets and encouraged members to develop some finance

initiatives.

One member was concerned about the effect on Medicaid dollars coming to the state and the lack of specific numbers. Specifically, this member was concerned about the effect on Native Americans.

Another member asked about the cost and availability of cancer drugs after sequestration.

Public Comment

Richard Mason, New Mexico Alliance of Health Councils and co-chair of the Sandoval County Health Council, provided a handout and urged that assessing New Mexico's health needs be a key function of these councils. Mr. Mason said that the LHHS should consider this during the interim and urged greater funding of the councils from the legislature.

Rick Vigil with the New Mexico Local Collaborative Alliance addressed behavioral health issues and previous legislation introduced addressing these issues. Mr. Vigil requested a study on the impacts of and how to address behavioral health services and cautioned that expenses will increase exponentially over time if these issues are not addressed. Mr. Vigil referred members to his group's web site and requested a \$195,000 appropriation for these purposes. One member commented that a memorial was passed in the 2013 legislative session regarding this issue. Another member commented that he would be glad to meet with Mr. Vigil regarding setting up the infrastructure.

Tina Olsen, New Mexico Citizens' Commission on Human Rights, mentioned Senate Memorial 44 from the 2013 session, which requests that the LHHS study the incidence and effects of overmedicating children. Ms. Olsen addressed the desire to have a balanced life without the need of physical or medication aids, specifically antidepressants.

Susan Loubet, New Mexico Women's Agenda, addressed Senate Bill (SB) 43 from the 2013 session regarding treatment for pregnant women who are substance abusers and urged the committee to coordinate with the governor so that any similar bill passed in the future would not be pocket-vetoed, as SB 43 was. Ms. Loubet also addressed the new \$100 million appropriation to the Temporary Assistance for Needy Families (TANF) Program and asked that the public be informed about how the appropriation will be used and how it is proceeding.

Elisa Martinez, Project Defending Life, provided a handout. Ms. Martinez discussed what she alleged to be 14 cases of serious and life-threatening injuries arising from care received in abortion clinics. Ms. Martinez stated that the Department of Health has no jurisdiction in doctor-operated abortion clinics. According to Ms. Martinez, abortion clinics are not inspected or subjected to any standards of care or regulation, leading to a setting where anything goes. Abortion doctors operate under a physician's license and as a regular doctor's office, according to Ms. Martinez. Classification as an ambulatory service center would be better because that would provide a better structure and regulatory control. Ms. Martinez also stated that there is currently

an unprecedented abortion epidemic — specifically, viable babies have been born and then killed. A late-term abortion fails 13% of the time, and the baby is born alive, according to Ms. Martinez. The concern is what is happening after the baby is born. The time frame for viable babies is 20 weeks to 22 weeks, but abortions are performed up to the time of live birth today in New Mexico. Ms. Martinez asked the committee to consider placing restrictions on these abortions.

Tara Shaver of Project Defending Life continued the discussion begun by Ms. Martinez. Ms. Shaver commented that 80% of New Mexicans oppose late-term abortions. She stated that an Albuquerque clinic performing these abortions is attracting people from all around the country. Late-term abortions are a three-day procedure that begins with a heartbeat check of the baby, cervix dilation on the second day and birthing the baby (assumed dead at this point) on the third day, according to Ms. Shaver. Ms. Shaver stated that her end goal is to protect women. Please refer to the handouts distributed to members by Ms. Martinez and Ms. Shaver.

One member commented that the abortion issue is more complicated than what was presented by Ms. Shaver and Ms. Martinez.

Pamela Blackwell of Health Action New Mexico addressed oral health access through dental therapists. Ms. Blackwell would like the opportunity to present her group's data to this interim committee and to regular standing committees during the 2014 session.

Dave Smith of the Drug Policy Alliance of New Mexico provided a handout to committee members. Mr. Smith addressed the need to treat drug violators instead of incarcerating them. Mr. Smith also spoke about pre-booking of those arrested if in possession of illegal drugs, and he requested an appropriation from the legislature to help implement the program. He raised concerns about drug overdose deaths, especially in rural areas. Tax credits for an opium-replacement drug are a good idea, according to Mr. Smith, and the tax credit needs to be increased.

Ruth Hoffman with Lutheran Ministries addressed SNAP concerns and the federal farm bill. Ms. Hoffman discussed the food stamp provisions from the farm bill and the need to have a conversation on hunger in New Mexico. Also of concern to Ms. Hoffman was TANF assistance reductions and transitional employment programs no longer under TANF.

Bill Jordan with New Mexico Voices for Children stated that the needs of struggling families must be discussed, as the state has one of highest rates of poverty in the nation. According to Mr. Jordan, New Mexico cut higher education more than any other state in the last five years, yet tuition costs are have risen 14%. Also of concern is the child care waiting list. Mr. Jordan was particularly concerned about families not receiving assistance because they earn just above the federal poverty line, and he admonished the LHHS because the legislature had not fulfilled previously made promises.

Jeremy Rutherford, March of Dimes, asked the committee to add a new screening to prenatal screening for congenital heart disease using noninvasive procedures. The new screening improves all outcomes and costs only \$5.00 to \$10.00 per person. Please see Mr. Rutherford's handout for more information.

Early Childhood Services

Mimi Aledo-Sandoval and Charles Sallee of the LFC gave a presentation on early childhood services. Please see the handout provided. The discussion focused on the importance of starting early with childhood services, with New Mexico ranking next-to-worst in child well-being. Also discussed were barriers to educational achievement and adverse childhood experiences and the effect that this adversity has on a child's development during the first three years of life. This should be a legislative priority according to the presenters.

Mr. Sallee discussed cost-benefit analysis, research needs and oversight authority of the new statewide program to provide early childhood home visiting services. Mr. Sallee stated that further analysis is available and can be provided if the legislators request it. New Mexico Results First and Head Start were two programs discussed by Mr. Sallee. He mentioned the cost per child, \$142,726, when children are removed from the home and adopted.

One committee member asked whether there is a report showing better outcomes and whether Head Start shows these outcomes. Having high-quality teachers in place should be a priority, according to the member. The member also was concerned about losing quality providers because of the more stringent regulations and rules rather than focusing on quality foster parents before thinking about regulating them. The presenters stated that the focus is more on a child's development and outcomes.

When asked about state funding for home visiting services, Mr. Sallee stated that most home visiting services are funded through the state general fund and that the federal government provides a little funding. He stated that in the 2013 regular session, the legislature appropriated \$550,000 in House Bill 2 to home visiting programming, but Governor Martinez exercised a line-item veto to remove this funding.

When asked about the effectiveness of pre-kindergarten or "pre-K" programs, Mr. Sallee mentioned a 2012 LFC report that shows better outcomes for children who had attended pre-K programs than for those who had not.

Mr. Sallee stated that the cost of providing child care may exceed the state subsidy at some facilities. The Children, Youth and Families Department is currently looking at costs regionally to ensure adequate reimbursement for facilities. A committee member requested a follow-up presentation regarding child care providers.

Another member asked whether any bills were offered last year for this issue (Senator John M. Sapien and Representative Larry A. Larrañaga each had one, as did Senator Ortiz y Pino,

along with a \$26 million to \$30 million increase in funding per year). New revenue estimates will be available in August. Also discussed was the effect of sequestration (see earlier handout) on single-parent homes and protective services.

One committee member was concerned that 71% of births in the state are being financed by Medicaid.

A member asked whether there was any work being done to prevent teen pregnancy statewide, mentioning the success of some programs that, however, are not statewide.

Mr. Sallee mentioned the question that some policymakers have asked, which is whether Medicaid managed care organizations (MCOs) should be required to provide home visiting services. He mentioned that new federal waivers may allow Medicaid dollars to be used in this way. MCOs do some intensive home visiting now. He stated that Secretary of Human Services Sidonie Squier has stated that a policy goal should be to tackle single parenthood.

One member requested further information on the effect of federal sequestration on the Head Start and Women, Infants, and Children programs.

There was a discussion of the lack of access to prenatal care for women in the state.

A committee member made favorable mention of St. Joseph Community Health's First Born home visiting program, which employs 46 home visiting professionals in central New Mexico.

A member asked whether Family Infant Toddler (FIT) programs are still working for children at risk in New Mexico. Rachel Gudel of the LFC stated that every school that applied for FIT funding received it for fiscal year 2014. The member stated her concern about those schools that do not apply.

New Mexico Health Insurance Exchange Board

Gabriel Parra, member, HIX board of directors, provided an update on the HIX. The board is looking at a hybrid exchange model, whereby the state creates its own small business exchange and the federal government will provide the information technology (IT) infrastructure for the state's individual market HIX. This process has begun. Funding issues were also discussed, and much of what has been appropriated has not yet been spent but will likely go toward outreach and marketing programs. The next board meeting is Friday, June 7. Mr. Parra stated that the goal is to have the HIX web site up and running to accept enrollment applications for coverage by October 1 of this year. By January 1, 2014, the HIX is supposed to be fully functioning, with a single HIX "face" providing access to both the federally operated individual HIX and the state-operated small business HIX. By January 1, 2015, the HIX will cease to partner with the federal government for individual market functions, and the state will perform all functions. Please see the one-page handout for more details, including highlights of the system as it is now.

Several committee members had questions and concerns. One member asked how and the degree to which the HIX infrastructure would be integrated with Medicaid users, which has not yet been determined. This member was also concerned about voter registration and social service program accessibility.

Mr. Parra also stated that a flow chart will provide the user with a road map with a single point of entry. The impact on the high-risk pool population was undetermined. The hybrid system will likely operate for one year. Approximately 35 states will have exchanges up and running within the next few months. The federal government charges a 3.5% premium fee for using the federal IT system. The contract is not finalized but will be available for review.

Another committee member was concerned that it would be hard to get so many agencies to work in one direction, given the fast track nature of this HIX.

Mr. Parra stated that the HIX is not authorized to exclude plans, with that decision left to the Insurance Division of the Public Regulation Commission. As long as a plan meets the federal Patient Protection and Affordable Care Act (PPACA) requirements, that plan may participate. Specific programs for specific populations can be provided so that as many programs as possible are provided and are competing for the applicant. Moreover, catastrophic coverage is allowed under the federal HIX. Mr. Hely explained that these catastrophic plans are only available for individuals under 30 years of age.

One LHHS member asked how the HIX can help the implementation and expediting of Medicaid claims. This is still unclear. This LHHS member stated that transition concerns and the availability of safety nets are an issue, given that big health problems (like congestive heart failure) could occur during this transition time.

Mr. Parra stated that this is why enrollment will begin in October — so that applicants can know and have some understanding as to what coverage they are eligible for by January. This transition time also allows applicants to more easily migrate to the new coverage plan between October and January.

Mr. Parra also stated that the Insurance Division is authorized to certify plans as qualified health plans, and any appellate process would be determined through rules that are written by the board. Further, the board can reevaluate and grade available plans.

One LHHS member asked about tribal enrollment and availability concerns. Specifically, this member was concerned about resolving definition differences between the HIX and the federal Internal Revenue Service.

Another member was concerned that many more people are looking for coverage than in the past. Mr. Parra stated that applicants cannot be denied coverage after January 1. The high-risk pool needs to be discontinued, and individuals in that pool need to be covered by the HIX,

according to Mr. Parra.

One LHHS member asked about the amount of outreach to Native Americans. Mr. Parra stated that the board is accepting public input and looking at a program to reach all populations throughout the state.

A member stressed the importance of the HIX having an ombudsman role and a legislative liaison. Mr. Parra stated that he would discuss this with HIX Chief Executive Officer Mike Nuñez.

One member asked what will happen if the superintendent of insurance has determined that a plan will be certified as a qualified health plan (QHP) to be offered on the HIX, but the plan does not meet the requirements for a QHP under federal or state law. Further, the member asked about what would happen if the QHP were performing poorly and about how QHPs would be rated.

A member stated the need for clarity on the future of the New Mexico Medical Insurance Pool. Mr. Parra stated that the federal high-risk pool would cease to offer coverage as of January 1, 2014 and that those individuals would be forced to seek coverage on the HIX or elsewhere.

A committee member asked whether outreach for the HIX would be offered in Diné and other languages spoken in New Mexico. Mr. Parra said that the HIX would seek to cover the state's population and provide linguistically appropriate services.

LHHS Interim Work Plan Review and Adoption

Representative Madalena asked Mr. Hely to present the 2013 LHHS work plan for review and adoption by the committee. The work plan includes comments that the LCS staff received from members and the public. The LCS staff will also respond to public comment from the morning. Please see Mr. Hely's handout.

Several LHHS members had questions and concerns. One member requested that the LHHS hear a presentation regarding the tobacco funds, the applications of the funds and whether the funds are in compliance with federal law requirements.

Another member talked about expanding the New Mexico attorney general's authority in pursuing Medicaid fraud.

A member stated that just because a person has health insurance does not mean that person has health care access. The percentage of University of New Mexico (UNM) graduates that stay to work in the state and attracting more college graduates to the state are issues that need addressing. What should be expected and requested from UNM? Lastly, this member stated that the committee should consider creating a new category for dental health in addition to physical health, and pipeline issues for physical and dental areas should be addressed.

One member said the LHHS should look at mid-level provider gateways into the system.

Another member opined that telemedicine does not solve access issues even if it is greatly used in New Mexico because it merely takes up the slack from other neighboring states providing it. Providers should be persuaded to practice in this area via legislation, according to this member. Mid-level providers in telemedicine result in little or no cost to the state. Mr. Hely will provide more general language in lieu of some of those specifics provided in the work plan.

One member stated that private organizations graduate twice the number of nurse practitioners as public institutions. This member wanted to know why and what public institutions can learn from these private entities to increase the number of graduates from public schools.

Another member stated that Glenn Ford and other experts should provide the committee with information regarding disabilities concerns and what other states do generally. The member also suggested that the LHHS break into two subcommittees during one meeting so that more topics could be discussed, with each subcommittee then briefing the other members in the afternoon as to what was presented in the morning to each subcommittee.

One member expressed a desire to have the LHHS travel to Hobbs, as it has not done so for about seven years. The member also said that there is a need for comprehensive dental education programs in the state.

A member discussed the need for access to dental care and the lack of attention to the results of a 2010 study on the issue of creating a dental school.

A member stated that loan repayments on Medicaid and what will be covered under Medicaid should also be addressed. He remarked that the PPACA, or "Obamacare", does not include dental coverage except for children. The impact of water fluoridation — or the removal of fluoride from localities' water — should be studied with regard to the Medicaid budget.

A member stated that additional facts are needed on the abortion issues discussed earlier in the day.

Another member talked about Centennial Care for tribes and managed care registration.

One member stated that she would like an updated UNM report regarding the pipeline. UNM sends medical people out to rural areas, but there are caps and non-compete issues as well. An invitation to Hobbs for an LHHS committee meeting was extended to all the members by this member.

Another member talked about the PPACA and the big picture of evolving health care issues

and what other states are doing. The member proposed discussing these issues over a working lunch during one of the committee's three-day meetings. This member stated that the state does not have enough doctors to handle the demand that the PPACA will create. Please refer to page 1 of Mr. Hely's handout on this issue.

One member stated that the state has 2,000 fewer doctors than it needs. This member said that the scope of practice as mentioned earlier should be discussed at a later meeting and questioned whether the committee should favor mid-level providers. Determining this would then lend guidance as to where to go next.

Another member expressed the need for compromise on these mid-level and dental assistant issues.

One member stated that every mid-level situation is different, and figuring out the rules for this issue would be important.

Another member talked about looking at Medicaid and tackling a long-term care program. In particular, this member was interested in any changes that have been made to this program. The member said that the committee should invite the Corrections Department to show that it is complying with procedures on laboratory work. These programs currently are being outsourced while New Mexico has the laboratory resources.

One member talked about adding a trip to Jemez to the schedule and waiving the September 30 deadline to stay in Santa Fe. An October meeting in Hobbs was discussed. A motion was made and passed by acclamation. The August meeting date will also be changed. The LCS requests that the July meeting stand as it is because it is only one month away and preparations have already been made for that meeting.

A motion was made to adopt the work plan with the additions suggested, provided that Mr. Hely be directed to work with the chairs to make changes to the work plan as requested. The motion passed by acclamation.

One member stated that this committee met four times a month during previous interims but is now meeting less frequently. He expressed concern about meeting only a few times as opposed to having more meetings, as in the past.

Another member stated that the LHHS should try to whittle down the number of topics the committee would discuss during the interim. Specifically, it would be very helpful if the LCS would electronically poll the members regarding the additions added to the work plan to focus on only the most germane issues for the upcoming legislative session.

One member suggested that the committee start its day earlier, at 8:30 a.m., so that it can have a fuller, more productive day.

A motion was made to prioritize those items on the work plan that are most important.

One member opined that the committee does not know what the governor will put in her special messages, and thus the importance of topics for the next legislative session — a short session in which germaneness is the deciding factor as to what may be heard — will not be known outside of the usual financial matters and vetoed bills.

Another member stated that the committee should spend its time on the germane matters and that the committee could anticipate this.

The motion to adopt the work plan along with the suggested additions passed by acclamation. It was left to the LHHS chair and LCS staff to whittle down the number of topics the committee would discuss during the 2013 interim.

Adjournment

There being no further business, the committee adjourned at 5:30 p.m.

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

**July 1, 2013
University of New Mexico (UNM) West Campus
Room 2170, 2600 College Boulevard NE
Rio Rancho**

**July 2, 2013
North Campus, Room 2112
Domenici Center for Health Sciences Education
UNM
1001 Stanford NE, Albuquerque**

**July 3, 2013
ABQ Health Partners
Auditorium, 5400 Gibson Boulevard SE
Albuquerque**

The second meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at approximately 8:45 a.m. on Monday, July 1, 2013, at UNM West in Rio Rancho.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Absent

Rep. Terry H. McMillan

Advisory Members

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt (7/2, 7/3)
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote (7/3)
Rep. Stephen Easley
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto (7/2, 7/3)
Rep. Sandra D. Jeff (7/3)

Sen. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

Sen. Lisa A. Torraco

Sen. Sander Rue

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Abby Wolberg, Legal Intern, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, July 1

Welcome and Introductions

Representative Madalena welcomed everyone to the meeting and invited the committee members and staff to introduce themselves.

Welcome and Introduction to the UNM West Campus

Elizabeth Miller, Ed.D., interim executive director and director of outreach, UNM West Campus, explained that her new title is director of outreach and community affairs. She introduced Dr. Wynn Goering, who has recently been appointed the chief executive officer (CEO) of UNM West; Diana Gourlay, building manager; and Reinaldo Garcia, Ed.D., director of educational services. The new UNM West building is a result of a series of partnerships with the city, the county and the State Land Office. She briefly reviewed the programming and degrees offered.

Representative Madalena recognized Rio Rancho City Manager Keith Riesberg, who welcomed the committee members on behalf of Mayor Tom Swisstack. Representative Madalena also recognized Sandoval County Commission Chair Darryl Madalena.

Several committee members addressed questions to Dr. Goering.

Dr. Goering explained that the building was funded by a gross receipts tax and that the mill levy is for operations of the medical center. The population of students is approximately 80% Anglo, which reflects the latest demographics of Rio Rancho.

As background, Dr. Goering has been in New Mexico for 16 years and was dean of a small college in Kansas. He enrolled in the Anderson School of Business for his master of business administration and went to UNM soon after. He worked at UNM's Taos and Gallup branches.

Liver Transplant Feasibility Study

Dudley Byerley, citizen advocate, and Julio C. Sokolich, M.D., New Mexico Surgical Associates, gave a presentation on a liver transplant feasibility study. Speaking from his proposal for the establishment of a multi-organ transplant program for New Mexico residents, Dr. Sokolich stated that New Mexico is one of 12 states without an active multi-organ transplant program. He reviewed the survival rate of transplant recipients. At present, patients are sent out of the state for transplants, and there is a potential to do 40 to 45 transplants a year in New Mexico. Most transplants lose money for a hospital, but liver transplants generate resources for all of the hospitals and help the entire community with opportunity to do research.

The transplant institute would be private and work with all of the major institutions in New Mexico, which at present do not collaborate. The initial investment for such an institute for in Louisiana was \$5 million, which could be recovered in less than five years. The feasibility study is close to completion and needs the support from the legislature to move forward. Dr. Sokolich has met with the Department of Health (DOH) and other institutions to pursue this option for the state.

A memorial for creation of a New Mexico Liver Transplant Institute was introduced and passed during the 2013 legislative session. It requested that the DOH and UNM do a feasibility study and develop a memorandum of understanding (MOU) with other health care providers in the state. Staff will send a report of the funding recommendations to the committee members.

Liver Transplant Facility Feasibility Study — DOH Efforts

Winona Stoltzfus, M.D., medical director, Health Systems Bureau, DOH, Steve McKernan, CEO, UNM Hospital (UNMH), and Pamela Demarest, executive director, Medical Surgical Services, UNMH, have a presentation on DOH efforts toward the liver transplant facility feasibility study. Mr. McKernan stated that an independent consultant will be hired to make recommendations for a feasibility study regarding a liver transplant facility and that information will be made available to the LHHS. The request for information for the consultant is being drafted and it is expected that it will take four to six months to complete the process and receive a recommendation from the consultant. A discussion for funding the study will follow.

Committee members requested a definitive answer as to whether UNMH is in favor of any kind of liver transplant program. In response, Mr. McKernan explained there were many reasons that UNMH discontinued its transplant program and so it is proceeding with caution with the liver transplant facility feasibility study. Preliminary meetings occurred during the establishment of the memorial, which did not provide funding for the study. This led the committee to decide it needed outside expertise to assist in the process. Mr. McKernan said he will keep the LCS aware of how UNMH is proceeding.

Committee members stressed the importance of having the study done by competent people, including local hospitals that currently have kidney transplant programs.

Mr. Byerley commented that getting the study done depends on obtaining funds for it.

Health Insurance Cooperative Plan

Martin Hickey, M.D., CEO, New Mexico Health Connections (NMHC), explained that the health insurance cooperative plan is a not-for-profit, member-governed health plan to form a value-based health care system. It is sponsored by the federal Centers for Medicare and Medicaid Services (CMS) with loan money that will be repaid, and the program is expected to be ready by October 1, 2013. An objective is to help rebuild the health care infrastructure in the state using the same principles applied at Kaiser and Geisinger medical centers. The hope is to change health insurance from the usual business paradigm of underwriting. The first initial audit was passed with no references or comments. The CMS brought in PricewaterhouseCoopers to audit every cooperative across the country.

During questioning from the committee, Dr. Hickey explained the following.

The cooperative is a health plan with the same rules and regulations that are required of Blue Cross Blue Shield, Presbyterian and Lovelace, and it was initiated from a grant by the federal Patient Protection and Affordable Care Act (PPACA). NMHC is one of six cooperatives awarded in the country and will focus on individuals at or below the federal poverty level and small businesses under 50 employees. Otherwise, it operates as any other insurance company in terms of transactions, with a focus on identifying sick people and getting them to community health workers and care organizations to improve health and lower cost.

There are 30 hospitals that have signed on or are close to signing. There is a specific fee schedule and three advisory committees composed of many physicians. If a physician takes on the care of a patient but the hospital is not contracted, the bulk of care is ambulatory and outpatient. NMHC works with the physicians and offers reduced or low copayments for drugs to make it easy for the patient to receive care.

Obesity is a disease that is not understood today and may be related to any number of things. Medicine is on the brink of understanding it in terms of psychological components.

The goal is to return the profits to the members and the primary care infrastructure and to make New Mexico healthier and more attractive.

Update from the New Mexico Health Insurance Exchange (NMHIX)

Dr. Hickey, member, Board of Directors, NMHIX, and Michael Nuñez, acting CEO, NMHIX, addressed the committee. The NMHIX was created to provide small employer groups and qualifying individuals with access to health insurance. So far, the board has been focused on the setup and the beginning parts of the exchange, but not yet on its long-term sustainability.

In response to questions from committee members, Dr. Hickey and Mr. Nuñez made further explanations.

The bill authorizing the exchange out of the PPACA has a large pot of money to help support state exchanges to get off the ground, but only 18 states have done so. That money is appropriated, and if it is not spent by the state, it will go away. New Mexico can ask for phase one federal money quarterly up until the end of this year and then one last time in calendar year 2014.

Project management is a standard activity in almost anything to do with information technology or any other complex project. This money is very well spent because it will guarantee that the necessary time frame is followed so that everything is done at the right time. It is a \$4.2 million contract, and six companies were evaluated through a request-for-proposal (RFP) evaluation process. The board of the New Mexico Health Insurance Alliance awarded the contract.

In reaching out and ensuring that Native Americans in remote areas are fairly treated, Native American Radio, powwows, chapter houses and newsletters will be used. Mobile units will go to rural community gathering places to do an effective job of sharing. By law, information has to be made available in different languages. The NMHIX will work hand-in-hand with the Indian Affairs Committee. Native Americans are exempt from any penalties in the PPACA, and it is in the best interest of the tribes for everybody to be enrolled. With regard to businesses, an employer with 51 employees is required to buy insurance, and it does not matter if any of the employees are covered by the Indian Health Service. If employees are covered by insurance through the employer, they are not eligible to participate in the NMHIX.

New Mexico is classified under the law as a state-based exchange, which means that it is eligible for the federal pool of money to use in starting up and it does not get paid back.

Representative Madalena accepted the correspondence from a committee member requesting potential endorsement from the committee to set goals as a matter of policy and that the goals be integrated into the plan of the operation that the NMHIX is developing. Representative Madalena put the letter on his table to bring back to the committee for further possible input and discussion. [The letter has been included in the committee members' packets.]

Primary Care by Nurse Practitioners and Certified Nurse-Midwives

Sonda Boulware, M.S.N., A.C.N.P.-B.C., president, New Mexico Nurse Practitioner Council, Randy McGuire, C.F.N.P.C., C.W.C.N., McGuire Wound and Oxtomy Center, Roswell, Elaine Brightwater, N.P., D.N.P., certified nurse-midwife, and Nancy Ridenour, Ph.D., A.P.R.N., B.C., F.A.A.N., dean of UNM College of Nursing, gave a presentation on primary care by nurse practitioners (NPs) and certified nurse-midwives (CNMs). Ms. Boulware explained that the expansion of coverage mandated by the PPACA is looming on the horizon and posed the question of who is going to care for all of the newly insured patients. Persons with health

insurance use more services than those without coverage. It is estimated that 15 million uninsured persons will secure coverage in 2014, and the number will increase by 35 million in 2016. Compounded with a growing population and aging baby boomers, access to primary care will be difficult. Despite having a specialty in cardiology, Ms. Boulware is being forced into the primary care realm due to the lack of providers in the area. Only one-fourth of medical school graduates plan careers in primary care, and by 2015, the nation will face a shortage of 62,100 physicians, of which 31,100 are primary care practitioners. She further explained reasons why there are fewer primary care physicians when the need for them is growing. Nurse practitioners in New Mexico must have at least a master's degree and must pass the national specialty certification examination and maintain at least 50 educational hours.

Mr. McGuire said he has been the owner of McGuire Family Care in Roswell since 2009. His wife joined him in family practice in 2010. As a NP, he treats everything from hypertension to diabetes, psychiatric disorders and imaging. Because of his specialty in wound care, he can do all of the imaging that primary care doctors can order from X-rays, bone scans, MRIs, CT scans, laboratory studies and evaluations. NPs have authority to consult at most hospitals. He can see a patient for years in his office as a primary care provider, but when it comes time to placing the patient in a nursing home, he has to turn the patient over to the physician that is the director of the nursing home, even though many of his patients prefer that he continue as their practitioner.

Dr. Brightwater stated that she has been a CNM since 1982 and a women's health practitioner since 1978. CNMs attend births and help the pregnant woman in labor and her family with the delivery. They take care of close to 30% of all deliveries in New Mexico and over 40% of nonsurgical or vaginal births in New Mexico, which is ahead of all other states. This committee has a history of contributing to the reputation of New Mexico as being visionary when it comes to dealing with nurse midwifery and NPs. It is important to realize that the national scope of practice for nurse midwifery includes care for women throughout their lifespans, so it is crucial to realize that CNMs are not exclusively just delivering babies.

Kristen Ostrem, UNM College of Nursing, said she is a family NP and a CNM, educated at UNM and working at a collaborative in Bernalillo. She is seeing more and more clients who are unable to access care elsewhere. It is a comprehensive practice and provides care twenty-four hours per day, seven days per week, working within the system to get people into care. She said she would appreciate the committee's support for advanced-practice nursing in the clinical setting.

Dr. Ridenour thanked the legislature for providing full advanced and independent practice for New Mexico advanced-practice nurses. In terms of work force, New Mexico is attractive to nurses from other states who like working in states where there is independent practice. There is a shortage of primary care providers and personnel to see the patients who need to be seen. There is a shortage of 236 NPs in New Mexico, and the state's limited production of NPs and physician assistants (PAs) will inhibit its ability to expand its primary care work force. UNM is the only provider in the state that produces PAs, family NPs, CNMs and acute-care NPs. She

read from the handout and presentation containing current and future statistics for the primary care work force. There is a need to increase NP and CNM student enrollment and graduation, and recurring funding will be requested to increase enrollment and additional master-level students each year.

The committee members asked several questions regarding how to provide health care in the future, the cost of the education and the fact that there is not enough faculty to educate nurses. The presenters explained that St. Francis also produces NPs. It is estimated that the cost to educate NPs at UNM is approximately \$75,000 per student, but the cost for tuition to the student is less than that. At St. Francis, the cost to the student is approximately \$30,000 a year. New Mexico State University (NMSU) produces psychiatric NPs. UNM and NMSU have an agreement not to compete, and they share resources to assist students at each school to get the degrees they are seeking.

Interstate and Interregional Medical Licensure Compacts

Lynn S. Hart, executive director, New Mexico Medical Board, and C. Grant LaFarge, M.D., medical director, New Mexico Medical Board, addressed the committee on interstate and interregional medical licensure compacts. Dr. LaFarge gave an update on the status of interstate and interregional compacts as they apply to New Mexico medical licensing. At the April meeting of the Federation of State Medical Boards, a resolution was passed regarding the concept of a compact that could be used to facilitate interstate licensing in the practice of medicine across state lines and particularly telemedicine, which is a rapidly developing methodology for increasing access to medical care. Interstate compacts are an effective tool for structuring interstate relationships, regulating private activity across state lines and furnishing government services on a regional basis. Interstate compacts offer an alternative to federal programs and regulation and are particularly apt for matters traditionally addressed by states, such as law enforcement and public health, safety and welfare. Agreements between states include items such as unrestricted licensure in the home state, approved medical residency training, passage of nationally approved examinations, board certification, freedom from disciplinary license stipulations and criminal background investigations. Once those details are forged, the states come together to form a license that would be a home state license where the physician practices most of the time and a compact license that would apply to the other states that are part of the compact.

Ms. Hart expressed her pride that the state is looking for ways to make it easier to streamline and coordinate with other states. It is common sense to look at the commonality among Colorado, Texas and Arizona and to do licensure applications from California. When a doctor is licensed in New Mexico, the file is made available to other states, which is not always reciprocal. There could be a national database that all practitioners and boards are required to report to if there is disciplinary action.

Representative Madalena acknowledged and introduced Sandoval County Commissioner Don Leonard.

Public Comment

Richard Mason, League of Women Voters of New Mexico, read from his handout regarding the NMHIX Act covering the cost of the navigators. Because federal money is finitely provided, he said it would be wise for the exchange to accumulate funds from the beginning so as to offset losses in the future. Accumulating funds to pay for future losses is something that should be in a long-term budget. Otherwise, the exchange might have to come back to the legislature for funding or cut back on services offered to New Mexicans.

Tuesday, July 2

Welcome and Introductions

Representative Madalena reconvened the meeting at 8:45 a.m. and invited the committee members and staff to introduce themselves.

Welcome from the UNM Health Sciences Center (HSC)

Paul B. Roth, M.D., M.S., F.A.C.E.P., chancellor for health sciences, dean of the School of Medicine, UNM HSC, told the committee that the UNM HSC is very focused on its ability to improve the health and well-being of the residents of New Mexico. It was disturbing to hear New Mexico's standing in the countrywide statistics presented on children's health. The UNM HSC looks at teenage deaths, pregnancies, education, family and community, risky behaviors and immunizations, which are issues that parents, communities, tribal governments and legislative leaders can address. If one thing is done to positively affect the health of New Mexico's children, it would be to address childhood obesity. This is something that cannot be helped individually, but collectively, and as a community, significant things can be done.

The Sandoval Regional Medical Center in Rio Rancho is a part of the UNM hospital system. It is designed to be a community teaching hospital, not like the tertiary care referral center at UNMH in Albuquerque. It has been in operation for about 11 months and is still growing. The plan is to have more nursing and other allied health professional students learning in the hospital. It is a level three trauma center, intended to initially stabilize critically injured individuals and transport them to UNMH.

Vetoed Health and Human Services Legislation from the 2013 Regular Session

Mr. Hely presented a handout listing the vetoed legislation from the 2013 regular session. He reviewed the individual pieces of legislation and the executive messages relating to that legislation.

In discussion, the committee members suggested that when the LHHS is looking at its legislative proposals for next year, they be reviewed to see if there is a way to modify them or take off a sunset provision that would make them more likely to be signed by the governor.

Large Employer Health Coverage Mandate — Health and Human Services Providers

Stephen Byrd, president, Employee Benefits Division, Manuel Lujan Agencies, Karen Wells, R.N., M.P.A., New Mexico Association for Home and Hospice Care, Anna Otero-Hatanaka, executive director, Association of Developmental Disabilities Community Providers, and Linda Sechovec, executive director, New Mexico Health Care Association, gave a presentation on the large employer health coverage mandate under the PPACA.

Mr. Byrd explained that he is a consultant with the Manuel Lujan Agencies and represents over 360 employers, many of which are large employers. He consults with them pertaining to what they need to be aware of to implement their preparation of the PPACA. He spoke to the committee from the information in his handout.

Ms. Wells said she is a registered lobbyist for the advocacy of home and hospice care services in New Mexico. The providers are all reimbursed on essentially a fixed-rate basis, with limited to no opportunity to raise charges to meet the additional costs. The PPACA is very complicated. There are serious penalties that will be incurred if the act is implemented improperly. The ability of the providers to implement the act is hampered by the fact that the providers are funded through government programs. Ms. Wells reviewed her handout with a matrix that is used during the legislative session to provide information regarding the cost of the Personal Care Option (PCO) program.

Ms. Otero-Hatanaka spoke from her handout regarding the PPACA. The agencies have no idea what it will cost to comply with the PPACA. The new service system under the Developmental Disabilities Medicaid Waiver program just became effective May 1, 2013. There are hundreds of budgets or services that have not been approved, and providers and their system are in chaos trying to figure out how they will meet payroll and continue to provide existing or new services without being reimbursed because of this.

Ms. Sechovec said that until she heard the previous speakers, she had thought she was "in the weeds" and alone in the struggle that employers are facing, especially those health care providers that are reliant on working with Medicaid. She then reviewed her handout regarding the PPACA employer mandates and their estimated impact on nursing facilities. Because of the complexities of the PPACA, it is unknown how much money to ask the legislature for in the upcoming 2014 session to cover additional administration costs.

Following a question-and-answer period and some discussion, a motion was made and seconded to send a letter to the Legislative Finance Committee (LFC) on behalf of the LHHS in support of Senate Memorial 46.

Further discussion and additional information followed regarding the language in the Senate Memorial 46.

Representative Madalena requested that Mr. Hely and Ms. Wells get together and discuss suggestions made by the committee members regarding the letter.

Ms. Wells explained that the memorial as originally drafted identified only those employers who had 50 employees or more, and there was a reasonable request that the study be narrowly focused to those employers that are affected by the provision. Ms. Otero-Hatanaka said her recollection is that it is a good memorial and suggested including in the letter developmental disability and delay programs. Ms. Sechovec said she is concerned that if the LFC gets involved, it needs to pay special attention to Medicaid-funded services and the impact on large employers.

The senator who made the motion about the letter said he was very comfortable with what had just been said as an amendment to his motion. The seconder agreed to the motion as amended. It was voted upon, as amended above, and unanimously approved.

Hidalgo Medical Services (HMS) Program Accreditation by the Council for Graduate Medical Education

Tamera Ahner, workforce manager, HMS, and Derek Nelson, chief medical officer and director of the Family Medicine Residency program in Silver City, gave a presentation on the HMS program accreditation by the Council for Graduate Medical Education. Ms. Ahner reviewed her handout and explained that HMS is a nonprofit community health center in southwest New Mexico that includes Grant and Hidalgo counties. Through its work force program, HMS has been able to reach into Luna and Catron counties.

Dr. Nelson introduced himself as a family physician who grew up in a small mining town in central Arizona and was the son of a miner. In developing the health career pipeline, it is important to reach kids in the elementary and secondary school levels to get the message out that, in fact, they can consider a health career and be encouraged to think about going into a health career. Children even receive a stipend to go to the Summer Math and Science & Healthcare Academy. Studies have found that 60% to 70% of medical students and primary care residents who have experience in rural environments tend to go back to rural environments. The more students who are educated in health disciplines, the more likely that the health professional shortage in rural New Mexico will be solved.

One of the legislators expressed concern over the closing of the Roswell teaching center and questioned how to expand this regional program and get the Roswell center reopened. He suggested that the LFC write a letter to the UNM public health department to help with the Roswell residency program for general and family practitioners and to expand what the HMS is doing.

Dental Education: Dental School, Western Interstate Commission for Higher Education (WICHE)

Howard L. Bailit, M.D.M., Ph.D., professor emeritus, University of Connecticut Health Center (via "telepresence"), Senator Mark Moores, commissioner, WICHE, Jose Garcia,

commissioner, WICHE, and Patricia Anaya Sullivan, commissioner, WICHE, gave a presentation on dental education. Appearing via "telepresence" from Connecticut, Dr. Bailit noted that there are national changes taking place in the health care system. There are two basic ways a dental school can have an impact upon access to dental care disparities. The traditional approach is to educate state residents and hope they have a significant number who move to certain areas of the state. The problem with this is that most will not move to underserved areas because of disparity of income. Most low-income residents cannot afford private sector care and dental insurance, and the fees are so low that many practitioners cannot afford to see Medicaid-eligible patients. Another reason many dental students do not go into underserved areas is because they come from the suburbs and upper-middle-class families and are planning to go back to those areas for their practices. Graduates are more likely to serve lower-income residents if students are recruited from those areas. Dental students do treat indigent patients, but because of the way most dental school clinics are operated, students seldom see more than two patients. A traditional dental school will have a limited impact on access disparities.

A way to lessen these disparities is to change the clinical education model. Instead of the traditional system of dental school-owned and -operated clinics, more schools are basing a large part of their clinical education on community-based delivery systems, i.e., federally qualified health centers, hospitals and private practices.

In 2009, there was an RFP in New Mexico for a four-month project to review the feasibility of creating a dental school that would reduce access disparities. Dr. Bailit has worked on similar projects in North Carolina, Florida and Wisconsin. He cited statistics of dentists in New Mexico relating to the population.

In terms of the dental school, the dental school report calls for a class of 40 dental students with an emphasis on those with disadvantaged, rural and minority backgrounds. The school could be located in Albuquerque at UNM. He stated that NMSU does not have the infrastructure necessary to support a dental school at this time. Students will spend the first few years taking basic clinical sciences at UNM medical school and spending summers between the second and third years in intensive training in the dental clinical sciences. Students will spend approximately one-half or more of the fifth year providing care to patients under close faculty supervision. They will be assigned to hospitals and private practices throughout the state for part of the third year and most of the fourth year. Students will come back to Albuquerque for classes and rotations at the Albuquerque dental clinic. The school will expand the dental residency program with around 25 general dentistry residents. Working in partnerships, the school will build four regional dental clinics in rural areas of the state.

The UNM medical school runs a very strong B.A./M.D. program that has been successful in recruiting minority students, and this program could easily include dental students.

This proposal is a different kind of dental school that is not as capital-intensive as the traditional bricks-and-mortar dental schools around the country and has a good access-to-care

component. The executive summary with the business model is on the web and will be disseminated to the committee. This study was funded through money that former U.S. Senator Jeff Bingaman provided to the state during the stimulus package.

In response to questions from the committee members, Dr. Bailit explained that a traditional dental school generally is separate from a medical school and is an educational laboratory where the student sees relatively few patients. This model would require a major investment in facilities and higher operating costs. What is being proposed is that the clinical education for the students would take place in federally qualified health centers and hospitals, and, in some states, students rotate through private practices. In this way, students get a lot more experience and the cost of education dramatically declines because the delivery system takes off one-half of the cost of a faculty member's salary. New Mexico has one of the most extensive networks of federally qualified health centers in rural areas of any state in the country.

Dr. Wendell, a graduate of NMSU and a veterinarian member of WICHE, is on the state veterinary board and has practiced in New Mexico for 27 years. In the 1950s, western states formed a collaboration to allow them to send students to each other's state schools. The goal was to aggregate demand for higher education, which made a lot of sense when western states were less populated. This program allows students to take advantage of reduced tuition programs for graduate school, dentistry and veterinary medicine. Undergraduates can go to schools in other states for much less than what in-state tuition would be. This allows for more diversity in the higher education program. Dr. Wendell reviewed his handout regarding the professional services educational program. New Mexico students are required to return to the state when they graduate to practice in New Mexico.

Building a veterinary school is not practical for New Mexico. The WICHE program offers students the opportunity to reduce their debt load and return to work in rural New Mexico. At present, there are three participating schools in Colorado, Oregon and Washington, with two additional colleges likely to be partners by the fall of 2014, the University of California-Davis and Western University of Health Sciences. New Mexico pays each student a support fee toward tuition. Colorado State University accepts the most New Mexico students, but it also has the highest out-of-state tuition of all of the other veterinary colleges in the U.S. Many graduates do not have the option to return to New Mexico because of the low average starting salary in the state and because their average debt load is close to \$200,000. The competition from the two additional colleges may lower tuition costs.

The WICHE program allows New Mexico students to come back to New Mexico and offers them the opportunity to reduce their debt load so they can take jobs in rural areas. Most graduates come back and work for established veterinary practices, many of which try to find new graduates to take under their wing and groom them for eventual practice takeover.

Donning his hat as a WICHE commissioner, Senator Moores said that the WICHE program is specifically designed for states that do not have the professional schools. If and when a dental

school is built in New Mexico, its students would not be eligible for WICHE for the dentistry component, but the dental school would be open to taking WICHE students from other states. His priority is to fully fund WICHE for next year. Many graduates come back to New Mexico for their fifth year of education with the dental residency program that was created by the legislature. They do rotations around the state, and that counts toward one of their three years of obligation.

Community Health Specialists Program

Francisco Ronquillo, health extension officer, Office for Community Health, UNM HSC, and Arthur Kaufman, M.D., vice chancellor for community health; director, Office for Community Health, UNM HSC, gave a presentation on the community health specialists program. Mr. Ronquillo explained that he has been talking with immigrants with health backgrounds. At present, he knows of 43 people who are medical doctors, nurses, dentists, an immunologist and an epidemiologist but who cannot practice in the U.S. because their certification and credentials are not recognized. These people have the talent, skills, desire and interest to work in their fields, rather than in restaurant and maintenance positions. They are an invaluable human resource, but the question is how to integrate these health professionals into the health care field. His hope is that UNM HSC can help to utilize these medical experts in communities that lack these types of health professionals. The suggestion is that a joint memorial could be introduced that puts together different health partners to help develop a pathway for these health advocates and educators.

In response to further questions, Mr. Ronquillo explained that California applies for a federal grant for which New Mexico could apply. While many foreign medical schools are recognized, no Latin American medical school graduates are recognized to practice in the U.S. Washington, California and Florida have projects where they put international medical graduate professionals through two- and three-year programs so they can pass their boards and go to work in their professions. He is proposing a more expeditious program where these people would come in as health promotion specialists.

It was suggested by several committee members to look at changing the statutes and have a step in a program whereby a licensed doctor from Latin America could fit as a support paraprofessional until the doctor is credentialed. Perhaps a work group could be organized to open up some of the statutes for midwives, NPs and PAs to see what the qualifications are so that these highly educated people could be immediately qualified to step into some of those positions. The presenters asked the LHHS to make a recommendation during this interim and have Mr. Hely and Ms. Mathis research this type of gateway.

Center for Health Workforce Analysis

Richard Larson, M.D., Ph.D., executive vice chancellor, vice chancellor for research, UNM HSC, and Dr. Kaufman gave a presentation on the Center for Health Workforce Analysis (CHWA) at UNM HSC. Dr. Kaufman said he has been working with Dr. Larson on the establishment and implementation of the CHWA instituted by HB 19 that was passed last year.

He reported on status, findings and outcomes. The work force data were moved to be under the supervision of Dr. Roth at UNM HSC and housed in Dr. Larson's computer servers. Staff has been hired and mobilized in the office to work on this. Dr. Kaufman reviewed the handout that showed the categories of activity and sample electronic survey results. He pointed out the importance of having a diverse work force in the state to help with the number of people who can be seen.

As a way to attract health professionals to areas such as Hobbs, agreements are made to give students free housing. After just a few years, family physicians and PAs have been hired by setting up such a model. To continue to decentralize and create hubs, programs are being developed in places such as Taos, Santa Fe and Santa Rosa. Developing an interdisciplinary team will be one of the next steps in transforming health care that will have a bigger impact on the health of the communities.

Dr. Larson reemphasized the importance of what a milestone HB 19 represented for the state and the need to go forward with the program. He said an academic health center such as UNM HSC is different from other health care providers, such as Presbyterian. UNM HSC not only is delivering clinical care but is also producing a work force for all of New Mexico. UNM HSC wants to match resources and training of health care professionals to what the state needs, and HB 19 represented the first time to collect solid data to assess that by linking data to registration licensure data and have it semi-automated to the survey data, which is downloaded into the database to get detailed data county by county, who is practicing there and the nature of their practice. Following national metrics of how many providers should be in this sort of situation and how many the county actually needs will allow UNM HSC to think of how many health care providers are needed. The logistics of accessing and storing these analyses will require sustained funding.

When pharmacists renew their licenses, there is not a standard survey they fill out, and so data on the nature of their practice cannot be obtained. The Board of Pharmacy has agreed to include a standard survey as part of its renewal process so it will ultimately be able to collect pharmacy data.

A committee member suggested that David Roddy, head of New Mexico Primary Healthcare Association (NMPHA), be on the New Mexico Health Workforce Committee. Since the committee members have such comprehensive backgrounds, the member also asked that a recommendation be made about the foreign-educated health care professionals to put them into areas of health care.

It was pointed out that many of the providers who are serving Native Americans are employees of the federal government but do not have a New Mexico license. Dr. Kaufman agreed that it is a problem, but a team of researchers is working to determine the federal Indian Health Service and military employees who will not be captured by the survey and how many came from and were trained in New Mexico.

In response to a concern about the personal data in the survey and who would have access to data, Dr. Kaufman explained that the CHWA has secured servers with protective firewalls, and from a security standpoint, the data are as secure as possible. The state receives the data and simply transfers data to the committee under an MOU that allows access to data.

Representative Madalena welcomed and introduced former Senator Dede Feldman.

UNM HSC Health Care Work Force Education Programs

Dr. Roth explained that premedical education occurs at the baccalaureate level and is undergraduate education. The next step leading to the practice of medicine is medical education, called undergraduate medical education, which is four years of medical school after the four years of the bachelor's degree. The next step is training in a residency program that can be anywhere from three to seven more years, called graduate medical education. Finally, when a graduate is done with residency training and wants to set up a practice, there is an incredible array of requirements and licensure that mandates continuing medical education to sustain certification in any particular area and maintain licensure. This is what is spoken of as the continuum of medical education.

Using a PowerPoint printout, Dr. Roth's presentation focused on doctors and dentists and addressed the B.A./M.D. program and the proposal for a B.A./D.D.S. program. He gave a general overview of the GME residency program and the primary care physician conditional tuition waiver. Dr. Roth said he will not ask for funding from the legislature until he is sure that there will be a continued commitment to annual and incremental permanent funding for the program.

In describing the B.A./D.D.S. program, Dr. Roth described a Navajo study that showed the number-one cause for children not attending middle and secondary school on the Navajo Nation was dental problems. Many years ago, an oral health summit recommended that New Mexico needed to build its dental programs. An alternative to building a dental school and to supplement the WICHE program is the B.A./D.D.S. program, for which the UNM HSC will come to the legislature to request initial planning funds. He was not speaking against having a dental school but of recognizing economic realities and building on the success of the B.A./M.D. program. High school students would be recruited to come into a customized undergraduate experience and negotiate with an out-of-state dental school. There have been discussions with several schools that would be willing to accept these students in their dental schools. Those students would return to New Mexico to complete their residencies. This is a way to more than double the amount of students in the B.A./D.D.S. program on top of the WICHE program.

Dr. Roth said he has asked two years in a row for funding for the B.A./D.D.S. program. He has been met with sympathy and support but, given the economics in the state, he was unable to receive funding.

Vanessa K. Hawker, UNM HSC, explained that the request for fiscal year (FY) 2015 is for planning funds of \$400,000. The total projected cost for the program is \$8.1 million. The object is to help students pay for tuition to dental schools that New Mexico contracts with so the students have less debt and then they can practice in rural and underserved areas in New Mexico.

Dr. Roth said he would not ask to fund this program unless there is a strong commitment to begin the eight-to-nine-year journey it will take to fully fund it. He does not want to admit students and then not have funds to pay for their final time in college.

A committee member urged the UNM HSC to wage a tandem campaign in both houses of the legislature and go to the LFC, the House Appropriations and Finance Committees and the Senate Finance Committee.

Public Comment

Glenn Ford explained that at one time he was a civil engineer and a supervisor and manager of a multimillion-dollar program as a licensed professional engineer. Twenty years ago, he sustained a brain injury that was not diagnosed and went untreated. He lost his job, career and almost his family. Three years after he first approached the legislature, he got an attorney to advocate for him and he was able to get into post-acute care. He now does advocacy as a volunteer to help people get those services. Unfortunately, today the circumstances he went through are exactly the same and the diagnosis in the community is almost nonexistent, even if a person is lucky enough to go into the emergency department of a hospital. Brain injury is a health care issue and can become a disability resulting in prison and homelessness. However, if it is diagnosed early, treatment can be successful. Once a person hits rock bottom and has lost everything, the person could eventually get into the Medicaid waiver program and get financial support. That is more severe, but he does not qualify because his wife has continued to work. About 90% do not qualify for these programs and they are called the silent epidemic.

Katie O'Donnell said she is a community health worker with the Pathways program. While UNM is providing excellent health care in Bernalillo County and there may be future when all New Mexicans have access to health care, the people working with patients every day and observing people navigating the university health systems see a different kind of picture. The UNM Care Financial Assistance program provides excellent financial assistance for those who can qualify. However, because of an incredible disconnect among the different departments at UNMH and miscommunication and misinformation, people are being denied UNM care. This has been publicly admitted by the director of financial services, who gave information that was publicly contradicted by someone on her team. That is a major concern. Another concern is that many Bernalillo County residents do not qualify because of their documentation status, which is not always clear because of the contradictory information received. People can qualify and be offered a 45% discount on their bill, which in reality is not enough coverage. Other counties provide excellent financial services to undocumented people. She asked that the university system publicly clarify all of its policies on a monthly basis and open its services to all financially eligible Bernalillo County residents who pay tax dollars.

An audience member named Sabina stated that her husband suffered a traumatic brain injury six years ago when a microburst hit a cottonwood tree that landed on him. She related their experiences when he was not communicative and could not walk and the indifferent treatment he received in the nursing home. He was transferred to a hospital with a rehab wing for brain injury patients. She suggested that medical care facilities address better education and training for their staff in regard to the care of brain-injured people who are unable to speak for themselves.

Damian Black said that he has brain damage and pointed out how difficult it is to explain his situation to people because it is not an apparent injury and is not something an observer can see without looking at records and background. He discussed his history of brain and other injuries and how he has dealt with them.

Kathy Salazar said that she has a handicapped daughter and uses the PCO. She has been told that PCO is being discontinued. It works for her because she is the caregiver for her daughter, who has special needs and cannot go to a group home because she needs so much care. She requested that the committee keep the PCO going and not force her daughter to go into another program.

The committee members discussed the PCO, and there was a suggestion that this be further addressed by the committee. The PCO was put into place to keep low-functioning people out of nursing homes, but since the recession, the budget has been reduced. It was suggested that Ms. Salazar speak with Ms. Mathis for information on future meetings when she can speak during the public comment period.

Wednesday, July 3

Welcome and Introductions; Approval of May 30, 2013 Minutes

Representative Madalena reconvened the meeting at 8:45 a.m., welcomed everyone to the meeting and invited the committee members and staff to introduce themselves.

The minutes of the May 30, 2013 LHHS meeting were approved as submitted.

Representative Madalena stated that a quorum had been established on the first meeting day of July 1, 2013.

ABQ Health Partners — Total Care Model

Jill Klar, chief operating officer, ABQ Health Partners, welcomed the committee to ABQ Health Partners. She explained that ABQ Health Partners is on a mission and has a passion to change the way health care is delivered in New Mexico, producing higher patient outcomes, higher patient satisfaction and lower overall health care costs. She reviewed the handout that included a history of the development of ABQ Health Partners.

In response to a question from a legislator, Ms. Klar explained the relationship between ABQ Health Partners and Lovelace, which terminated in the fall of 2013. At present, ABQ Health Partners is not a contracted provider for Lovelace, although it is still working in the Lovelace facility and still takes patients there. Lovelace health plan patients cannot be seen unless their care is treated as out-of-network benefits. ABQ Health Partners can see commercial, Medicare and Medicaid patients, but it is not set up to take uninsured patients. The former Lovelace doctors are still with ABQ Health Partners. At the end of 2007, the Lovelace group and health care system decided to spin off and become completely independent.

Robert Mayer, chief information officer, ABQ Health Partners, stated that physicians at ABQ Health Partners use electronic medical records so that a patient can go anywhere in the state to any provider and access records. It is exchanging records with 11 other medical care groups through the NMHIX. This avoids duplicate testing and catches previous conditions.

Health Care Provider Covenants Not to Compete

David Johnson, Esq., Montgomery & Andrews PC, and James Martinez, M.D., president-elect, New Mexico Medical Association (NMMA), gave a presentation on health care provider covenants not to compete.

Mr. Johnson explained that he is a health care lawyer and represents health care providers. Part of his practice involves covenants not to compete, and he often finds himself on both sides of an issue. He is neither a strong proponent of covenants not to compete, nor is he on the other side; he represents both physicians and medical groups and hospitals interested in enforcing the covenants not to compete. These can also be called noncompete agreements, restrictive covenants and covenants not to compete. He described the various types of covenants not to compete that are used to protect business information, trade secrets and business plans.

Dr. Martinez told the committee that he is a physician who has practiced in Albuquerque for 22 years. He stated that the NMMA is neutral on the matter of covenants not to compete and believes the contract is between the physician and the employer group. Its members are both employees and physicians and independent physicians. The cry heard from the independent practitioners is that hospital systems have deep pockets and can buy whomever they want.

In response to a committee member asking what is expected of the legislature, Dr. Martinez said that he would like to see legislation that eliminates the noncompete covenants, even though the NMMA is neutral. The committee member said that the LHHS would need to see some sign of a large amount of support for that concept before being able to put it into legislation.

Donated Dental Services

Linda Paul, executive director, New Mexico Dental Foundation, and Larry B. Lubar, D.D.S., gave a presentation on donated medical services.

Ms. Paul explained that her organization is a 501(c)(3) nonprofit and a charitable arm of the New Mexico Dental Association (NMDA). She described the work that New Mexico dentists do each day to help change lives. Though all dentists in New Mexico provide pro bono work each week, the foundation helps dentists in an organized way to provide treatment to those who otherwise would not be able to afford care. The mission is to inspire benevolent dental outreach and promote dental health in New Mexico. She described several major programs and student opportunities. She introduced Dr. Lubar, who practiced dentistry in New Mexico for the bulk of 49 years before his retirement. He was the volunteer event chair for the first Mission of Mercy at the fairgrounds in Albuquerque in 2010. He has donated thousands of dollars of dental treatment to those in need through the foundation's donated dental services program.

Dr. Lubar gave an overview of what dentistry is like in New Mexico. He has also been president of the NMDA and served as its representative to the Medicaid advisory committee. The dentists in New Mexico are second to none and an incredible group of men and women whose first goal is to take care of their patients to the best of their ability.

Ms. Paul explained that the NMDA has received money from the state and is requesting that a legislator carry a bill asking for an additional appropriation. It has a four-year waiting list in Albuquerque for people seeking donated dental services, but it does not have funding for a case manager. A line item within the UNM budget has been in place since the inception of the program. It is spent for services and education of dentists on dealing with and teaching how to deal with disabled individuals.

Public Comment

Michael Spanier said that he worked in state government and was on the LFC. He referred to the large employer mandate of the PPACA and mentioned that there has been a one-year delay in that mandate to January 2015. He encouraged the committee to move forward with a letter to the LFC because the FY 2015 budget will be considered at the next session.

Through the implementation of Centennial Care, the PCO self-directed option will be eliminated in January 2014. It is an option that offers the very best balance of independence and support for the participants who will not succeed in going to an agency-based model. He expressed his concerns about the closed process that the Human Services Department (HSD) went about in making the decision. He encouraged the committee to invite Secretary of Human Services Sidonie Squier to a future hearing to further discuss the issue.

In response to questions from committee members about the cost of the PCO versus other relative costs, Mr. Spanier said he would get specific information on costs and participation to the committee so that Mr. Hely can disseminate it to the members for productive discourse on the issue.

On a personal note, Mr. Spanier honored the Granite Mountain Hotshots and sent his thoughts to their friends and families for the courageous work they do.

Ms. Otero-Hatanaka commented on the PCO program and said there are many people with developmental disabilities who are on the waiting list for Medicaid services and may be getting services through the PCO program. The developmental disability Medicaid program, as well as the families, are excluded from Centennial Care at the current time, although the long-term plan of the HSD is to include them at some point.

Mike Kivitz, president and CEO of Adelante Development Center, Inc., wanted the committee members to know of the ongoing and growing crisis in the developmental disability arena. The state is doing something very ambitious in trying to change four major systems at the same time: the Medicaid waiver standards, the way people are evaluated for what service package they will get, what the rates are and what service packages people are then eligible for. The state has been working on this for two years, but is unprepared to approve budgets, and so organizations such as his are operating without assigned budgets. There is currently no way to get the extra care for those few individuals who have high needs. There is no communication with the HSD and no one can give the long-time providers information.

Daniel Weeks said that he was here on behalf of himself. In the last couple of years, he has had the opportunity to help some folks and their friends and families who have had to go through the conservator process, and he has observed that there is not a lot of focus on the family, even though there is a lot of focus on protection of the elders. But the family involvement is not focused on enough. The process needs more transparency and fiduciary oversight and safeguards with respect to the actions of the conservators themselves and provisions for elimination of some obvious conflicts of interest with respect to the action of the conservator or guardian. He said that there is a memorial being prepared, and the committee will receive more information as the memorial study proceeds. In the meantime, he urged the committee not to forget about family involvement.

Emily Darnell Nuñez said that early childhood programs are finally doing some good for young children, but there is still a need for regulations, dialogue and communications. She suggested that the memorial will help iron out some of the issues going on with the elderly and the community. The paradigm in the state needs to shift about exploitation and the need to identify how to support families who are the ones better able to take care of elderly family members. If a guardianship or conservatorship needs to be in place, nothing should change about family relationships. It is heartbreaking for those involved when the protected person is being abused and exploited and does not get to see or be near family.

Medical-Legal Partnerships

Yael Cannon, Esq., assistant professor of law, UNM School of Law, and Ellen Leitzer, Esq., executive director, Senior Citizens' Law Office (SCLO), discussed medical-legal partnerships. Professor Cannon introduced the new dean of the New Mexico School of Law, David Herring. As background, Professor Cannon said she taught for three years at American University in a program serving low-income people in Washington, DC, with disabilities and special health care

needs, particularly children. Prior to that, she worked on children's legal issues at the National Medical Center in Washington, DC. She spoke from a presentation regarding the UNM Medical-Legal Alliance.

Ms. Leitzer read from her letter to the committee for her testimony on medical-legal partnerships.

Professor Cannon added that the school performs legal services on behalf of children, especially those with health care needs, and collaborates with the various health care professionals, which is the best model for delivery of services. The school is beginning to explore partnerships with different foundations, such as Kellogg, for how to reach other parts of the state. With technology and partners in communities and on the ground, an ideal would be to have a pilot project in the north, one in the south and one in collaboration with the tribes.

One committee member pointed out that the funding was originally at \$6 million and is now at \$1.2 million, yet the need throughout the state continues. There is the need to work collaboratively to get adequate funding.

Professor Cannon said that being creative about tapping into possible PPACA funding is something that medical partnerships are looking at throughout the country for bringing services to preventive care. She spoke about a woman with a hearing impairment who has borderline cognitive disabilities and is very difficult to treat. The UNM School of Law has been helping her to get family legal guardianship, even in adulthood.

Ms. Leitzer responded to a committee member regarding physician-ordered treatment limitations and end-of-life treatments and said she would like to partner with the committee to look at those policies.

Elder Abuse and Exploitation — SCLO

Marsha Shasteen, SCLO staff attorney, Gregory MacKenzie, attorney at law, and Darryl Millet, attorney at law, discussed elder abuse and exploitation. Ms. Shasteen said that she is a staff attorney at the SCLO, which now has a new executive director, Ms. Leitzer. She addressed the committee using a handout that she had prepared.

Mr. MacKenzie said he has been practicing law for 20 years, spending the vast majority of his time litigating the questions of undue influence and exploitation and dealing with contested guardianships and conservatorships. He sees financial exploitation occur in transfers between family members, families as to strangers or third parties, and then fiduciaries. He referred to his handout for his testimony.

Mr. Millet explained he is an attorney in private practice in Albuquerque. A large part of his practice is devoted to conservatorship services for incapacitated persons due to dementia, injury or some other form of disability that makes it impossible for people to take care of their own

money and property and to be protected from those who would take advantage of them. He spoke from his outline of testimony and reviewed some cases with which he has dealt.

The SCLO is seeking statutory recognition for these problems that would give it a tool to deal with the problem. Mr. MacKenzie said it would be helpful if there were a statute that said a person trying to commit undue influence is liable for the attorney fees of the person who brought the claim.

Ms. Shasteen confirmed that it is difficult for someone to think of retaining a lawyer after all of the person's money has been stolen. She has looked at statutes across the country for model language. In her view, California goes so far as to discourage people from feeling comfortable in doing transactions. Disability Rights New Mexico is a group to which the SCLO intends to contact. Every day, inherent in the SCLO's work, there is the tension of having to balance protection of the elderly against the freedom of the elderly. SCLO does not want to take away from people the dignity of being able to take a risk so long as it is within a reasonable realm.

Mr. MacKenzie added that a mechanism is needed for a restraining order to automatically freeze assets because, in many cases, at the end of the lawsuit the assets are gone.

Mr. Millet said he would work with the LCS on crafting language that provides protection without undue interference. Once the simplest possible statute is approved, it can be tweaked throughout the years when additional issues are discovered.

A legislator suggested that it might be faster to go to the New Mexico Supreme Court and ask for a civil procedure where a protective order can be filed at the beginning of a case. Without a message from the Governor's Office, the legislature cannot introduce a bill at the upcoming session, which will give it two years to get the necessary groups behind this. Another suggestion was to get on the agenda of the Courts, Corrections and Justice Committee right away. The more interim committees that endorse a bill, the better. The Office of the Attorney General (OAG) also should be on board.

Medicaid Fraud and Elder Abuse Unit; Hate Crimes Against Elders

Maria Griego, program evaluator, LFC, Jody Curran, director, Medicaid Fraud and Elder Abuse Division, OAG, Dave Pederson, general counsel, OAG, Joan Gilewski, nurse investigator, OAG, and Kathleen Hart, director, Adult Protective Services Division, Aging and Long-Term Services Department, spoke about the Medicaid Fraud and Elder Abuse Unit and hate crimes against elders.

Ms. Griego referred to a report published in July 2011 by the LFC. She spoke from the report and focused her comments on a progress report, updated the findings of the evaluation and provided the current status of the situation for evaluation titled Medicaid Fraud, Waste and Abuse Control.

Mr. Curran said that the Medicaid Fraud Control Unit investigates and prosecutes three broad areas of violations of the law: Medicaid fraud in the criminal context, such as a doctor, dentist or nurse who is providing services; Medicaid fraud civil, which is basically criminal without the criminal intent aspect; and resident abuse, neglect and exploitation. Those cases are prosecuted under a general criminal statute that is available to the OAG and all of the local district attorneys. In addition to being charged with that investigation prosecution, all 13 judicial districts investigate and prosecute under this statute. Communication with the HSD is essential to the OAG's success and is required by the Code of Federal Regulations (CFR). In order to receive Medicaid money in New Mexico, the OAG is required to work, cooperate and exchange information with the HSD. He and his staff meet to discuss critical issues once a month to improve the flow of information and quality of referrals.

Mr. Pederson said he is a criminal lawyer and has been a prosecutor and defense attorney for his entire career. He said he was here to talk about hate crimes against the elderly. This past session, SB 229 was introduced and would have reinstated the previous sentencing enhancement, the old-age enhancement as it was called in 1980 when it was first created. Mr. Pederson gave background on development of the old-age enhancement statute.

Representative Madalena acknowledged and introduced Gino Rinaldi, secretary of aging and long-term services.

Ms. Gilewski explained that she is a registered nurse and works for Mr. Curran in the OAG investigating abuse, neglect and exploitation cases. She is on the front line for investigation, training and outreach in adult protection services.

Ms. Hart yielded the floor to Secretary Rinaldi, who explained that his department investigates approximately 6,000 cases of neglect, exploitation and abuse each year. The majority of cases are neglect of adults.

One committee member pointed out that the HSD as an agency is too big and has too many functions to be managed out of one place and asked if the OAG is able to form an opinion, given what is known about it.

Attorney General Gary King commented that the current cabinet positions go back to the mid-1970s. There has always been an issue of how to combine things so that they can be well-managed, and there are management tools that help to do that. Interagency cooperation is important among agencies to help overcome these things. In modern times, it would be difficult to divide those departments up without changing the overall substance of government. Even though it is a fascinating idea, the legislature would have a difficult time reorganizing that, especially working without the governor and the executive. It is more a matter of trying to find efficient and economical ways to manage what is being managed rather than changing the structure.

Charles Sallee, deputy director of the LFC, said that something the legislature has looked at for the past couple of years and should continue to look at is strengthening the inspector general functions that exist throughout state government as a way to make sure that the largest departments are operating in the most efficient and effective way. Ms. Griego's team identified the Inspector General's Office at the HSD as being subsumed and is now reporting to a deputy secretary. The office has not been engaged in overseeing Medicaid fraud or integrity or how the HSD's Medical Assistance Division is overseeing managed care. That is a missed opportunity that should be revisited to make the department a more independent reporting structure.

Public Comment

Léonie Rosenstiel, M.P.H., a responsible guardianship advocate, submitted a letter from her testimony on elder abuse and guardianship matters before the Disabilities Concerns Subcommittee on November 9, 2012. She said the problems are coming from another direction as well: lack of oversight of appointed guardians who are appointed by the court. The process and proceedings are sequestered and not released to the public. The families may even be barred from seeing the person under the guardianship. She cited cases where a developmentally disabled person whose appointed guardian looted the trust fund and left the person destitute. These things happen to people who are not able to communicate effectively or think sequentially; they are being taken advantage of by family members and now the state, with no process in place or a provision in the law for guardians. She recommended that the secrecy be stopped so that family members can go to court and get reports on the finances and the situation. A person needs to be protected against possible exploitation before and after a guardianship is declared.

Marsha Southwick said she is an advocate for elder civil rights and runs a web site for people concerned about guardianship. The U.S. Government Accountability Office reports many cases where people's rights to their own money is handed over to someone else. If there is no accountability, there is no recordkeeping. She became involved in this enterprise because she has a friend in New Mexico who had \$2 million spent in two years, even though his care was not that great. The family cannot find out where the money went. There is the need to think about the potential for abuse when removing an elder's civil rights to money, freedom and legal representation.

Alleged Behavioral Health Provider Fraud

Secretary Squier and Diana McWilliams, executive director, Interagency Behavioral Health Purchasing Collaborative, discussed "credible allegations of fraud" that the HSD made against 15 behavioral health provider agencies pursuant to federal regulations. Secretary Squier explained that because of a new process in the HSD system, information on irregular types of billings from providers that had not previously been available started showing up. In addition, Ms. McWilliams and Secretary Squier stated that several whistleblower allegations were made against behavioral health provider agencies. With that information, the HSD hired an independent firm to audit 15 providers and all 15 failed the audit. Information was delivered to the OAG with the HSD's credible allegations of fraud. Secretary Squier stated that the credible allegations of fraud involved over \$36 million in payments to the provider agencies and that she

had no discretion but to hand over the credible allegations of fraud to the OAG. Upon receipt of the HSD's credible allegations of fraud, the OAG decided to make an investigation into the matter. Secretary Squier said that she did not know when the OAG would begin its investigation. Secretary Squier stated that she did not have the authority to disclose the audit findings, as they were now the subject of a criminal investigation and therefore not subject to the state Inspection of Public Records Act. Several handouts regarding the investigations were provided to committee members.

In response to several comments and questions from the committee members, Ms. McWilliams explained the methodology used in the process of meetings and regarding the findings.

Attorney General King also spoke about ways to work with the providers. There is guidance in the CFR regarding credible allegations of fraud, and there are limitations with what can be shared.

A member indicated that he thought it was inappropriate that an emergency procurement process, which circumvented Procurement Code provisions, was used by the HSD in obtaining the services of Public Consulting Group (PCG), the Massachusetts firm that performed the audit pursuant to the results of which the HSD made the credible allegations of fraud, and the Arizona provider agencies with which the HSD has contracted to manage provider agencies under investigation.

A member questioned the statistical extrapolation methodology that PCG used to determine the amount of payments that the provider agencies might owe with such a small sample of claims. Secretary Squier stated that the CMS usually accepts a sample of 50 claims, and the federal Department of Health and Human Services' Office of the Inspector General accepts 100 claims as a sample size, but the HSD used a larger sample size of 150 claims.

Ms. McWilliams stated that, even after ruling out technical errors, the error rates were well over those rates established by federal guidelines. Some of the provider agencies had error rates of 25%.

Another member stated that providers are innocent until proven guilty of fraud and that Secretary Squier's assertion that the 15 entities against which a credible allegation of fraud had been made were guilty of "egregious fraud" was inappropriate and may subject the HSD to defamation suits.

Following questions from the committee members and responses from the HSD representatives, Representative Madalena noted for the record that Secretary Squier was increasingly disrespectful to the committee members and had left the room. It was recommended that the providers be invited to an upcoming Behavioral Health Subcommittee meeting.

The meeting adjourned at 7:45 p.m.

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

**July 25, 2013
Room 307, State Capitol
Santa Fe**

**July 26, 2013
129 Canal Street #B
Pueblo of Jemez**

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at 9:16 a.m. on Thursday, July 25, 2013, in Room 307 of the State Capitol in Santa Fe.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza (7/25)
Sen. Gay G. Kernan (7/26)
Sen. Benny Shendo, Jr. (7/26)

Absent

Rep. Doreen Y. Gallegos
Rep. Terry H. McMillan
Sen. Mark Moores

Advisory Members

Sen. Jacob R. Candalaria
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia (7/25)
Rep. Sandra D. Jeff
Sen. Linda M. Lopez (7/25)
Sen. Bill B. O'Neill
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson
Sen. Lisa A. Torraco

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Stephen Easley
Sen. Daniel A. Ivey-Soto
Sen. Cisco McSorley
Sen. Sander Rue
Sen. William P. Soules

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

Staff

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

Abby Wolberg, Legal Intern, LCS
Rebecca Griego, Records Officer, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Thursday, July 25

Representative Madalena welcomed everyone and asked for introductions. Senator Ortiz y Pino stressed the importance of hearing from public officials on issues that will affect New Mexicans for the next decade and said that is why the agenda has been adjusted in the way it has.

Update on the Behavioral Health Provider Investigations

Ms. Mathis provided a file to members with copies of a July 15 letter sent by the Behavioral Health Subcommittee to State Auditor Hector Balderas, asking him to investigate the Public Consulting Group, Inc., (PCG) audit. On July 17, Ms. Mathis said, a federal court in Albuquerque heard arguments on behalf of eight audited providers that are seeking injunctive relief, alleging that the state deprived them of liberty in the form of property (withheld payments). If funding is not restored, many providers will have to close their doors. Statute holds that there must be due process. The Human Services Department (HSD) has denied requests to lift pay suspensions for 12 of the 15 affected providers; one was lifted and two others were partially lifted. Ms. Mathis also provided copies of a follow-up letter to Mr. Balderas from several subcommittee members with further questions. She also provided in each file a copy of the HSD credible fraud referral guidelines.

Information that may be relevant to this audit continues to come to light, said Ms. Mathis, including a copy of a settlement agreement between the state and a company called Public Partnerships, LLC, which is an affiliate of PCG. The settlement involves repayment of alleged overpayments in funds for the Mi Via program. The agreement was signed on January 3, 2013, and the no-bid contract with PCG was signed in February 2013.

Mr. Balderas thanked members of the committee for the opportunity to review audit requirements because there seems to be some misunderstanding about the duties of his office and the agency at the point of controversy. The Office of the State Auditor is the only state agency tasked to give independent opinions. Fraud risks are always there. A \$36 million liability is identified by the PCG audit, but a bigger liability involves millions of federal dollars when the state auditor is denied access to documents by an organization created and funded with federal dollars. This point has been lost in some of the debate. The state wants to catch fraud at every level and keep confidences. It is also the state auditor's job to give opinion on whether an agency is doing a good job of auditing.

Mr. Balderas summarized the federal Single Audit Act of 1984, which applies to all state or local governments that use federal money to fund programs. His office is charged to deliver statewide annual financial and compliance audits. This is not just by state mandate, he said, but also because the state cannot accept billions of federal dollars without an independent auditor who is able to do the job without interference. It is no problem to work with an organization's procedures, but when those procedures are used to deny access, all federal dollars are at risk, and not just to that specific organization.

Last year, the state auditor identified \$5 million of irregularities at the HSD, Mr. Balderas said. The department could have done a better job of oversight, and it was given a finding of noncompliance pertaining to audits of providers. By law, the HSD has to have methods or criteria for identifying suspected fraud. Now, the state auditor needs to test whether the agency has done a good job in auditing that risk and exposure. The state auditor has been denied access to the report. The HSD cited the risk of public disclosure of investigation details. The secretary of human services failed to comply with a subpoena deadline of July 22 to provide that report to the state auditor, Mr. Balderas said.

Jim Ogle, co-chair of the legislative committee of the National Alliance on Mental Illness-New Mexico, offered a PowerPoint presentation to committee members titled "2013 Behavior Health Audit: A Family Member's Perspective". While acknowledging the possibility of some fraud in the system, Mr. Ogle said the immediate concern of families and consumers is whether their usual providers will be there when they show up for an appointment next week. Reported software glitches and the 100 percent failure rate for the 15 audited agencies are certainly reasons to be skeptical of the findings, which imply that the HSD and the statewide managed care behavioral health entity, OptumHealth, should be investigated to determine how the 15 nonprofits were able to pass audits last year and why now they have all failed. Mr. Ogle urged the HSD to rule immediately on lifting payment restrictions for "good cause". "The smaller providers are starting to close and hundreds of years of behavioral health experience will be walking out the doors". Mr. Ogle described strategies presented at a national dialogue on mental health in Albuquerque on July 20 for the community, for youths and for community action. The significance of the Medicaid rule change on February 2, 2011, which lowered the requirements for "reliable evidence" of credible allegations of fraud, may have been overlooked by providers, he said, but now they are paying, and that will make consumers the ultimate losers. Mr. Ogle urged legislators to work with New Mexico's congressional delegation to modify this section of law "before it destroys the country's behavioral health system".

Barri Roberts, executive director of Bernalillo County's Forensic Intervention Consortium, told committee members that any interruption of behavioral health services will interfere with the intricate and vital relationship that the entire community has created. There is going to be an increase in homelessness, in prisoners and in first-responder situations, she predicted. Regardless of whether there is fraud, what is happening is a huge break in the continuity of a system to which entire communities have contributed, she said, "and it seems like a very abrupt

and unprofessional way for HSD to handle it". Ms. Roberts urged legislators to protect the dollars spent through general appropriations and the welfare of people living with mental illness.

Attorney Robyn Hoffman, who said she has been in contact with multiple authorities in her representation of one of the audited providers, offered to share some legal information. The standard for referring a credible allegation of fraud is now so low that it is improper for the federal agency to use the word "fraud". Fraud is criminal action that has intent to commit fraud against someone, she said. What the HSD has found in its own discretion is what it found credible. Someone's credibility is discretionary, based on different opinions. Secretary of Human Services Sidonie Squier has decided that whatever evidence of fraud she has seen is credible under these very low standards, Ms. Hoffman said. "What I see is unconstitutional disruption of behavioral health and no due process in responding, and that is the basis of the federal court lawsuit which went to hearing last week", she said. There has been no notice of impropriety and none of the providers even know if there have been overpayments. All of these claims are being hidden behind a shield of criminal investigation, but this is not a criminal investigation, she said. There have been no criminal allegations. It is a significant interruption of services that will have a huge impact on homeless and prison populations, Ms. Hoffman predicted. "It is a shutdown, not a transition."

Questions/Concerns

During the discussion following presentations, committee members had numerous questions on the following topics.

More detail about the 2012 HSD audit and the HSD's denial of the PCG report to the state auditor. Mr. Balderas said that the 2012 audit of the HSD, which identified \$5 million in irregularities, was a compilation of various reports over many years and that it involved an independent auditor reviewing various audit reports from the federal inspector general and agency reports. Regarding the PCG audit, Mr. Balderas said that the HSD has not responded yet to the subpoena. He has been working with the attorney general (AG) and the HSD for a larger purpose so as to avoid the courtroom, he said. The request was direct as a matter of law and practice. The state auditor has engaged with the AG to assure the protection of confidential information, and he also explained the importance of not being delayed as an auditor. Mr. Balderas denied that political posturing was involved. "I aggressively safeguard my jurisdiction", he said. At issue is whether the Office of the State Auditor could do its duty according to federal agency requirements and attest to whether the HSD has performed properly.

Al Lama, assistant AG, said that only select portions of the report — those that relate to provider conduct that is alleged to be fraudulent and subject to criminal liability — are what the AG has concerns about. With respect to the rest of the report, the AG has no fight with the auditor. The concern is what happens to that information once it is transferred to the Office of the State Auditor, as it is not a law enforcement agency, Mr. Lama said. Later in the discussion, Mr. Lama disclosed that he had just been notified that the district court judge confirmed the AG's request that the state auditor ratify confidentiality to maintain the investigative process. This

allows the AG to ensure that the process is done with integrity, Mr. Lama said. "I am happy to say we are moving forward, and the auditor will get a copy of the entire report." Mr. Lama assured committee members that the investigation is a priority in his office, and four additional criminal investigators have been assigned to it.

Confusion about who ordered suspensions in provider payments, and why. Questioning the reliability of OptumHealth software that revealed suspicious billing patterns by the 15 providers in 2012, a member said it is her understanding that the new computer system used by OptumHealth was untested, and she is concerned with the reliability of its data-mining process. Another member told Mr. Lama that there is great confusion and concern about who made the "credible allegations of fraud" because "this is not just an allegation, it is an execution that is putting many people out of business". Allegations of fraud are discretionary, Mr. Lama said, and they are vested within the department. Who gets to decide to pull funding? When the federal Patient Protection and Affordable Care Act (PPACA) was enacted, there was a significant change to the way Medicaid fraud investigations are to be performed. The HSD receives information, and this is documented through referral or through the managed care organization (MCO), and the HSD has the ability, and the responsibility, to investigate any suspicion of improper billing to Medicaid funding. The AG determines, through its own investigation, whether actual fraud, civil or criminal, has occurred. While there can be good-cause exceptions, that state agency's job is to decide whether pay suspensions are appropriate, he said. The AG is not authorized to be involved with this decision according to federal law. "One reason we keep asking about this is that it is almost incomprehensible that this can go on without any due process for the providers. I understand the law, but this is ludicrous.", the committee member said.

Responding to a question about the loss of qualified staff at agencies, Mr. Ogle described an investigation that took place several years ago of missing top-secret computer disks at Los Alamos National Laboratory. The investigation disrupted many peoples' lives and careers, Mr. Ogle said, and the charges eventually were proven by the Federal Bureau of Investigation to be nothing more than a clerical error. Referring to the current crisis with behavioral health care providers, Mr. Ogle said, "It's going to take a generation of people moving through this system in order to forget this."

Where is Secretary Squier? The committee chair said that Secretary Squier had been invited to this meeting, and Ms. Mathis verified that Secretary Squier and Diana McWilliams, acting chief executive officer (CEO), Interagency Behavioral Health Purchasing Collaborative, had been invited to continue the discussion, but at that time, Ms. Mathis received an email response from Matt Kennicott, communications director, HSD, saying that, in light of how the secretary had been treated and how long the questions took, the HSD believes it has fully answered the committee's questions. The HSD declined the offer to attend today's meeting.

How will the Arizona providers be paid? Some members expressed concern about the costs of the management contracts. Others expressed outrage at the high rates (up to \$300 per hour) detailed in a copy of one of the contracts. Charles Sallee, deputy director, Legislative Finance

Committee (LFC), said he received an adjustment request from the HSD to move funds from another cost category to the contractual services category to pay for the management contracts. The costs of these contracts are \$7.4 million for three months of services. A total of \$18 million for an anticipated six-month transition was requested by the HSD. The HSD is running a large surplus, he said, so it will have more than is needed. The HSD's position has been that using these funds will not affect services because the department is using surplus funds, Mr. Sallee said. Another member discussed the HSD's contract with OptumHealth, which requires that there be no interruption in the delivery of services. When the HSD suspended payments to the original providers, and if new providers are being paid with these transitional funds, does this not create an enormous windfall for OptumHealth?, he asked. LFC staff members said they could not answer that but would look into it.

Committee members discussed the impacts on family members and other consumers when services are disrupted. Ms. Hoffman said that an easy solution to the problem of continuity would have been for Secretary Squier to enter good-cause findings for all agencies to continue service, because of the huge numbers of consumers involved — 30,000 — during the investigation. Ms. Hoffman believes that this is an artificially created crisis. Another committee member read an excerpt from an email he received about a conversation between a New Mexico provider and the head of one of the new Arizona agencies, who said that the HSD had originally approached the agency last fall about taking over some providers in New Mexico. "The PCG audit didn't take place until February", he pointed out. Another member asked if the Arizona providers would be audited in the same manner as the New Mexico providers have been.

Public Comment

Andrea Serna, a licensed mental health counselor who works at Casa de Corazon in Espanola, told the committee that she has been hearing from families and patients who are scared and confused. The organization has been doing the best it can with downsizing.

Martha Cook told the committee that most people working in the field are driven there because of personal experience, and the passion that behind that work is huge. Local Collaborative 1 has been meeting for years, and this week, members are scared. In addition to the unknowns associated with the PPACA, now there is this crisis. "And what about the Children, Youth and Families Department? TeamBuilders serves five thousand kids in New Mexico. I challenge the committee to do something quickly."

Carter Bundy, representing state employees in the American Federation of State, County and Municipal Employees, urged the committee to consider repercussions for people who work at state agencies and the potential of safety issues with the impact of terminating services.

Ellen Pinnes of the Disability Coalition presented, on behalf of Bill Jackson, a resources information handout, which was emailed to all legislators.

Ann Hayes Eagen, represented by Ron Hale, is coordinator of the 38-member New Mexico Alliance of Health Councils. She sent a letter to Governor Susana Martinez asking that HSD suspensions be lifted. It is unrealistic to think that what New Mexico had can be replaced by out-of-state companies, she said. There are many questions about the credibility of the audit, but it is clear that this is a systemwide failure with shared responsibility. OptumHealth, she said, has not fulfilled its contract obligations, even with as much money as has been paid to it.

Valerie Romero said she was present on behalf of children and people who come from the "wrong side of the tracks". She has experienced firsthand how the Children, Youth and Families Department fails children with behavioral health issues, and she feels that the state does not need to take services away, it needs to expand them. She said she has loyalty to the company she works for, and she has not seen any viable evidence of fraud.

Megan Grey, behavior management service program support for TeamBuilders, wanted to remind the committee that it is more than funds that are at risk — it is the poorest and most vulnerable children. Pointing to children in the room, she said, "Here is a row of kids that sat for three hours today, and not one of them misbehaved, and it's because of what we do, day in and day out."

Bruce Evans, an advocate who has worked on mental health issues for many years, said he knows a lot of providers throughout the state, and he has seen a long, slow slide in mental health care. He believes that a lot of the fraud issues have to do with substance abuse providers, where much is subject to clinical interpretation. There has been a lack of vision and poor quality leadership, Mr. Evans said. He has worked with the executive branch before, but now some of those holding executive positions, in his opinion, are not qualified.

Julianna Koob and Linda Siegle, representing the National Association of Social Workers, which was with 800 members in New Mexico, offered the services of their members to work toward a solution. "There is no way not to have a gap in services."

New Mexico Health Insurance Exchange

Jason Sandel, vice chair, New Mexico Health Insurance Exchange (NMHIX) board of directors, and Mike Nunez, chief executive officer (CEO), NMHIX, presented an update on the work that has been done so far. (See handout.) The board has established four standing committees: 1) finance, operations and benefits; 2) information technology; 3) marketing, public relations and outreach; and 4) Native Americans. Advisory committees are being established, and meetings are being scheduled for all stakeholders. An outreach director was hired on August 7. A federal "Level One" grant was awarded to NMHIX for \$18.6 million, and another grant will be requested to finance NMHIX operations through 2015. The NMHIX must become self-sufficient by January 2016. The NMHIX will make monthly progress reports to the committee. It has established good communications with the federal government, Mr. Sandel said, and has established a good flow of information.

A lengthy letter from Sovereign Hager, staff attorney for the New Mexico Center on Law and Poverty (see handout), to the chair of the NMHIX, the superintendent of insurance and the New Mexico Health Insurance Alliance asserts that the NMHIX is not meeting federal requirements in outreach, and it claims that having Medicaid coordination handled by the HSD is inconsistent with federal law.

Questions/Concerns

Several committee members expressed concern about the separation of Medicaid enrollment to the HSD from the NMHIX. Mr. Sandel said the technology has been worked out with the HSD for communication with the federal hub. People will be referred to the HSD for Medicaid enrollment, he said. A member disagreed. "As a matter of policy, I don't want people being bumped around, and the law requires the NMHIX to do more than refer", the member said. Other questions about who has authority for enforcement were referred to Ms. Mathis and Mr. Hely.

Mr. Sandel said that the board received six project management bids for the NMHIX and that PCG was the one with health exchange experience. The Health Alliance Exchange Board made the decision to hire PCG, he said. Representative Madalena asked about the Native American liaison and whether one person could cover all of New Mexico. Mr. Sandel said the NMHIX is working to make contact with people for outreach, with a focus on rural areas. Another committee member noted PCG's lucrative, multiple contracts with the state and asked if the committee could find out how many contracts there are.

Health Insurance Regulation Update

David Barton, chief counsel, Office of Superintendent of Insurance (OSI), told the committee that there is not going to be "sticker shock" in terms of insurance prices on the exchange, and it will be beneficial to have a greatly expanded insurance pool. Lisa Reed, PPACA implementation coordinator for the OSI, said that for the individual exchange, the OSI received 59 plans from five carriers. The OSI also received stand-alone dental plans from eight different issuers. The Small Business Health Options Program, the SHOP exchange, received 57 plans from four carriers. Plans will upload to the federal platform (see handout). Pre-PPACA rates are hard to compare to post-PPACA rates, she said, because of things such as preexisting conditions, but it looks like they are right in the ballpark of what rates would be and no more than five percent higher.

Questions/Concerns

Ms. Reed was asked about catastrophic plans, of which there are only two that have passed review. The catastrophic plans have very high deductibles, and the purchaser must be under 30 years of age, she said. You could buy catastrophic coverage outside of the exchange, she added. In New Mexico, there will be navigators to help people go through the plans and see what these people are eligible for, such as Medicaid, disability or tax credit on the exchange. There still will be indigent funds at hospitals. Even with preexisting conditions, anyone is eligible for any plan. Another member asked why the state is split into five regions on the map in the handout. Ms.

Reed responded that rates vary according to region, but the PPACA limits the number of geographic rating areas.

Health Disparities in New Mexico

Carlotta A. Garcia, M.D., director, Office of Health Equity, Department of Health (DOH), explained that a health disparity means differences in the incidence, prevalence, mortality and burden of disease and other health conditions that exist among specific population groups (see handout). New Mexico is a minority-majority state and has concentrated pockets of poverty, Dr. Garcia said, and one in five residents does not have health insurance. Staff members in her office facilitate cultural competency trainings and health trainings, provide translation and interpretation, conduct vaccine clinics and act as tribal liaisons for the DOH. Dr. Garcia provided a handout describing all collaborative health communities, including those in the New Mexico Office of Border Health. It is a very hard thing to be a Native American in New Mexico in regard to disparities, Dr. Garcia said, but Native Americans are accessing many programs, and her office has an annual report for the Indian Affairs Committee meeting at the end of July. Her office has done very well with a small amount of funding, she said.

Yvette Kaufman-Bell, executive director, Office on African American Affairs (OAAA), described her constituency as a minority in a minority-majority state. The latest estimate for 2012 is that 3.1 percent of New Mexico's population is African American, with one-fourth living below the federal poverty line. The OAAA's charge is to identify solutions relevant to issues concerning African Americans in New Mexico, she said. Partnering with the University of New Mexico (UNM) Center for Education Policy Research (CEPR), data were collected for the first time about challenges that affect the health and quality of life of African Americans. There are many health disparities, Ms. Kaufman-Bell said, and 69.9 percent of African Americans in New Mexico are obese. Other health issues for this group are high blood pressure, smoking, high cholesterol, diabetes, HIV/AIDS and a high infant mortality rate. The OAAA has collaborated with 23 other organizations in outreach to 11 New Mexico counties with a combined population of 11,000 African Americans.

Dr. Peter Winograd, director, CEPR, showed the committee a PowerPoint presentation of data that had been mapped by county throughout the state (see handout). New Mexico's rates for a child's chances of success are among the worst in the nation, he said, and the state has one of the highest rates of families living below the federal poverty line. This type of mapping clearly shows the effects of disparity, Dr. Winograd said.

Questions/Concerns

A committee member questioned Dr. Winograd about reasons for New Mexico's African American population having a higher infant mortality rate. Data on African Americans are minimal, and more information is needed, Dr. Winograd said, yielding to Dr. Jamal Martin from the audience. Dr. Martin is a public health scientist-practitioner who teaches family and community medicine and African studies at UNM. Data are very important, he said. With excess deaths, and smaller populations dying younger and sicker, people need to talk about

inequity and what is fair and unfair, Dr. Martin said. Through this type of econometric data, the state can make better policy decisions in order to improve health quality for people. Ninety-five percent of health care dollars are spent for treatment, while only five percent go toward prevention. Prevention is better than treatment, he said.

Community health workers could be trained in an affordable and timely manner, another member suggested. Perhaps a vacant position in the department could be reclassified as a liaison to work with Dr. Winograd and his team.

Another member asked about the issue of sickle cell anemia and African Americans. Dr. Martin responded that it is important to remember that sickle cell is a trait, not just a disease. There is a group dedicated to sickle cell research funded by the state. The member suggested bringing in a presentation to the committee from that group, the Sickle Cell Council of New Mexico.

Ms. Kaufman-Bell said that enlarged maps from Dr. Winograd's presentation will be given to committee members and are posted on the web site. A committee member reminded others that a documentary, "The House I Live In", about the war on drugs, will be shown in Albuquerque at the KiMo Theatre on August 6, and admission is free and open to the public.

Public Comment

Yolanda Cruz, a health councils and communities coordinator, urged continued partnerships with those who do the data and mapping. Health equity is when everyone has access to conditions, environment and opportunity to maintain good health and living, she said. If people do not have access to healthy food or access to safe places to play and exercise, then they cannot make the choice to live a healthier lifestyle. In advocating for the health councils and working with others, one needs to pay attention to the differences in distribution of health status, she said. The DOH does a great job as a state agency, but it does not have the resources to thoroughly evaluate local areas.

Mr. Hely made an announcement about the *border health* case, noting that the judge had denied the request for a temporary restraining order on the HSD's pay hold. Ms. Mathis said that there are very stringent procedural requirements for obtaining a temporary restraining order and what is necessary to show harm, and the court order was due to a failure to show proof rather than lack of merit.

The committee recessed at 4:52 p.m.

Friday, July 26 — Pueblo of Jemez

Representative Madalena reconvened the meeting at 9:15 a.m. in the Community Resource Center at the Pueblo of Jemez. He introduced Vincent A. Toya, Sr., governor of the Pueblo of Jemez, who welcomed members of the committee and staff and then delivered a prayer.

Governor Toya introduced Maria Clark, CEO of the Pueblo of Jemez's health center and director of the Pueblo of Jemez Health and Human Services. Governor Toya described his pride in the clinic and in the pueblo's control of its own health services, which use Indian Health Service (IHS) programs and is currently negotiating for Department of the Interior programs. The health center offers advanced life support, and it plans to add a fitness center.

Health and Human Services Program, Tour of Jemez Clinic

Following a tour, Ms. Clark told the committee that the Pueblo of Jemez provides services to all Native Americans, but it is also looking to become a provider for non-natives along the service corridor, something that is permitted by the IHS as long as it collects full payment for services. The federal sequester has already cost the IHS \$1.4 million, and funding cuts make it difficult to attract physicians and physical therapists to the area, which is just far enough from Albuquerque to make it hard to access. The clinic includes a dental center with six chairs. Ms. Clark introduced Lisa Mayes, dental clinic coordinator.

Ms. Clark conducted several PowerPoint presentations (see handouts) for the committee. One included a position statement by the tribe regarding its support for permanent legislation to prohibit mandatory enrollment of Native Americans in MCOs. In the past several years, the HSD has sought approval from the Centers for Medicare and Medicaid Services (CMS), through Section 1115 of the federal Social Security Act, to waive the federal law prohibiting mandatory enrollment of Native Americans into MCOs without any ability to opt out. The 1115 waiver request was submitted without tribal consultation, and the CMS asked the HSD to withdraw the waiver application and resubmit it after written notification to the tribes. The waiver was resubmitted without meaningful tribal input. New Mexico tribes demanded and received two different consultations with the CMS, which later upheld Native Americans' right to choose. However, still excluded are Native Americans who qualify for long-term care and are mandated to enroll in an MCO, and the ruling does not prevent the HSD from pursuing additional waivers in the future; hence the need for permanent state legislation that fully values tribal sovereignty. An addendum to the position statement declares that the HSD continues to dismiss the importance of tribal consultation in its actions and publications, with special objection to a new Centennial Care brochure stating that adults can start applying for the new Medicaid expansion category starting January 1, 2014, when, in fact, Medicaid is mandated to start taking applications on October 1, 2013. There are clear outreach and enrollment issues concerning Medicaid expansion, the position paper states, and the HSD is deliberately keeping that information low key, which is troubling.

In February 2013, Representative Madalena introduced House Bill (HB) 376 to amend the Public Assistance Act to remove Native Americans from mandatory enrollment in Medicaid managed care. Members of the committee discussed the fate of HB 376, which, despite widespread support, did not pass, and possible ways to revive it — perhaps this time through the standing House Health, Government and Indian Affairs Committee.

Ms. Clark showed another presentation (see handout) describing the Pueblo of Jemez's senior citizens program, which provides services with the highest priority to those with the greatest economic and social need through a collaborative team approach. Areas of focus are nutrition, physical fitness, information and assistance, health screenings, home services, transportation and assistance with utilities. Ms. Clark also discussed how the pueblo has taken advantage of provisions in the federal Indian Health Care Improvement Act (IHCIA), which allows the IHS, tribes and urban Indian organizations (ITUs) more flexibility to provide many new services.

Ms. Mayes described a tribal home care program at the Pueblo of Jemez that mirrors the developmental disabilities waiver. The pueblo has not yet found a way to get reimbursement, but it is continuing to search for options. One of the features of the new IHCIA is an enhanced insurance claims collection process, whereby long-time nonpayments can be turned over to the United States Treasury, and the Internal Revenue Service will tack on fees and interest, "and we can get paid that way", Ms. Clark said. Many patients have been dropped from collections and no longer get hassled by providers for payments. The IHCIA also allows ITUs to use federal funds to see patients for whom regular insurance would be a financial burden and to pay for Medicare Part B premiums for those who cannot afford it.

Questions/Concerns

After several questions about the senior citizens program at the Pueblo of Jemez, members once again turned their attention to the issue of behavioral health providers. One advisory member recommended that the committee send a letter to the CMS on some of the issues discussed. She said she is not willing just to sit by and watch what is going on with these "hostile takeovers". The HSD seems to be ignoring things, and the behavioral health community is being ignored, she said. Another member said he was just notified that Easter Seals El Mirador had just been decertified and replaced by an Arizona company. "Things are starting to move, and we need to act quickly", he said. Another member asserted that because federal funds are involved, "we need to get our congressional leaders involved". She said she is worried that if the committee does not respond accordingly, it could jeopardize federal funds for clients. There was a consensus that a letter needs to go out, but the chair noted that there was not a quorum of committee members present. After a discussion with staff attorneys, Senator Torracco was appointed a voting member of the committee, and a quorum was announced. A motion to draft the letter was made and passed with no objections.

The need for other letters was discussed by committee members, and a motion was made to send a letter to Secretary Squier asking her to continue payments to providers under a good-cause exception while the AG's investigation is under way. The motion passed with no objections.

Medicaid Centennial Care Enrollment and Outreach

Julie Weinberg, director, Medical Assistance Division, HSD, provided a PowerPoint presentation to the committee (see handout). In February, the HSD signed contracts with the four Centennial Care MCOs: Blue Cross Blue Shield of New Mexico, Molina Health Care of New

Mexico, Presbyterian Health Plan and United Health Care Community Plan of New Mexico. These entities are undergoing readiness reviews and must "go live" on January 1, 2014. All Medicaid recipients will have from October 15 to December 1, 2013 to select their MCOs, Ms. Weinberg said. Recipients who are required to be in Centennial Care but who do not select an MCO will be assigned to an MCO. There will be a 90-day period, beginning January 1, to select a different MCO. Native American recipients are not required to be in Centennial Care but can choose to enroll, except for those who meet nursing home level of care or have both Medicare and Medicaid and are required to be in Centennial Care.

Ms. Weinberg described educational events beginning the second week in August. Advertising spots on radio and TV started running in mid-July in three waves: 1) what is Centennial Care?; 2) find out about events in your area; and 3) the time is now to make the choice about your care. These events will also include information about adult Medicaid expansion, eligibility requirements and where to apply, she said. Expansion eligibility begins on January 1, and people can apply online through YES-NM or at an integrated service delivery office, although people can choose to apply earlier, beginning October 1, she said. If applying in October, the applicant will receive a letter notifying the applicant of eligibility approval effective January 1. If the applicant does not qualify, a letter will be sent notifying the applicant of the denial and informing the person that the application was sent to the exchange for evaluation.

Questions/Concerns

Ms. Weinberg was asked about the ability of a particular MCO to provide services across the state. She said that her division is looking very closely at that, and if it is not comfortable, the entities will not be allowed to go live. They have been submitting their networks since May. MCOs have to provide directories to let participants know which doctors are in their networks, she said. The division is paying particular attention to behavioral health, as a number of MCOs have not previously been responsible for delivery of long-term or behavioral health care services, Ms. Weinberg said. The goal of Centennial Care is to combine mental and physical health services. "We want the health care delivery to consider the whole person", she said.

Asked if MCOs are approaching any of the New Mexico providers or if they are talking to the Arizona teams, Ms. Weinberg said the MCOs are holding off for the next few weeks before approaching anyone. The new contracts will have language that agencies are obligated to identify overpayments and can try to collect them, and they will have one year to identify overpayments and 15 months from the date of service to collect, she said.

Responding to criticism that the HSD has not been aggressive in outreach about Medicaid expansion, Ms. Weinberg said that the approach is going to be through education about Centennial Care and the process for enrollment. It is not going to be an aggressive outreach effort, she said, but there will be people to sign up individuals. A member asked Ms. Weinberg about the \$75,000 to \$80,000 budget for outreach. She said it was mostly spent on broadcasters. "These people pictured in the brochure don't look like New Mexicans", one member observed. "There's nothing in the brochure about working with community organizations."

Another member asked Ms. Weinberg what is going to happen with behavioral health care as it exists. Will the MCOs take over before Centennial Care is active? Ms. Weinberg said that, in general, the MCO contracts with an agency, not with the clinicians directly; the clinicians contract with the agency.

A member asked about educational sessions around the state and whether a person can apply at those sessions. There will be a presumptive eligibility person at the meetings, Ms. Weinberg said. Applications cannot be submitted until October 1 because the system will not be ready to process them. The member responded, "I really hope we are not at an impasse and that we can move toward eligibility representation. I think it is important that we implement this no-wrong-door as robustly as possible."

Ms. Weinberg provided a contact number for administrative staff: (505) 827-3106.

Health Coverage Enrollment and Outreach Roundtable

Cathleen Willging, senior scientist, Behavioral Health Research Center of the Southwest (BHRCS), began the roundtable discussion with a PowerPoint presentation (see handout). She said that the PPACA intends to maximize coverage for individuals through job-based coverage, the exchange, Medicaid and Medicare, with a welcome-mat effect; people currently eligible are finally able to access those services. Her organization has 13 members and produces a wide variety of briefs, written clearly and without jargon, highlighting research findings, presenting basic facts on timely topics and offering policy options, she said. The BHRCS has been focusing particularly on issues relating to health care, immigration and labor. The purpose of the day's roundtable was to discuss how the PPACA and expansion of Medicaid will result in improved access to health care and better health for New Mexicans. Under federal law, there must be a unified application for Medicaid and the NMHIX that is streamlined and paperless so that people can apply for Medicaid and be sent to the exchange.

Ms. Hager spoke of the importance of outreach efforts. The law requires outreach to vulnerable and underserved populations, she said, adding that while the HSD has hired additional caseworkers, there has been no outreach about Medicaid expansion. The law requires a consumer assistance program to do outreach and provide application assistance, or "guides", she said. These are navigators, in-person assisters and certified application counselors. They must be trained in Medicaid and exchange eligibility, give fair and impartial information about health plans and Medicaid, be culturally and linguistically competent and have knowledge about the needs of the community. In New Mexico, the exchange currently has no plans to do Medicaid outreach or enrollment assistance, Ms. Hager said. Challenges in outreach and assistance in New Mexico include multiple languages, different community needs and disproportionately rural populations, Ms. Hager said. While almost everyone is concerned about affordability, surveys show that about 80 percent of New Mexico say they do not know anything about the new coverage options.

Erik Lujan, policy analyst with the New Mexico Indian Council on Aging, spoke about ensuring outreach to Native American populations. There is a unique relationship between federal and tribal governments, he said, and tribal members have a unique legal and political status based on citizenship, not race. Native Americans are exempt from requirements to acquire health insurance coverage and from cost-sharing, regardless of income, when enrolled in an exchange plan and services are received at an IHS or Tribal 638 program. Tribes can pay premiums for qualified individuals subject to terms and conditions of the exchange. Indian tribes, tribal organizations and ITUs may apply for navigator grants, provided that they meet the eligibility requirements. Funding for outreach and education comes from the Native American Community Service Center and from the Level One establishment grant.

Gabriel Sanchez, Ph.D., interim director of Robert Wood Johnson Foundation Center for Health Policy at UNM and director of Research for Latino Decisions, described a research project with Latinos in Colorado (see handout) conducted with no screen for citizenship or voter registration and in Spanish or English, at the subject's discretion. Its purpose was to discover Latinos' knowledge of the PPACA and best practices for outreach. Approximately 52 percent reported being at least somewhat informed, and 47 percent said they were not informed. Hospitals and doctors were the most trusted source of information about the PPACA. The survey indicated that 24 percent of respondents did not have any insurance coverage at all. Dr. Sanchez said the survey concluded that information about the PPACA is very low, but desire is high. Latinos reported that costs of health care are creating significant burdens on their families. The federal government and the state need to improve and increase outreach about the PPACA among Latinos, he said.

Questions/Concerns

Ms. Willging was asked by a committee member if there are any indications that there will be improvement in the state's system. She is concerned that current providers already suffer capacity issues and have not come up with strategies to absorb expansion of the insured base. If anything, there may be a reduction in capacity in terms of behavioral and mental health providers, Ms. Willging said. Primary care is an important portal, but there is a need to build capacity in the primary care arena to improve recognition and understanding of mental health issues, Ms. Willging said.

2012 Senate Memorial 57 Working Group Report on Chronic Obstructive Pulmonary Disease (COPD)

Susan Baum, M.D., M.P.H., medical director and epidemiologist, Chronic Disease Prevention and Control Bureau, DOH, described COPD as an incurable lung disease that makes it increasingly difficult to breathe over time. It was the fourth-leading cause of death in New Mexico in 2011, and cigarette smoke is the most common cause, accounting for nine out of 10 deaths. The 15 percent of COPD sufferers are people who never smoked but were exposed to workplace or secondhand smoke or to other air pollutants.

The working group had access to the most up-to-date data on the burden of COPD in New Mexico, and it reviewed results of recent COPD research conducted on a group of current and former New Mexico smokers, according to Dr. Baum (see handout).

Laura Tomedi, Ph.D., M.P.H., said that COPD has three major burden components in New Mexico: prevalence, mortality and hospitalization. Information from 2011 indicates that 97,000 people were diagnosed, and that the undiagnosed could run as high as 200,000. Risk of developing COPD increases with age, and there is a jump after age 45, when smokers start to experience lung decline. White New Mexicans have a higher risk, as do women, though this may be, in part, because they are more likely to access health care and be diagnosed, Dr. Tomedi said.

Dr. Baum referred members to the report's recommendations of effective strategies for prevention, including preventing smoking initiation, promoting smoking cessation and preventing environmental and occupational exposures that can cause or worsen COPD. Best practices for diagnosis and management of COPD include promoting smoking cessation in patients with COPD, using the most recent clinical practice guidelines in *Diagnosis and Management of Stable COPD* and adopting the most recent U.S. Preventative Services Task Force recommendations in *Screening for COPD Using Spirometry* (see page 5 of the handout). Recommendations also include increasing public awareness about COPD via a media campaign.

Questions/Concerns

In response to a question about electronic cigarettes, Dr. Baum said there is no evidence to support that e-cigarettes are less harmful. They are not approved by the federal Food and Drug Administration as a smoking cessation product, she said, but there are many products available that can triple the chance of quitting.

Dr. Tomedi pointed out that New Mexico has a grade of "F" for tobacco control advertising and funding, a "C" for tobacco tax and a "C" for cessation.

A member noted that there is a high rate of asthma at the Pueblo of Jemez and asked Dr. Baum if she could comment on what might be the reason. Asthma is a common condition, Dr. Baum said, and falls into the same category as COPD. It is complex and might be related to many things. Any particulate matter in the atmosphere for anyone with asthma or COPD can irritate that person, including dust.

Public Comment

Esperanza Dodge told committee members that she supports "no-wrong-door" access with Medicaid. She said she is scared, as her Medicaid ends in December, and she only knows about the expansion because she works at Young Women United. "Even with a master's degree, I am still confused, and most New Mexicans don't show up to events, and the jargon is difficult to understand", she said. "Let's be active and put people at ease by letting them know they can apply on October 1 instead of waiting until January 1, when there will be lots of applications", she added.

Monica Truvia said she also is involved with Young Women United, and Medicaid is important to her as a single mother, and she wants it to be easy to understand and apply for.

Christian Redbird said that people with busy lives do not have the time or the money to get help in applying. She is currently uninsured but would like to find out whether she would qualify.

Rebecca Andelasi with Kiwa Health Cooperative said that MCOs should be held accountable and be mindful that tribes do not have contracts with MCOs for reimbursement. "We ask that we can talk and be part of implementation", she said.

Evelyn Blanchard urged the committee to support passage of SB 376. Managed care does not fit well with Native American circumstances and the ways in which these people can access care, she said. Each tribe has its own way of looking at the world, and forcing it to do managed care impedes its ability to do what it needs to do.

Maureen Wakondo said she would like to see the exchange do more outreach.

Susan Loubet with New Mexico Women's Agenda commented on a joint memorial to continue the Family-Friendly Workplace Task Force that did not pass last year, and she would like a letter from the committee indicating that it would like to hear from this task force. A member made a motion to do this, and the motion passed with no objections.

Adjourn

The committee adjourned at 5:56 p.m.

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

September 4-5, 2013
Barbara Hubbard Room, New Mexico State University
1810 E. University, Building 284
Las Cruces

September 6, 2013
Skeen Library, New Mexico Institute of Mining and Technology
Socorro

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at 9:10 a.m. on Wednesday, September 4, 2013, in the Barbara Hubbard Room at New Mexico State University (NMSU) in Las Cruces.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan (9/4, 9/5)
Sen. Mark Moores
Sen. Benny Shendo, Jr. (9/4, 9/5)

Absent

Advisory Members

Rep. Phillip M. Archuleta (9/4, 9/5)
Sen. Sue Wilson Beffort (9/4, 9/5)
Sen. Craig W. Brandt
Rep. Nathan "Nate" Cote (9/4, 9/6)
Rep. Miguel P. Garcia
Rep. Sandra D. Jeff
Sen. Linda M. Lopez (9/6)
Sen. Cisco McSorley
Sen. Bill B. O'Neill (9/5)
Rep. Paul A. Pacheco (9/6)
Sen. Mary Kay Papen (9/4, 9/5)
Sen. Nancy Rodriguez (9/6)
Sen. Sander Rue (9/6)
Rep. Edward C. Sandoval

Sen. Jacob R. Candalaria
Sen. Daniel A. Ivey-Soto
Sen. Lisa A. Torracco

Sen. William P. Soules (9/4, 9/5)
Rep. Elizabeth "Liz" Thomson

Guest Legislator

Sen. Howie C. Morales (9/6)

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Branden Ibarra, Intern, LCS
Nancy Ellis, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Wednesday, September 4 — NMSU

Welcome to NMSU

Following committee and staff introductions, Garrey Carruthers, president of NMSU and former governor of New Mexico, welcomed committee members and guests to Las Cruces. Governor Carruthers humorously described his institution as "The Yale of the Yuccas". "This is a great university", he said, mentioning NMSU programs in agriculture, the sciences and public health, among others. There should be a three-tier formula for funding of higher education in New Mexico, Governor Carruthers said: one for science universities; one for comprehensive universities; and one for technical training universities. The University of New Mexico (UNM) and NMSU are collaborating on a public health initiative addressing drug use, alcoholism and obesity in the state. Last year, NMSU received a one-time matching fund endowment of \$20 million from the legislature. Governor Carruthers stated his intention to ask for another one-time \$20 million appropriation that he is certain NMSU has the ability to match.

NMSU Doctor of Nurse Practitioner Program

Dr. Pamela Schultz, Ph.D., School of Nursing, NMSU, told committee members that in response to new requirements that nurse practitioners have doctoral degrees in order become certified, NMSU has made changes to the master's degree in nursing curriculum. For practitioners already certified, there is a master's-to-doctorate track, and new students will be on a bachelor's-to-doctoral track, Dr. Schultz said. There are over 200 programs like NMSU's throughout the country, with many more poised to begin. In response to a question from a

committee member, Dr. Schultz said that while there is some grandfathering of current providers, it will take time for the work force to accept these new changes. In the long term, these practitioners will deliver better care, she said. Another committee member asked about the increased time and costs associated with attaining a doctorate. The committee member was concerned that the requirement of a doctoral degree flies in the face of efforts to expand the health care work force. Dr. Schultz replied that NMSU is still admitting approximately the same number of students at the baccalaureate level. "We've all heard of the nursing shortage", she said, and the greatest shortage is among those who are qualified to teach, i.e., those with a doctorate. Asked by another member if the School of Nursing needs additional resources from the legislature, Dr. Schultz said that the school cannot admit all who are qualified for the doctoral program, thus additional funding could help increase those numbers.

Minutes Adopted

A motion was made to adopt the minutes of the July 1-3, 2013 meeting held in Albuquerque and Rio Rancho. The motion passed without objections.

Child Abuse Prevention Panel

Shelly A. Bucher, L.M.S.W., and Esther Devall, Ph.D., certified family life educator, Family and Consumer Sciences Department, College of Agriculture, NMSU, provided a PowerPoint presentation to the committee entitled "Prevention of Child Maltreatment" (see handout).

Child maltreatment is defined as any act of commission or omission by a parent or other caregiver that results in harm, potential for harm or threat of harm to a child, Ms. Bucher said. Acts of commission include physical, sexual or mental abuse. Acts of omission include physical, emotional, medical or educational neglect; failure to supervise; and exposure to violent environments. Child maltreatment is a huge public health issue, Ms. Bucher said, citing 2008 figures from the Centers for Disease Control and Prevention indicating a \$124 billion impact for that year alone. The long-term effects of child maltreatment include smaller brains, learning disorders, juvenile delinquency, suicide, higher rates of sexually transmitted diseases and alcohol and drug abuse. In New Mexico, the average reported incidence of child maltreatment is 12 per 1,000 children, she said, which is higher than the national average of 9.9 per 1,000 children. Under New Mexico law, every person is mandated to report child maltreatment, Ms. Bucher said.

Dr. Devall described risk factors for child maltreatment: poverty, young maternal age, single-parent status, isolation, substance abuse, depression and lack of understanding of child development. Prevention is far more effective and less costly than treatment and involves education and family support, especially for families with risk factors for child maltreatment. Media campaigns increase public awareness, and parent education, nurse home visits and parent support groups are effective ways to combat child maltreatment.

NMSU is the southwest regional site of the National Child Protection Training Center, Dr. Devall said. Through training, education, awareness, prevention and advocacy, the center

serves child-focused professionals working in New Mexico, Arizona, West Texas and Southern California and students whose careers will bring them into contact with children. State-of-the-art training and education help prepare current and future professionals to more effectively intervene in cases of child abuse and neglect (see handout). The training center provides evidence-based training and technical assistance to prosecutors, law enforcement officers, child protection workers, therapists, advocates and others who work with children. Also through the training center, child advocacy studies (CAST) is being offered at NMSU to students majoring in disciplines that will involve interaction with children. NMSU's CAST is one of only two programs in the western United States, providing an 18-hour interdisciplinary undergraduate minor in family and child welfare policy.

Dr. Devall urged legislators to restore funding of \$1 million for intensive, evidence-based parenting classes. "I'm tired of New Mexico being last in everything", she said. "I want New Mexico to be first."

Jared Rounsville, director of the Protective Services Division (PSD) of the Children, Youth and Families Department (CYFD), told committee members that child abuse presents complex and challenging issues. The PSD responds to 16,000 to 18,000 reports annually. One thousand eight hundred children are in foster care in the state. Mr. Rounsville described several current division initiatives, including a media campaign to educate parents about not leaving their child in a hot car and ongoing development of a short code (#SAFE) to connect to a phone line, staffed 24 hours per day, seven days per week, for immediate reporting of suspected child maltreatment.

Yolanda Berumen-Deines, secretary of children, youth and families, said that child abuse is generational and multilayered and includes many risk factors. Destructive experiences impact the developing child's brain, increasing risks for emotional, behavioral, academic, social and physical problems throughout life, Secretary Berumen-Deines said, and she referred to extensive research conducted by psychiatrist Dr. Bruce Perry, an international authority on children in crisis. The CYFD is very supportive of family wellness education, she said. Being aware of the issues, parents and child care providers can be trained on how to interact with the child to heal those damaged connections, Secretary Berumen-Deines said.

Questions/Concerns

A committee member expressed the opinion that foster parents have the hardest job in the state and that the CYFD must continue to support them and expand foster parent training. Secretary Berumen-Deines said that the agency has initiated mandatory statewide training of foster parents based on a neurosequential model of therapeutics developed by Dr. Perry. She said that there has been a "culture change" within the CYFD in the past several years and that it is becoming more decentralized and is utilizing teams in each office.

Another member asked if calls reporting abuse are accepted anonymously. Mr. Rounsville responded that anonymous calls have always been accepted, but the agency prefers to

be able to identify the caller if there is a need for follow-up. A member told Secretary Berumen-Deines that she has received calls from several adoptive parents regarding the need for services in their area, and there are none. They need to be supported, the member said. Other concerns addressed by committee members included the efficacy of the statewide citizen review boards, which are charged with providing monthly monitoring of CYFD cases, and warnings about the increase in the use of multiple psychotropic drugs in children.

The high vacancy rate of child protective service workers — as many as 150 positions, or 15 percent — is of great concern to another committee member. He asked if there have been any steps taken to try to fill these positions. Recruiting is the challenge, Secretary Berumen-Deines responded. The agency has been working with NMSU and UNM to encourage social work students to consider joining the PSD, which also is seeking approval for salary adjustments in order to pay more to recruit these positions. The challenge in frontier areas has been to get qualified persons on board who will actually stay, she said.

Accelerated licensing of new agencies recruited from Arizona concerned another member, who is a licensed New Mexico provider herself. Why not put New Mexico practitioners on the fast track for licensing, as well?, she asked Secretary Berumen-Deines. Normally, this is at least a 120-day process. The subject of increased penalties for abusers was brought up by another member, who noted that Secretary Berumen-Deines had spoken in favor of that. In certain areas where the actions of a person permanently impair, or result in the murder of, a child, there is a basis for greater punishment, Secretary Berumen-Deines said. Certain individuals no longer take responsibility for their behavior or for the consequences, she said, and a higher consequence is appropriate for some conduct.

There was extended discussion among committee members of reporting protocol and requirements for suspected child maltreatment, which also is the subject of a proposed series of programs at the National Child Protection Training Center at NMSU.

Home visitation of low-income, first-time mothers — 70 percent in New Mexico are on Medicaid — was not supported by the CYFD to be a reimbursed service, another member noted, and why not? Secretary Berumen-Deines said she would be willing to discuss this further, but she would rather argue for extended assessments for trauma than for home visits.

Vincente Vargas of the Cooperative Extension Service at NMSU told committee members of a current \$394,000 request from the extension service for funding of rural health programs, including several for child protection and family wellness.

Public Comment

Tina Olson, executive director of New Mexico's Citizens Commission on Human Rights, urged committee members to examine the overuse of psychotropic drugs in children. Many of the increasing numbers of children diagnosed with attention deficit hyperactivity disorder (ADHD) are exhibiting nothing more than normal behavior, she said. In New Mexico, children

as young as three years are being put on strong drugs "for mental disorders". Children are the future of New Mexico, Ms. Olson said, and public outlets are needed to educate residents on the dangers of these drugs.

Dr. Jody Kinkaid, a practicing naturopath and former holistic veterinarian, told committee members that maternal nutrition is very important. In veterinary medicine, an animal missing even one meal post-birth can result in brain damage, he said. Conventional medicine treats the human brain with medication, Dr. Kinkaid said, whereas the real problem is the failure to recognize mind-body-spirit connections. Drugs depress cognitive function, and parents need to be informed of all side effects of psychotropic drugs and should not be coerced to medicate their children.

Tour

Committee members and LCS staff departed in NMSU vans to tour the Reduced-Gravity and Biomechanics Lab, with a presentation by Ou Ma, Ph.D., P.E., College of Engineering, and Robert Wood, Ph.D., professor and academic head of human performance in the Dance and Recreation Department at NMSU.

Lunch was provided by the university, and a presentation by faculty from the College of Engineering followed. Speakers were introduced by Ricardo Jacques, dean of the college, and included Anthony Hyde, Ph.D., director of the Manufacturing Technology and Engineering Center, Patricia Sullivan, assistant dean of the college, and Cynthia Bejarano, Ph.D., director of the College of Arts and Sciences at NMSU.

Concerns Regarding Children and Psychotropic Medications — Senate Joint Memorial 44

Tony Stanton, M.D., has spent many years teaching psychiatry and working in a program with developmentally disabled children. Dr. Stanton said it became very clear to him that he was being asked to medicate children for behavioral problems. "I came away with two questions: What has happened to this child up to this point, and who can we identify who could be helpful to this child?"

Fred Baughman, Jr., M.D., a psychiatrist and child neurologist, described the history of ADHD, beginning in the 1970s, as one driven by drug companies with a profit motive. In early advertising, the phrase "may be caused by chemical imbalance" was used, and that was the start of the chemical imbalance theory. Heavy marketing reinforced the theory, Dr. Baughman said, and over time, chemical imbalance became accepted as fact. "There is no such disease", he said. It is a total fraud, he said, and it has never been validated as a cause of ADHD, whose treatment almost always includes medication.

Dr. Baughman cited a 1988 National Institutes of Health review of 13 brain scans of children who had been on long-term treatment with amphetamines (including Ritalin and Adderall), which showed a 10 percent brain shrinkage. Upon this basis, it was concluded that ADHD was a disease. In 2003, it was determined that the shrinkage noted in the brain scans was

due to amphetamine exposure, he said. Many providers today believe that chemical imbalance is the cause of many disorders, and they resort to drugs for treatment.

The frequency of strokes and sudden cardiac deaths caused Canada's equivalent to the federal Food and Drug Administration to ban Adderall, but the U.S. military continues to put soldiers on antipsychotic drugs, and they are dying in bed, Dr. Baughman said. Antipsychotics more than double the rate of sudden cardiac deaths, he said, and their long-term effects on children have never been studied. In the U.S. today, between seven and 10 million entirely normal children have been put on these dangerous drugs — which are, essentially, "speed", he said.

Dr. Baughman also spoke of the almost universal lack of fully informed patient consent from parents for the use of these drugs in children. In the foster care system, 50 percent to 75 percent of children are on psychotropic drugs, he said, and sometimes in unconscionable combinations. Each label, each drug, says to the child, "I am not normal".

Questions/Concerns

One committee member said she had personal experience with being pressured to start a child on drugs. "When you are being told your child has ADHD, they don't even talk to you about behavior modification", she said. Dr. Baughman reiterated his opinion that emotional or behavioral problems do not constitute a disease. Asked by another committee member if migraine headaches is a disease, Dr. Baughman responded that there are scientific studies using scans where blood-flow images and other physical markers demonstrate this physical condition. A member asked whether lower back pain is a disease. Dr. Baughman said that it is not a disease per se, it is a symptom of a condition. When asked whether autism is a disease, Dr. Baughman responded that "autism" is an indefinite term, not a specific disease. It describes a pattern of behavior. The member expressed disagreement with Dr. Baughman's opinions.

Psychiatry has spread the chemical imbalance theory, Dr. Baughman said, and psychiatrists are violating informed consent when they drug children by suggesting that there is brain disease. Asked by a member if he felt consent should be written, Dr. Baughman said yes. Dr. Stanton added his opinion that psychiatry has been led down the path to evaluate symptoms, but he feels it is crucial to look at the entire life of the child.

Another committee member told Dr. Baughman that, having heard the testimony, he felt there is great disagreement, and it is inaccurate to paint all psychotropics for all ages with such a broad brush.

Local Efforts to Examine Pediatric Psychotropic Prescribing

George Davis, M.D., director of psychiatry at the CYFD, said he was going to segue the conversation to his own area of interest: trauma (see handout). Dr. Davis said he agrees with a committee member's comment that often trauma is being treated with psychotropics. There is a higher use of these drugs in the Medicaid population, and higher yet (13 percent to 45 percent) in

children in foster care, he said. Their use is higher among males (19.6 percent) than females (7.7 percent). Since psychotropic use increases dramatically in foster care, it is clear that the drugs are being used to medicate environmental stressors, poor attachment and neglect/abuse issues, Dr. Davis said. Pressure to "simply prescribe" comes from managed care, limited time and resources, ease of maintenance and to reduce dangers to self and others.

There are side effects for psychotropic drug use, Dr. Davis told the committee, including sedation, agitation and gastrointestinal and metabolic disturbances, and their use implies misdiagnosis and indicates a lack of alternative therapeutic services. It also pushes a system toward warehousing, he said, and sets a low standard where the primary aim is sedation or deescalation.

In 2011, Congress passed the Child and Family Services Improvement and Innovation Act, which requires states applying for federal child welfare grants to establish protocols for appropriate use and monitoring of psychotropic medication in foster children, Dr. Davis said. New Mexico has begun work on its own plan, including development of "red flag criteria" — children age five years and under on any psychotropics, children on five or more psychotropics and children on two or more psychotropics from the same class (see chart in handout). Monitoring was mandated in the state's contract with OptumHealth, and letters of concern were sent to some prescribers. The new contract with Centennial Care will result in improved data collection and direct review by the CYFD and UNM child psychiatrists, he said.

David Mullen, M.D., medical director, Child Psychiatric Hospital, UNM Hospital, said psychotropic treatment sometimes has unacceptable side effects, and the effects of long-term use are not known. Children who present with serious problems — hyperactivity, profound depression, etc. — deserve some help, and those are reasons to use medications. But, he said, there definitely is overuse, and the profession is not speaking about it with one voice. Dr. Mullen teaches multifold intervention, and psychotherapy may be first, he said. "There is pressure on our profession to prescribe and undue pharmaceutical influence in what we do."

Careful interviews of all parties, including caretakers, are necessary before prescribing medication to children, Dr. Mullen said, in order to consider possible medical problems and establish an indication of why prescribing is the best benefit. Dr. Mullen prefers the lightest possible touch, starting low (in dosage), going slowly and continuing to monitor the child.

Questions/Concerns

Several members asked if there should be tracking in the prescription drug database or requirements of a prescriber before the prescriber writes a prescription for a child. A member asked what methods California and Texas used to reduce psychotropic prescribing. Dr. Mullen said he will send the committee information about efforts in those states. Another member asked if written consents would help. Dr. Davis said yes, and Dr. Mullen agreed that it is reasonable, but he was uncertain about its impact. Dr. Davis said that written consents should advise of other alternatives to psychotropic drug use, such as counseling or therapy. Further discussion on

methods of prescription data mining prompted a member to say he is considering introducing a memorial at the next legislative session.

Another member commented on "more than four" drugs being prescribed concurrently to a child. "Isn't this over the top?", he asked. Dr. Davis said if he sees a child on an antipsychotic, a depressant, a stimulant and something for sleep, this profile always means that the child has been abused. When a committee member asked who is doing the prescribing, Dr. Davis said that national data indicate most of the prescribing is being done by pediatricians.

The committee recessed at 5:40 p.m.

Thursday, September 5 — NMSU

The meeting reconvened at 9:15 a.m. Representative Madalena announced a change in the agenda: continuing care communities, scheduled for 10:30 a.m., was canceled.

Prescription Drug Pricing

In a presentation about extreme drug price fluctuations (see handout), Dale Tinker, executive director of the New Mexico Pharmacists Association, first described to committee members a series of groups that are behind every pharmacist/patient transaction. Pharmacy benefit managers (PBMs) are the contractors between pharmacies and insurance providers, with cost containment as a basic component. PBMs set the price that pharmacies will be reimbursed for dispensing prescriptions. This payment includes the cost of the medication plus a dispensing fee. Insurance programs use a tool called the maximum allowable cost (MAC) pricing to control costs of generic medications. PBMs find the cheapest generic drug to establish a MAC price, but they do not disclose the name of the drug or where it can be found. It may not be available locally or from that particular pharmacy's wholesale supplier. But the biggest problem, Mr. Tinker said, is that manufacturer price increases can be dramatic and frequent, and the jump may not be reflected in MAC pricing for several weeks. When prices increase but reimbursement does not, the pharmacy suffers the loss.

PBMs are not licensed in New Mexico, Mr. Tinker said, and while some of the very large ones are well known, there often are mergers, and many smaller ones are unknown. PBM contracts are complex legal documents, he said, and the pharmacy is in violation of its contract if it does not accept the established reimbursement, even when it is below cost. PBMs do not disclose the cost basis of their MAC pricing, do not respond to price fluctuations and do not allow a mechanism to address pricing disputes in a timely manner, he said. Six states have passed legislation to regulate PBMs. On behalf of the pharmacist members of his organization, Mr. Tinker asked legislators to craft a bill requiring licensing of PBMs through the Office of Superintendent of Insurance.

Ken Corazza, owner of Medicine Chest Pharmacy in Albuquerque and chair of the New Mexico Poison Control Board, brought copies of receipts for committee members to see as

examples of enormous jumps in the costs of generic drugs — some as much as a 3,000 percent increase from his last order. "This is almost unbelievable", Mr. Corazza exclaimed. "It is pure greed." When the patient comes to fill a prescription, that price jump becomes a big problem at the counter, he said. Sometimes, the patient just walks away, deciding not to take the drugs. This is not a sporadic hit-and-miss process, he said, but rather it appears to be a conspiracy. Often, all companies that make a particular drug have the same kind of price increase at the same time. Some of these drugs have been on the market for 20 years; they are not new or recently developed. These price spikes are not just in New Mexico but are nationwide, Mr. Corazza said, and he described himself as a pharmacist making a 911 call for everyone to be mindful of what is happening.

Jason Parrish, Pharm.D., director of retail pricing for Express Scripts, said that MAC price lists are developed by each individual payer. There has not been much price fluctuation recently in brand products, he said, but fluctuations in generics have been wide-ranging, impacted by daily changes in the marketplace. "We are in the same boat when the prices come out, we're facing the same challenges", he said. In an effort to help limit unfavorable impacts on pharmacies, Express Scripts has set up an online appeal process for pharmacies.

David Root is director of state government affairs for Prime Therapeutics, a PBM that is owned by Blue Cross Blue Shield of New Mexico. Prime Therapeutics administers benefits for New Mexico's Medicaid clients, and, Mr. Root said, it has saved \$5 billion for the state. PBMs are not manufacturers, Mr. Root explained, and do not make drugs or set wholesale or retail prices. Prime Therapeutics uses three national wholesale compendiums to generate its MAC list. Tinkering with MAC pricing in New Mexico will have an impact on the payers, he warned, including Medicaid, employers and whoever else offers benefits. Prime Therapeutics has set up an appeals process and provides a manual so the pharmacist understands the mechanism for appeal, he said. Pharmacists do not make a profit on every drug they sell; the MAC is like a basket of different drugs that hopefully will generate a fair return for pharmacies overall. "We are the adjudicators of the process, but we do not set up or design that program for public and private payers." Prime Therapeutics' goal is to maximize health care dollars, Mr. Root said. "We do not want to drive pharmacies out of business."

Questions/Concerns

A committee member stated that the member was "more confused now than I've ever been" by the panel's testimony. "How does a drug go from \$30.00 one month to \$750 the next?" Generic drugs are therapeutically equivalent to brand name drugs, Mr. Root said. Price increases of older generic drugs may be because there are not a lot of manufacturers producing them, or because the generic drug actually has become the only one on the market — an "orphan" drug. This is the way the marketplace works, he said. "How do we justify these huge increases? We do not", Mr. Root said. "It is not justified, and we have to buy at those prices, too, but the PBMs have nothing to do with this."

There are laws in other states that require that if a drug price goes up, it has to be updated in the MAC pricing within seven to 10 days, said Mr. Corazza. The Medical Assistance Division of the Human Services Department (HSD) really needs to look into what is happening, because, in his opinion, it is absolute greed on the part of the manufacturers, and it is going to impact the Medicaid budget.

"I'm a little concerned that we need to have a third party at the table — the manufacturers", said another member. Mr. Hely confirmed that he had invited representatives from the Generic Pharmaceutical Association to attend today's meeting but had received no response.

In a proposal to regulate PBMs, manufacturers are not being addressed, a committee member noted. "You are right", said Mr. Tinker. Nonetheless, it is time to set up a platform where pharmacies — most of which operate on a two to three percent margin — can be properly reimbursed. "How to solve the problem of greed, I don't know", said Mr. Tinker. This is not a market-based industry, observed another member. What if we eliminated the middleman? The burden then would be on the insurance industry; right now, it is insulated. Another member asked why Walgreens and CVS are not complaining. They are just as concerned, Mr. Tinker said, but because they warehouse inventory, it can be weeks before they are impacted by price spikes.

Members also discussed the public safety impacts on patients who cannot afford their co-pays and walk away without their prescriptions or self-medicate with other drugs.

"What happens when a physician is denied a prescription?", another member asked. Mr. Tinker explained that the payer has a benefit design, a formulary or authorization requirement, and, in those instances, the PBM is the messenger that tells the pharmacist that the prescription is denied. Plans may adjudicate their own appeals or have a separate entity that adjudicates appeals. If the physician is e-prescribing, he or she may find out immediately while the patient is still in the office that there has been a denial of the chosen drug.

A member asked Senator Ortiz y Pino about the fate of last year's Senate Bill (SB) 360. It passed all senate committees, Senator Ortiz y Pino said, but never had a hearing in the house. It got put aside because the New Mexico Health Insurance Exchange was a priority. Last year, the Insurance Division of the Public Regulation Commission received many consumer complaints on drug price increases, and major PBMs and the New Mexico Pharmacists Association worked collaboratively on this, he said. Asked if SB 360 should be resurrected, Senator Ortiz y Pino said that it might not address MAC pricing concerns. Licensing PBMs and requiring similar procedures for uniform MAC repricing that would apply for all PBMs would help address the problem, he said, and, with industry support, he would be willing to sponsor this.

Public Comment

Dr. Terry Meyer stated that he had come to ask support of the physician aid-in-dying lawsuit in New Mexico that will go to trial in December. Compassionate Choices is supporting the physicians and patients. It was noted that this will be on the committee's agenda in Hobbs in October.

Bob Hearn, with Tierra del Sol, said he is trying to assist families who have emergency needs from flooding and fires. There has been emergency response, he said, but nothing to help meet the needs of folks in recovery after flooding. They need food and transportation, as their lives have been disrupted, but they are not in immediate danger and so they do not meet requirements for continuing aid. Catholic Charities is helping to move trailers, and any other assistance would be appreciated.

Josafina Mata, executive director of Contigo Campesino, an organization focused on community need in volunteer respite care, is a resident of Dona Ana County. She said she is here to support dental therapists and dental programs that address health disparities in rural areas.

Sandra Gonzales-White, a volunteer community health worker, said she came to express her support for dental therapists. Cost of dental care is high, and there is lack of access to dentists in rural areas, she said.

Kay Lilley, regional director of Progressive Residential Services in Dona Ana County, and Anna Otero-Hatanaka, executive director, Association of Developmental Disabilities Community Providers, said they wanted to share with the committee some of the changes with the developmental disabilities services and supports home- and community-based Medicaid waiver ("DD waiver"). In 2011, there was a five percent cut to providers and additional cuts for services, they explained, and this put DD waiver providers in the position of cutting both administrative and direct care staff. In May, rates and services were cut again. Now, agencies cannot pay enough to retain staff, and providers have been serving some clients for at least a year without getting paid. Despite inquiry, the providers have no idea why they have not been paid. After a 42 percent rate cut, many employment services have been discontinued. Ms. Lilley and Ms. Otero-Hatanaka are asking for support from the committee for positive changes in the DD waiver program.

Dental Therapy

Pamela Blackwell, J.D., project director for oral health access for Health Action New Mexico, a statewide health care consumer advocacy organization, said that New Mexico ranks thirty-ninth in the U.S. for the number of dentists per 1,000 population. Thirty-four percent of third graders have dental decay, she said, and very few dentists in New Mexico accept Medicaid. Poor oral health leads to absence from school and work and causes other health problems.

Ms. Blackwell is recommending the use of dental therapists, working as part of a team with a dentist, as a sustainable model in New Mexico that is cost-effective. This is a career and

job opportunity for rural and tribal areas, where the need is greatest, she said. The federal Patient Protection and Affordable Care Act (PPACA) prohibits states from having dental therapists unless the state allows this scope of practice. In 2011 and 2013, legislation was introduced in New Mexico with broad statewide support, but it did not pass. Legislation needs to include a career pathway for dental hygienists and needs to determine how to resolve the tribal sovereignty issue. This crisis will only get worse, Ms. Blackwell said. It requires action and a solution.

Frank A. Catalanotto, D.M.D., professor and chair, Department of Community Dentistry and Behavioral Science, University of Florida College of Dentistry, said dentistry visits to the emergency room have skyrocketed, with 800,000 visits across the country, 61,000 of these requiring hospitalization. Other patients are given antibiotics and pain medication and told to visit a dentist the next day. A new study reveals that 35 percent of lower-income high school seniors have not been to a dentist in four years, Dr. Catalanotto said, mainly because of cost. One in five children is in dental pain, according to the Florida study, and school performance suffers. This is now cutting across to the middle class, Dr. Catalanotto said, with a drop in the number of adults seeking dental care — again, mainly due to cost.

The dental therapy model is working in Alaska and Minnesota, Dr. Catalanotto said, and it is a great fit for New Mexico. Dental therapists are less expensive to educate and return to the community, he said, and the program is evidence-based, cost-effective and safe. A dentist with a doctorate is trained in about 500 competencies; dental therapists are trained in 90, with a major emphasis on prevention. Training more dentists is the most expensive solution, Dr. Catalanotto said. The best solution is this new work force model.

Sarah Wovcha is the executive director of Children's Dental Services in Minneapolis (see handout), the oldest nonprofit providing dental services in Minnesota. Her organization has quadrupled in size since 2000, now serving 30,000 people a year, Ms. Wovcha said, and it is the single largest provider in schools and Head Start centers. There are two types of new dental providers authorized in Minnesota: dental therapists and advanced dental therapists. These therapists are allowed to work remotely under the supervision of a dentist, leaving dentists free to perform more complicated care and increasing their productivity, Ms. Wovcha said. This was originally opposed by dentists in Minnesota, but now it has gained support from the dental community.

Terry Batliner, D.D.S., M.B.A., a dentist from Boulder who is associate director of the Center for Native Oral Health Research at the Colorado School of Public Health, spoke about oral health in tribal areas. According to an Indian Health Service (IHS) study, in the Navajo Nation, 60 percent of children two to five years of age have untreated tooth decay, he said. In the Pueblo of Santo Domingo, that rate also is 60 percent, and adults have even worse oral health. In multi-state Indian nations, the tooth decay rate for children is 70 percent. In order to change this, treatment must also include prevention, Dr. Batliner said, and the IHS has not done a good job at this. Excepting Alaska, Title 10 of the PPACA prohibits expenditure of federal dollars on dental

therapy unless the state where the tribes reside makes dental therapy legal, Dr. Batliner said. "I ask for your help for native solutions for native communities."

Kathleen Bettinger, R.D.H., director of the interim dental hygiene program at Dona Ana Community College, said she was speaking on her own behalf. Ms. Bettinger told members that she traveled to Alaska to visit dental therapy teaching programs in Anchorage and Bethel, and she was very impressed. Students come from communities that have mentored them, she said, and there is huge community support. The coursework has a very linear structure, and students are able to move ahead based on skills. They acquire a full scope of knowledge and gain clinical experience right from the start. Dentist supervision is strictly adhered to by phone or internet, and standing orders limit therapist services. Dentists are trained and supervised within their own peer group. The facilities in Alaska are modern and very patient accessible, Ms. Bettinger said.

Questions/Comments

Committee members had questions and comments on the following topics.

Length of training for dental therapists. This legislation would provide two paths: a dental therapist program requiring three years of training, or a registered dental hygienist completing intensive training for three to six months. "We want to give schools flexibility in how they set up their programs", Ms. Bettinger said. Minnesota and Alaska are the only two states that currently have dental therapists, but 15 other states are looking at it, she said. In Alaska, they must be recertified every two years; in Minnesota, there is no recertification, but each must complete continuing education requirements.

Use of telemedicine. "Could you have a supervising dentist at either UNM or NMSU supervising in real time?", a member asked. "Yes", Ms. Bettinger answered. This is a competency-based program, and a therapist must get prior approval from the supervising dentist for extractions. The dentist might be supervising up to four therapists. In Alaska, the dentist does get training in how to supervise therapists, Ms. Bettinger said. Telemedicine may also hold promise for orthodontia, where much of the adjusting already is being done by auxiliary personnel anyway, another member suggested.

Support for new dental therapy legislation. In response to a question about possible support from the Office of the Governor, Ms. Bettinger said that her group is working on that issue but is unsure of the governor's position. The New Mexico Dental Association (NMDA) is still opposed, noted another member; it says there are enough dentists in New Mexico, and it is not sold on the therapist concept. Ms. Bettinger said the group had several meetings with the NMDA and will continue to try to gain consensus. The New Mexico Dental Hygienists Association does support the hygienist-based model for therapists that is now being proposed, she said. Another committee member offered the opinion that using dental therapists is a good idea, but graduates should be required to go back into underserved areas for a period of service — and that this should be spelled out in the legislation — in order to get more buy-in from the dental community.

Federal funding and tribal sovereignty. There is a provision in the PPACA that if a state passes a law to permit the practice of dental therapy, federal grant money is available for training and education, Ms. Bettinger said. Community solutions need to be explored, said another member, adding that the Navajo Nation is very interested in dental therapists, but federal funding must be available. The Alaska program, which has been studied extensively, has been working very well getting dental care into the rural communities where it is needed, Ms. Bettinger said.

Representative Madalena informed members that there is a video of what Alaska Natives have done with dental therapy, and he would very much like to locate it and bring it to the committee to be viewed.

Fluoridation and Water Supply

Rudy Blea, program director, Office of Oral Health, Department of Health (DOH), said that making sure oral health is just as important as medical and behavioral health is the goal of his office (see handout). Detailing the relationship between oral health and disease in New Mexico, Mr. Blea said that water fluoridation is an easy and relatively inexpensive preventive measure to combat tooth decay. Fluoride is natural and it is very effective, he said. Community water fluoridation is the adjustment of natural fluoride levels in public water systems to an optimal level to prevent tooth decay. Studies have found that every \$1.00 invested in community fluoridation reaps \$38.00 in savings from fewer cavities. Twenty-six of New Mexico's 33 counties are considering it.

The cities of Santa Fe, Farmington and Raton provide fluoridation of their water supplies, and Albuquerque has partial distribution of fluoridated water. He urges the legislature to promote community fluoridation throughout the state, he said. A public education media campaign is under way encouraging all New Mexicans to "drink water", Mr. Blea said, reminding committee members that oral health is essential to all health.

Motion for Letter Regarding Behavioral Health Statistics

It was moved that a letter be sent to the Behavioral Health Services Division of the HSD asking that the committee be provided with statistics on the number of clients being served by the 15 audited agencies two months before the takeover, and the same data for the new agencies as of today (September 5, 2013). The motion passed. A member asked that the committee review the letter, before it is sent, at its October meeting in Hobbs.

Another motion asked that a letter be sent to the chief executive officer of La Frontera requesting his attendance at the next committee meeting in Hobbs. This, too, passed unanimously.

Grant, Luna and Hidalgo Counties Inmate Support Program Pilot Project

Matthew Elwell, director of the Luna County Detention Center, and Mike Carrillo, director of the Grant County Detention Center, presented the committee with a plan for a pilot project (see handout) that aims to reduce the in-and-out jail cycle for the mentally ill. Creating a collaboration, as directed by House Joint Memorial 17 (2011), this program model will show that

counties can save dollars and improve lives by providing a follow-up plan for when the inmate is released. Recent statistics show that 26 percent of inmates at detention centers are on psychotropic medications, Mr. Elwell said. Recently, a 27-year-old schizophrenic inmate spent 418 days in detention on misdemeanor charges. He is noncompliant and has no treatment guardian. "We need mental health counseling in our facility", Mr. Elwell said. Law enforcement is acting as treatment, and employees of correction centers end up becoming managers of the mentally ill. They need to be trained for the job, he said. These inmates also would benefit from coordinated case management and life skills development to increase success with community reintegration upon release.

Mr. Elwell and Mr. Carrillo told the committee that their proposal asks the legislature for \$63,000 per year per county to fund a three-year pilot project. There are 29 jail facilities in the state, and cost savings and the success of inmates are the overarching goals of this collaboration.

Questions/Concerns

This group is probably all on board with the concept, said one committee member, but more detail is needed, especially on how to measure the data. Another member commented that it is terrible that being mentally ill is a crime. Far too much is being spent on things that do not work, she said. This is a classic example of how behavioral health costs get shifted, said another. It is a great project, the member said, but goals need to be quantified. The key to this will be aftercare and family involvement. Representative Madalena suggested that Mr. Elwell and Mr. Carrillo come back to the committee in November with actual legislation.

The committee recessed at 5:35 p.m.

Friday, September 6 — Skeen Library, New Mexico Institute of Mining and Technology, Socorro

The meeting reconvened at 9:15 a.m. Representative Madalena greeted committee members and staff and then turned the gavel over to Senator Rodriguez, chair of the Disabilities Concerns Subcommittee, since the day's topics are of special concern regarding the disabled.

Recommendations for Sustainability of the DD Waiver Program

Ruby Ann Esquibel, principal analyst for the Legislative Finance Committee (LFC), and Pamela Galbraith, program evaluator, LFC, described the DD waiver program as one that offers a broad array of community-based services, in lieu of institutional care, to individuals with developmental disabilities. The DD waiver program is managed by the Developmental Disabilities Supports Division (DDSD) of the DOH and is administered by both the HSD and the DOH through a joint powers agreement. Medicaid waivers are granted to states from the federal Centers for Medicare and Medicaid Services (CMS) to allow them to provide home- and community-based programs for developmentally disabled individuals as an alternative to institutionalization.

The present budget situation, with increasing costs and a rapidly growing waiting list, requires action, Ms. Esquibel said. The most costly services are supported living, family living and day habitation. The legislature appropriates funding for the DD waiver program, which then becomes the basis for the Medicaid match. There are multiple regulations and two state departments that administer the program and more than 300 providers critical to the delivery of services.

In fiscal year (FY) 2008, each DD waiver program client received \$71,400 in services (see handouts) and was eligible for an additional \$7,400 in regular Medicaid services, ranking New Mexico near the top 10 as one of the most expensive states in the country. A federal requirement is that the state's individual costs always be less than the institutional rate, which now stands at nearly \$99,000, Ms. Esquibel said. The number of people on the DD waiver waiting list has risen from 3,700 in FY 2008 to nearly 6,000 in FY 2013, despite efforts by the legislature to move more people off the list and into the program. An LFC evaluation of the program in June 2010 (see handout) highlighted the unsustainable spending levels and the need for cost containment, Ms. Esquibel said. "We are growing the dollars but not the number of people being served", she said, and this is a "red flag".

The LFC report's recommendations to the DOH and HSD include, among others, finding an appropriate tool to evaluate enrollees and their service needs; conducting a study of services to determine if New Mexico rates are above or below other states; moving forward immediately with cost-saving strategies using information from stakeholders and this report; and validating financial data in managed care organization (MCO) spending reports. (Claims data for services provided to those on the waiting list were examined over a three-year period, and it was found that the MCOs received \$91 million more than the cost of providing those services to this population.) Ms. Esquibel also mentioned the negative fiscal impact of the *Jackson* class action lawsuit, noting that the LFC report urges the DOH to develop and implement plans to meet outcome expectations and to submit semiannual disengagement progress reports on *Jackson* to the LFC and LHHS.

In 2011, the legislature appropriated an additional \$1 million for FY 2012 to reduce the number of individuals on the DD waiver waiting list by approximately 50 people. In 2012, another \$2.8 million was appropriated for the same purpose, reducing the number by about 150 persons. Despite this increased spending, the DDS reverted \$4.1 million to the general fund for FY 2012 and \$2.8 million for FY 2013 and made only modest increases to clients served by the DD waiver.

Questions/Concerns

Members discussed these findings and had questions on the following topics.

Problems with HSD data. A committee member wondered why no "credible allegation of fraud" has been made against the MCOs that received \$91 million more than the cost of services they delivered. Ms. Galbraith responded that the HSD reports that it does not use claims data to determine whether amounts paid to MCOs are sound. The HSD provided data, she said, but

there were huge discrepancies. Another member asked how the legislature is supposed to make good decisions if it does not have good data. Apparently, the MCOs had a problem accurately reporting their administrative costs, Ms. Galbraith said. There may be reasons for those discrepancies, but they were not explained. The committee member noted that service agencies have been closed down by the HSD, and they apparently do not have the same rights that state government has to address "apparent discrepancies".

Reversion of nearly \$7 million to the general fund. There is a waiting list with 6,000 people on it, one member noted. "Do we know who needs what?", he asked. Ms. Galbraith responded that some needs may be known. The DOH has told the committee that it knew these needs, the member said, but it appears that the state is in the same boat as it was seven years ago, dealing with the same issues and with clients not having their needs met. "Are some individuals on the waiting list getting Medicaid services?", Ms. Galbraith was asked. She responded that claims data are available for those getting Medicaid services, but there must be a needs assessment for those on the waiting list. The LFC recommended that the most disabled persons be evaluated first and that assessments be made for the most critical applicants.

New enrollment in the DD waiver program from the waiting list "has not met legislative intent", a member observed. Ms. Galbraith concurred that appropriated funding has gone unused. "We are here for policy", the member noted, "and it's not about funds; that's not the problem. The problem is that they (DOH) are not spending what has been appropriated."

Cuts to provider services. As a parent of a child on the DD waiver, a member told the rest of the committee that no one trusts what will happen next. "You could get a letter tomorrow that says your services will be cut in half, or that you have to choose between types of therapy, and which is the most important? Cost containment is certainly not painless." The member also told of friends who had to quit their jobs to stay home and care for a developmentally disabled family member. The committee member pointed out that some of the individuals sitting in the audience, several of whom have earned college degrees, would have been institutionalized in the past. "Even if there are less dollars, the quality of life in a community-based setting is priceless." Another committee member concurred. Rural New Mexico is being hit the hardest when there is talk about how much is being cut back. "If society can't take care of its most vulnerable, then who are we?", she asked.

Community Provider Panel on Developmental Disabilities Programs and Services

Ms. Otero-Hatanaka described the impacts of the redesign of the DD waiver program (see handout). The purpose of the redesign is to save money, she said, by reducing services to individuals currently in the DD waiver system in order to fund services for persons on the waiting list. Among the many changes that took place May 1 is the use of a new assessment tool, the Supports Intensity Scale (SIS); implementation of new service packages that reduce the number of hours of care an individual can receive for certain critical core services; and rate reimbursement cuts for core services, per recommendations made by an out-of-state survey contractor, Burns and Associates. Some providers have reduced their services, others have

closed their doors and there will be more agencies closing down because of quality assurance issues, Ms. Otero-Hatanaka said. "The community structure is being dangerously eroded."

Lisa Cisneros Brown, a speech-language pathologist who is representing therapists statewide, is an agency administrator and direct caregiver and was part of the team that met with Ms. Galbraith during her research for the LFC report. The adverse impact of SIS standards is a drastic reduction of services, Ms. Brown said. New Mexico sent dollars elsewhere for administering the SIS and for the Burns rate study, which was so complicated that agencies needed help in order to respond. Now the state is paying \$800 per SIS assessment, and there are many requests for reassessments, she said. Ms. Brown gave examples of an individual who cannot speak having been evaluated for less care and more time alone; of an interpreter who participated for four hours of SIS, but the test actually took more than six hours; and of a team member who stopped the evaluation because of interviewer rudeness to her client. Seventy percent of those who have a reassessment get a different score, Ms. Brown said. Placement in an A, B or C category means the client can have only one therapist, and family members must choose between the risk of their loved one falling or choking (aspiration choking can cause pneumonia and death).

Arlene Lindsey is manager of the DD waiver program, Tresco, Inc., which has been in existence for 45 years and now serves 140 individuals under the DD waiver program. There has been much discussion about the SIS, and Ms. Lindsey gave committee members an example of a recently-assessed consumer. He is on the DD waiver, lives at home and has health problems and depression and uses a cane and a walker. He has been getting 36 hours of assistant care, including nursing oversight of health care plans, travel to Albuquerque to see a specialist, meal preparation and help with finances and multiple medications. Just to manage his medications requires 14 hours a week, she said. With the new assessment, he will not have enough hours to even address his medication needs. Ms. Lindsey asked the committee, "Who will be responsible for this client?". She was told that her agency is responsible, even if it is not permitted to provide appropriate services.

Questions/Concerns

A member asked if individuals in "supported employment" are required to be paid minimum wage. Ms. Galbraith, from the audience, responded that there is an exemption from the federal minimum wage, and unfortunately, that sends the message that you are not a "real" worker. Goodwill Industries has decided that it will no longer participate with the state on employment because the rates are so low, said another member. DD providers may be "next on the chopping block".

Therapists are leaving the DD waiver for moral reasons, a member said. Ethically, they cannot just provide care for one hour a month. This population has a target on its back, Ms. Otero-Hatanaka said. Our system is crumbling, she said. People really need to know what is going on. It has been a double whammy, with a new rate system and cuts. Rates for providers need to be raised, not cut, she said. A member asked how much was needed to properly support

community providers. Any increase would help, Ms. Otero-Hatanaka responded; it has been 10 years since they got a raise.

Legislators need to request the LFC to do more analysis and number-crunching, so there can be better comparative figures of what is going on in other states, a member said. Then there would be a baseline, and intelligent figures could be plugged in. It is almost like ignorance is bliss, he said. Another member commented on cuts to supported employment. In the *Jackson* lawsuit, the state is being hammered for not enough of it. Why this disparity?, he asked.

Consumer Perspectives on SIS Assessments and Other Issues

Doris Husted, director for public policy at The ARC of New Mexico, said she was here as the consumer voice of those who have had SIS assessments.

Adam Shand told committee members he is very excited to be part of a pilot group of 500 to take the SIS. He took the test with his mother, who is his home-based provider, but he has asked for a reassessment. "I am very capable with technology, but I do need help physically", he said. "I have been blessed with a strong voice, and I use it to advocate." Mr. Shand said that everyone should band together in advocacy to help individuals reach their full potential. "We are all just people, and we are all in this together."

It was noted by a committee member that Senator Candelaria has recognized Mr. Shand's work as a self-advocate on the senate floor.

Vicki Galindo is the parent of a Down syndrome child who took the SIS assessment in June after weeks of her parents' preparation. Ms. Galindo said she had heard a lot of negative stories about the SIS and knew that the person who would conduct the assessment "literally had our daughter's future in her hands". There were a lot of good people at the assessment, she said, including her daughter's case manager. It took about an hour and a half, and the results came in about three weeks.

Amira Rasheed had team members who helped her prepare — her physical therapist, case manager and the coordinator of services. "I fall into a lot of gray areas on the SIS, which took about two hours, but hopefully I can get a letter that agrees, and will provide the services I need." Ms. Rasheed holds two college degrees and is working toward a master's degree.

Robert Kagel, parent advocate, said he has appeared as an expert witness in federal and state court. The results of his son's first SIS were "ridiculous", he said. After complaining to the DDSD, his son went from D to F; he is severely disabled and requires assistance with 99 percent of his needs. Now his son just got his group H evaluation, and Molina Healthcare got approval to provide services last week. Mr. Kagel said two of his son's providers have not been paid, and two of them said they are quitting the DD waiver program.

Mr. Kagel said that the reason other states can provide DD care cheaper than New Mexico is because they have private institutions or large numbers of intermediate homes. Who

are these Burns people?, he asked, referring to the rate study. Mr. Kagel is highly critical of the Burns study and what he calls the bogus use of the sole-source SIS. Federal law provides public input whenever the waiver is changed, Mr. Kagel said. The task force members are mostly from Albuquerque, and they had only one meeting. "Then they did statewide dog-and-pony shows, sent letters to providers and families, then put some small thing on their web site", Mr. Kagel said. Total comments for the entire year, including work force and 10 regional meetings, were 24 from individuals, and only two comments on the SIS, he said. Task force members were not told that the game plan was to kick people off Medicaid residential services, Mr. Kagel said. New services include crisis support, but no providers are listed who provide crisis support; they say they will not touch it. Providers have no idea what their income will be over the next year and no idea who will be getting what services, Mr. Kagel concluded.

Public Comment

Mike Kivitz commented on additional reasons for the disparity in New Mexico's higher DD waiver costs, besides those cited by Mr. Kagel. Policy decisions, such as having only three to four individuals in a group home, and \$75 million to support families drive up the individual total cost of services. The rates to providers do not need to be cut, said Mr. Kivitz, who is president and CEO of Adelante, an Albuquerque DD waiver provider. "The board of my agency is meeting now to figure out how to cut \$1.5 million from Adelante's budget by reducing retirement and benefits for staff."

Pam Lillibridge, who holds a master's degree in public administration, said that the important theme is having clients able to get what they need. "There is a big gap between the SIS and our opinion", she said. "You don't promote independence by taking everything away." She said her agency, Tresco, in Socorro, is still considered responsible even if it is not paid to deliver appropriate services.

Jessica Valmeister is the parent of a disabled child and spoke of the lack of acute crisis facilities that will accept children with fragile medical conditions and behavioral health issues. When her son was in crisis, there was nowhere to take him, and emergency room personnel suggested a voluntary surrender of custody to the CYFD for respite care and some kind of treatment. She had been to multiple state levels and had even gone to the media for help. There was just nowhere for children like hers to go, she said. Her son died last year.

Jim Jackson, executive director of Disability Rights New Mexico, said he had notes about the *Jackson* case, in which his organization is involved, and is experiencing the same frustrations as the legislature. He feels that *Jackson* benefits others in the DD waiver community, not just *Jackson* class members. Mr. Jackson also feels there is a serious leadership issue and low level of commitment within the DOH and is frustrated with the reversion of nearly \$7 million. What will it take to get the DOH to commit to take folks off the waiting list?, he asked. The SIS is not a professional evaluation as to therapy needs, Mr. Jackson said. An entire category for individuals with the most serious needs has evaporated.

Brian Tierney, a partner in Direct Therapy Services in Las Cruces, supports most of what has been said. There are severe delays in budgets and payments. Billing and approval of payments are a serious problem. There is money being transferred back that should instead be applied to bills that have not been paid before the end of the fiscal year, he said.

Lori Rossburn, a speech-language pathologist, said that with all of the people being flown in from Arizona and Canada, what the state is taking away from services is criminal. "It is unconscionable what is being done here. We pay tons of money to Molina to not pay our bills, and not approve our budgets", she said. "Clients ask, why are they doing this? Tell them to stop! We serve at the will of the department, and other therapists are afraid to come here", she said. "People we love and serve are getting hurt."

Tammy and Stuart Melloy live in Albuquerque so their daughter can get the care that she needs. Their daughter is on 100 percent total care, with a feeding tube, epilepsy, diapers and chronic respiratory issues. She scored an F on the SIS assessment and will lose two-thirds of her therapy hours. She has been using 14 hours of therapy a month but now will have just 30 therapy hours for the entire year. Ms. Melloy is her daughter's caregiver, and she gets 750 hours of substitute care and wants to know why she cannot use the dollars from substitute care and apply them to therapy. This new package of care is not individualized at all, Ms. Melloy said.

Cathy Stevenson, director of the DDSD, who was sitting in the audience waiting for her own presentation, stood and said she would follow up on the Melloy case.

Peggy Denson, director of Zia Therapy Center in Alamogordo, noted that the state has been increasing the expense but not increasing the number of persons served on the DD waiver. Providers' expenses are growing, but their bottom lines are going down. The average cost per consumer has decreased, and now there is a wide margin between that and the cost of institutionalization. These cuts are on the backs of the consumers and the providers, she said. There is a crisis of staffing, and qualified folks cannot be attracted or retained. Implementation of the new DD waiver has been delayed and delayed, and this has wrecked any opportunity to plan or budget. Every SIS only tells part of the financial story. Just wait until January 1, when there is Medicaid expansion and PPACA expenses increase dramatically, she warned. The center's owners are talking about the possibility of downsizing Zia.

Barbara House, whose daughter is one of the original children at the Zia Therapy Center, said she has received a letter from a person who needs full care but who now must go out in the community to get services and another letter from a person who has a son in a wheelchair and must go out in the community to get services as well. We are headed backwards, she said.

Kent House, Ms. House's son, spoke of his disabled sister, who is 57 years old, and how his parents worry about what is going to happen to her. The system is crashing now, he said, and families have to become involved. Services are not being delivered in an honest and trustworthy way. The SIS is not an honest test; it is not right, Mr. House said.

Nannie and Rosemarie Sanchez said the purpose of the DD waiver is to provide services, and they then read a statement: There is a lack of agencies that provide person-centered services, and information is not being provided to families of the disabled. The Sanchezes would like to join with two Democrats and two Republicans who are pushing for a citizens oversight and review committee.

Sustainability of the Developmental Disability System

Peter Cubra, an Albuquerque attorney and advocate for people with developmental disabilities, described how he came to his professional interests. He was raised with a cousin who was born with profound cognitive disabilities, and his dad would always say to him, "There, but for the grace of God, go you." Mr. Cubra subsequently became a special education teacher in Michigan. In the 1970s, disabled people in Michigan came out of institutions and into the community, and Mr. Cubra's concerns about the resulting "mess" was what propelled him to law school. When he came to work in New Mexico, he and Mr. Jackson decided they were going to try to get people here out of the institutions and into the community. In 1987, they filed suit against the state because there was not a community system sufficient to meet the needs of the disabled.

Federal Judge James A. Parker is a cautious, conservative judge, Mr. Cubra said, but they were able to convince him that there was discrimination against the disabled, and in 1990, Judge Parker ruled in their favor. The fact that the goal of the lawsuit has not yet been accomplished is why the case is continuing, he said. In October 2012, the court again ruled in their favor on 99 of 104 alleged violations of the agreement with the state in the areas of health care, safety and meaningful employment for those who want it. A compliance administration now has been set up, and Dr. Sue Gant has been authorized by the judge to help craft plans that are clear and specific, and, hopefully, to bring this case to an end.

"Our community system is once again discriminating against these people", Mr. Cubra said. The SIS is slamming people into the wrong category at an alarming rate, and many people are afraid to retest and be stuck with the score. The *Jackson* class has been exempted, a tacit acknowledgment that people will not get what they need, Mr. Cubra said. This system is deteriorating because of the SIS, he said. "My clients will not be able to get the services they need, and they are entitled to services that do not exist."

Mr. Cubra said he appreciates why payment of attorney fees in *Jackson* is a concern for the taxpayer in New Mexico, but those are negotiated rates, he said, two-thirds of normal rates. A committee member noted that the state had just signed a contract with an Arizona provider for \$300 per hour, more than Mr. Cubra's hourly rate. There are 10,000 people either receiving services on the DD waiver or waiting to receive services, Mr. Cubra said. The question is: Are we going to pony up to help these 10,000?

Questions/Concerns

A member asked what is the obstacle to closing this lawsuit so those funds can be used to service New Mexicans. Ms. Stevenson strongly defended the state's efforts to satisfy its obligations for the 23-year-old lawsuit. "The bar continues to rise", she said. Another member asked Ms. Stevenson about the reversions of nearly \$7 million to the general fund. The money does revert, she said, but it will need to remain in the base. Sometimes it is not reallocated. That money is tied to a person, Ms. Stevenson said. It is given to the division for line-item services.

Status and Funding of SIS Activities

Ms. Stevenson introduced Cristina Hill, who described the SIS assessment (see handout). The interview is face-to-face, Ms. Hill said, and the results of the assessment are group assignments. The current number of individuals assessed who are requesting a retest is 20 percent, she said, and 70 percent of those are being reassigned to a different category.

Molina Healthcare was the focus of another member's question. He asked for numbers on the bills that have been submitted by providers but have not been paid in the last six months. The member also asked for information on which services are being denied and said that the SIS uses some kind of algorithm that is not published. It is available, Ms. Stevenson countered; it is not published, but it has been distributed.

Concerns about Canadians coming into New Mexico to administer the assessment were also discussed. Can we train New Mexicans?, a member asked. Ms. Stevenson said that trained and certified assessors seemed important, rather than using a trainee. "Since this is such an important life-changing decision, we felt we needed an experienced interviewer."

Another member expressed serious concerns about liability for therapists. He asserted that the SIS is being used to decide therapies. Another member urged Ms. Stevenson to bring a thorough breakdown of the amount of general funds allocated to the waiver to the next meeting. This committee is looking for solutions, he said.

Ms. Stevenson's explanation of the reversion was clear, a member told her, but why is there so little increase in the number of those served? Ms. Stevenson said she would have more information at the next committee meeting.

The committee adjourned at 5:30 p.m.

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

October 2-4, 2013
Bob Moran Hall, New Mexico Junior College
1 Thunderbird Circle
Hobbs

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at 9:30 a.m. on Wednesday, October 2, 2013, in Bob Moran Hall at New Mexico Junior College in Hobbs.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Sen. Gay G. Kernan
Sen. Mark Moores

Absent

Rep. Doreen Y. Gallegos
Rep. Terry H. McMillan
Sen. Benny Shendo, Jr.

Advisory Members

Sen. Sue Wilson Beffort
Rep. Nathan "Nate" Cote
Rep. Sandra D. Jeff (10/2, 10/3)
Rep. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill (10/2)
Sen. Mary Kay Papen (10/2)
Sen. Nancy Rodriguez (10/3, 10/4)
Sen. Sander Rue (10/2, 10/3)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta
Sen. Craig W. Brandt
Sen. Jacob R. Candalaria
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Paul A. Pacheco
Sen. William P. Soules
Sen. Lisa A. Torracco

Guest Legislators

Rep. Donald E. Bratton (10/3, 10/4)
Rep. David M. Gallegos
Sen. Carroll H. Leavell (10/2, 10/3)

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, LCS Records Officer
Nancy Ellis, LCS Staff
Branden Ibarra, LCS Intern

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Wednesday, October 2**Introductions**

Representative Madalena welcomed everyone and asked legislators and staff to introduce themselves.

Welcome to New Mexico Junior College

Steve McCleery, Ph.D., president of New Mexico Junior College, said that on behalf of Lea County, "we are thrilled that you are here and we would like to show you how municipalities have come together with the state to provide great quality services". Hobbs had a population of about 28,000 just 10 years ago; today it is 40,000, Dr. McCleery said, while Lea County grew from 53,000 a decade ago to nearly 80,000 today. Oil and gas are driving the economy in Lea County, Dr. McCleery said. "It is so robust, and we embrace that and know that we cannot grow it without the state. You are our partner."

Legislative Finance Committee (LFC) Health Care Work Force Report and Department of Health (DOH) Perspective

Jack Evans and Rachel Mercer-Smith, program evaluators for the LFC, provided the committee with printouts (see handouts) of the state's health professional shortage areas (HPSA) in primary care, dental and mental health services. Mr. Evans and Ms. Mercer-Smith described for committee members the conclusions of a report delivered to the LFC in May on the adequacy of New Mexico's health care work force produced by the DOH and other allied agencies (see handout). There are nearly 450,000 New Mexicans who currently lack health insurance, Ms. Mercer-Smith said, and it is estimated that 172,000 will become insured in 2014 as a result of the federal Patient Protection and Affordable Care Act (PPACA). With shortages and maldistributions throughout the state in primary care physicians (PCPs), dentists, nurses and clinically trained behavioral health care practitioners, New Mexico should expect some deterioration in access to health care as the PPACA unfolds, they said, following pent-up demand for services.

Going over conclusions contained in the report's executive summary, Ms. Mercer-Smith described chronic problems of concentration of professionals in urban areas and the aging of the work force. Practitioners can be trained in half the time at half the cost, she said; nurse practitioners and physician assistants (PAs) can perform 70% to 80% of common procedures. There is a shortage of nurses in New Mexico — 3,000 by this report's estimate — and the state also needs more psychiatrists and psychologists. A smarter service delivery model will help the state do better. There is benefit from coordinated care, Ms. Mercer-Smith said, and a team approach to help reduce hospital admissions and keep New Mexicans more healthy by stressing prevention.

Recommendations of the report include providing the DOH with adequate resources and a suggestion that the legislature work more closely with the University of New Mexico Health Sciences Center (UNM HSC) to recruit and maintain the work force. Loan repayment, loan-for-service and other financial assistance programs should be expanded, the report recommends, and general fund dollars could be used to help expand the number of residencies in primary care. The report also recommends that the state train more advanced practice professionals and expand the number of master's-level social workers. Despite the push for doctorate-level programs in nursing, it is recommended that the state's educational institutions retain their master's-level programs to graduate more nurses. It was recommended that the state expand dental hygienist training and that it revisit the concept of dental therapists. Barriers to achieving these recommendations include a shortage of qualified faculty and also regulations that may limit providers from working to the full extent of their licenses. It advised a full review of health care practice acts.

Michael Landen, M.D., state epidemiologist, DOH, reinforced the comments of Ms. Mercer-Smith and Mr. Evans regarding the LFC report, and stated that, clearly, the state needs to expand its work force for better, smarter distribution and that there is an opportunity to take a systematic look at health care coverage. Disease does not match up with the health care distribution, he said. Care of chronic illness is a key type of health care provision as an outpatient, Dr. Landen said; too many patients with diabetes are getting more of their care in the emergency room. Dr. Landen also suggested that more prescription monitoring could be done by the Board of Pharmacy.

Dr. Landen provided a handout pursuant to which he discussed great disparities in health outcomes in the state, with the southeast and northwest areas of the state suffering some of the worst outcomes relating to deaths due to disease status; diabetes; heart disease and other chronic conditions; and substance dependence. He noted the correlation of these poor health outcomes with the lack of health care providers and the high rates of uninsured and underinsured individuals in these areas.

Representative Madalena turned his gavel over to Senator Kernan to chair the rest of the LHHS meeting in her home district.

Questions/Concerns

Committee members had questions about the information in the LFC report and other presentations in the following categories.

Enlarging scopes of practice. A member commented to Mr. Evans that, based on this report, it sounds like the DOH is in support of dental therapists. New Mexico needs to expand the level of services for dental hygienists as soon as possible, Mr. Evans said, and it is important to look at dental therapists as a way to expand much-needed services. The idea of dental therapists should be revisited and brought back to the table, he said. PAs need reciprocity with other states, Mr. Evans said, and their scope of practice could be expanded. The issue is more pronounced for rural areas. Maybe after PAs have been in the work force for three to five years, they could be granted the same duties as a nurse practitioner. Another member noted that nurses have lobbied to prevent this. Dr. Landen urged members to encourage collaboration among the licensing entities. Another member mentioned the possibility of establishing a "super board"; nobody, it seems, is looking at the bigger picture. If the state does decide to enlarge scopes of practice, offered another member, the state needs to ensure that new providers do not all go back into urban areas. Perhaps there could be a promise that the provider will practice for a certain amount of time in an underserved area.

Other recruitment issues. A group of podiatrists met recently in Albuquerque, a member said, and their issue is that Medicaid will not pay them for certain activities; there are gaps in what Medicaid will pay. They also brought up related issues, the member said, such as gross receipts tax, which is exempted only for managed care organizations (MCOs). The podiatrists feel that they are paying an unfair burden. "What if we just said no gross receipts tax for medical care?", the member speculated. Mr. Evans said that this is an excellent topic to look into, as caps on medical liability might be expanded to dentists, and in general, for recruiting in the state. "We are recruiting against other states", another member noted.

Overdose from opiate addiction. A member asked if the death rate from drug overdose is still highest in northeastern New Mexico and Bernalillo County. Mr. Evans said that counties in southern New Mexico are having overdose problems, but it is becoming more evenly distributed throughout the state. The member asked that this information be sent to the committee.

Better use of resources. Sometimes a practitioner is better than a physician for an initial visit, said a member who is also a physical therapist. A physical therapist may know the foot better than a doctor. People who have expertise may be best to see first, trying to use medical personnel more intelligently, she said. Telehealth needs to be utilized more, offered another member. Mr. Evans agreed that in the future, telehealth will be used extensively, with raised levels of confidence. Obtaining a master's of social work requires over 3,000 hours of direct supervision, Mr. Evans noted. If the rules were loosened up, there could be a lot more social workers. Telehealth can be used in dentistry, where a dentist could be supervising multiple students and/or staff without having to travel to the classroom, he added.

Non-compete clauses in hospital contracts. A legislator expressed distress over his belief that many physicians are being lost in southeastern New Mexico due to non-compete clauses. A committee member stated that what is happening in Lea County is almost "bait-and-switch": physicians are enticed to leave private practice and become employees of the hospital, but when they go to renegotiate the contract, the hospital has put in the non-compete clause. The DOH does not allow non-compete clauses, members were told; some courts have found them unenforceable. The chair told committee members there will be a presentation this afternoon by Lea County that will discuss why physicians are leaving the area. Legislation may be needed to forbid non-compete clauses, a committee member stated.

Letter to Congressman Steve Pearce. A committee member requested that staff send a letter to Congressman Pearce that would request his office's attention to the concerns raised about health outcomes in southeastern New Mexico.

Minutes Approved

A motion was made, seconded and passed unanimously to approve the minutes of the July 25-26, 2013 LHHS meeting.

Health Care Work Force Recruitment, Retention and Attrition; Payment Issues and Targeted Delivery Systems

David P. Sklar, M.D., associate dean for graduate medical education and professor emeritus of emergency medicine at UNM HSC, said he wanted his presentation to give context to the LFC presentation. Dr. Sklar provided members with a PowerPoint presentation (see handout) that defines the problem in several categories: inadequate production of providers, increasing population with increasing needs, inefficiencies within the delivery system and the loss of providers through migration, retirement, disability and death.

It will be a long haul to fix these problems, Dr. Sklar said, addressing each category in more detail. Nurse practitioners and PAs do require shorter training, but they still need supervision after graduation. It is very important to look at populations and learn to address their issues in a more efficient way, he said, because the current fee-for-service health care system increases productivity instead of encouraging case management, and attrition of the work force — New Mexico has the oldest population of physicians — can be slowed with different kinds of incentives. A delay of retirement by two years could help to hold the line, Dr. Sklar said. All of these issues need to be addressed, not just one. With an aging population and more chronic illnesses, the patient-to-physician deficit is projected to be 100,000 by 2025. A team-based care model can help reduce this demand. Medical schools did expand, Dr. Sklar said, but the state has not increased the budget for graduate medical education. Loan repayment programs can be used to encourage physicians to choose primary care and also to address the shortage in general surgery, but increased state funding is needed for rural residencies, Dr. Sklar said. If nothing is done, market forces will solve the work force shortage with reduced quality of and greater disparity in access to care.

Jerry Harrison, Ph.D., director of New Mexico Health Resources, Inc. (NMHR), described the work of his nonprofit organization as a clearinghouse for recruiting and retaining health professionals in the state (see handouts). There is fierce competition for physicians, and there needs to be fast person-to-person networking, Dr. Harrison said. There has been a push toward physicians going to work for hospitals, with many of them specializing. This is also a trend with nurse practitioners and PAs, he said. Established in 1981 and now a national model, NMHR has recruited more than 1,400 health care professionals to the state, averaging now about 55 placements a year. This includes physicians, dentists, nurse practitioners, PAs and others.

Asked what is working in recruitment, Dr. Harrison listed the New Mexico Health Service Corps, which awards a stipend based on a two-year commitment; awards that pay for malpractice coverage or for student loan debt; and the rural health care practitioner tax credit, which provides between \$3,000 and \$5,000 in income tax credit. Studies found that those who receive scholarships leave their positions earlier than those who get loan repayment. The best, and least expensive, recruit, Dr. Harrison said, is someone who lives in the community. When a new recruit is brought in, someone needs to determine if the match is a good one, he said. The problems of recruitment and retention are not confined to rural areas; urban areas suffer shortages, too, Dr. Harrison said. All formulas, both federal and state, are keyed to HPSAs (see handouts).

Questions/Concerns

A legislator described the success of the local hospital district in Lea County, which now includes a dental clinic. The local hospital district is a way for rural areas to help take care of their populations, Dr. Harrison agreed, but there are many communities who have decided not to tax themselves.

In response to a question about NMHR, Dr. Harrison said his board of directors is composed of 17 persons, each representing a geographic area of the state and each of whom is elected to a two-year term. The board of directors tries very hard not to overrepresent Albuquerque and Santa Fe in relation to the rest of the state, he said. Its annual budget is between \$600,000 and \$750,000, and it has contracts with the DOH, Blue Cross Blue Shield and Molina Healthcare, among others.

Dr. Harrison described a recruitment program used a number of years ago that placed billboards on the interstate between Santa Fe and Albuquerque to entice physicians to come to New Mexico to practice. Sometimes people would call NMHR and say, "I want to come here and work". That \$1,000 a month might not be a bad investment, a member commented. Dr. Harrison said his organization pays a lot of attention to identifying New Mexico providers wherever they are and trying to bring them back to New Mexico.

UNM Work Force Report

Richard S. Larson, M.D., Ph.D., vice chancellor for research at UNM HSC, presented a summary of the initial report of a statewide work force committee on health professional

practices. House Bill (HB) 19, passed in 2012, mandated the UNM HSC chancellor to appoint the committee to devise a survey for state licensing boards and applicants, to analyze incentives to attract more students into health care careers and to develop plans to improve health care access. All licensing boards now have been instructed to attach a survey to license renewal mailings, which occur every three years on a staggered basis, Dr. Larson said, and all license data are now transferred to the database at UNM HSC.

There are many different types of nursing degrees, said Dr. Larson. The PPACA will impact the bachelor of science in nursing degree (BSN) group the most, since the higher percentage of BSNs at a hospital, the higher the quality of care is rated at that facility. There will be pressure for nurses with associate degrees to upgrade to a BSN. Dr. Larson's group projected that 2,306 additional registered nurses are needed and that 1,840 of these need to be BSN-prepared by 2020. All of the nursing programs in the state have formed an organization and have agreed to recognize all of the same courses, and unaccredited programs need to become accredited, he said. There needs to be enough training slots to place nursing students throughout the state because they are more likely to stay where they are trained.

Distribution is also a problem with PCPs, for which a current shortfall of 219 is projected by the committee. In order to grow the supply of PCPs, more residency slots need to be funded. There are currently more physician graduates than there are residencies available, so growth is capped, Dr. Larson said. There are 530 residency slots at UNM HSC, 450 of those paid for by the federal government, but it could be expanded to add 45 more if funding were available from the legislature. Dr. Larson also suggested more funding for physician extender programs such as Project ECHO to help address the PCP shortage.

Practicing psychiatrists in the state continue to decline, according to the report, with a current total at 258, and with 12 counties having no access to psychiatrists, Dr. Larson said. There are some nurse practitioners who specialize in psychiatry. The group recommends that the number of resident positions in psychiatry should be increased, possibly through state funding, and Project ECHO may also be part of a solution.

The Kaiser Family Foundation reports that New Mexico currently has 1,071 professionally active dentists, but there are issues with rural/urban distribution and economics. The committee recommends that the state increase the number of Western Interstate Commission for Higher Education (WICHE) slots so that all New Mexico students who wish to become dentists can be provided grants to attend out-of-state dental schools. Other recommendations include expanding loan repayment programs in exchange for practice in underserved areas and establishing a BA/DDS program to recruit and support New Mexico's pre-dental and dental students, particularly those from rural and minority communities. The committee also recommends the establishment of a community dental health coordinator to assist persons with access barriers.

In response to a member's question about the possibility of more frequent licensure data collection, Dr. Larson explained that some boards do not even have the capacity to put in these

surveys. As the committee, which has been empowered by HB 19, becomes more familiar with the data that it currently gathers, refinements could be made. Dr. Larson reminded LHHS members that HB 19 is an unfunded mandate and UNM HSC needs \$320,000 to pay for this ongoing work. The member said he would like this included as committee-endorsed legislation.

Grow Your Own Work Force

Danielle Moffett, M.A., work force program director for the Center for Health Innovation, Hidalgo Medical Services in Silver City, described the center's "Forward New Mexico" approach to cultivating a future work force (see handout). The model involves gaining commitments from students while they are still in secondary school. Stage 1 is getting kids interested in math and science and after-school programs. There are field trips to UNM, summer camps and paid internships for those 18 years of age and older. Stage 2 is supporting students through undergraduate education and staying connected until they apply to medical school or a graduate program. Stage 3 is expanding graduate and resident programs and providing access to a variety of providers through Hidalgo Medical Services clinics; also, housing adjacent to the clinics is provided. Stage 4 is retaining and recruiting these home-grown providers. Stage 5 is supporting improvements in health care professional policy and programs and increasing supply and access. Forward New Mexico began in 2011, and the first year in Silver City, nine students signed up; this year, 45 signed up. Ms. Moffett said that they are proposing that this be a model. It could work anywhere, she said, be cost-effective and part of solving the problem.

Arthur Kaufman, M.D., is vice chancellor for community health and a professor of family and community medicine at UNM HSC. Dr. Kaufman described a model for increasing New Mexico's family medicine residencies (see handout). Most residencies are funded by Medicare and are frozen, he said, and teaching hospitals do not fund resident rotations in community or rural areas. The legislature last year funded eight residencies in primary care, "but we need to get them out of the lock of the big hospitals", Dr. Kaufman said. Some community health centers and community hospitals will share funding of a resident's community rotation. Family medicine continues to be the most sought-after physician specialty for employers, Dr. Kaufman said. In his proposal, he urges the state to explore the use of Medicaid funding for additional residency slots in primary care (this has been done in Ohio, he said) and to utilize general funds to supplement rural family medicine residencies and rural psychiatric residencies.

Lea County Health Care Plan; Sole Community Provider and Indigent Funding

Mike Gallagher, Lea County manager, welcomed the committee to Lea County and thanked members of the legislature for their hard work. Lea County covers 4,400 square miles, has a population of 66,118, has an unemployment rate of 3.8% and last year was the fastest growing county in New Mexico, Mr. Gallagher said. There are two sole community provider hospitals in the county, Nor Lea and Lea Regional. Mr. Gallagher provided information to committee members on a current Lea County health care study (see handout) and described issues with sole community provider and county indigent funding programs (see handout).

The health care study currently under way has been engaging community members in town hall-style meetings with robust participation, Mr. Gallagher said, and its purpose is to address the fact that, collectively, local health care providers are not meeting the needs of the community. Lea County hospitals are caring for less than half of county residents requiring hospitalization; more than \$140 million in potential revenue is being lost as residents go elsewhere for services. There is a critical shortage of clinicians in Lea County, and several physicians who were employed in Lea County have left. Non-compete clauses in contracts are an issue.

Mr. Gallagher described the county's one-eighth percent gross receipts tax, which became effective in 1990 and currently produces about \$5 million in revenue. Half of this revenue is sent back to the state as the state-mandated contribution to Medicaid, while the remaining half provides funding for the two sole community provider hospitals, county inmate medical services, county nonprofit behavioral health agencies, the county diabetes program and indigent burials. Now the Human Services Department (HSD) has proposed to redirect the second half of these tax funds to fund the uncompensated care pool and to increase Medicaid base rates for inpatient services under Centennial Care (see handout). There is great concern among counties that have this tax that they will no longer be able to meet the needs of their own indigent programs and Medicaid contributions, Mr. Gallagher said, and fear that they may eventually be forced to increase the tax burden on residents. Every county that has this tax has expressed opposition to the HSD proposal, he said.

Questions/Concerns

A member noted that the HSD is not asking for any additional funding this year, but it is proposing to take this revenue from counties. Senator Leavell said that the idea may not have been well thought out by the HSD and that he would like to see a letter from this committee to the HSD expressing opposition. A committee member made a motion to send a letter to the HSD noting concerns and to direct staff to prepare it for review at the next meeting in November. Another member proposed amending the motion to suggest that the HSD come to this committee to present its side of the issue. The amended motion was seconded and passed with no objections.

Public Comment

B.J. Choice, pastor at St. John Missionary Baptist Church in Hobbs, said 35 years ago he was a member of the Human Services Board, and he complimented Senator Kernan and Senator Papen and her late husband, a physician who did much for Lea County. Pastor Choice thanked committee members for coming to Lea County and for addressing health concerns.

The meeting recessed at 5:30 p.m.

Thursday, October 3

Welcome and Introductions

Senator Kernan reconvened the meeting at 8:45 a.m. and asked members and staff to introduce themselves. She then introduced Sam Cobb, mayor of Hobbs, who welcomed

committee members. Hobbs is having growing pains, Mayor Cobb said, regarding housing as well as health care. The city hopes to incentivize the private sector to help with some of the housing issues, and it may need a boost from the legislature. Mayor Cobb also said that Hobbs wants to assemble a health care delivery system that will be the envy of the region.

The meeting opened with a committee member asking, "Why is gas \$.50 a gallon higher here in oil country"?, which drew laughter from other members, who also had noted the higher gas prices. The mayor responded that it is the truest form of the free enterprise system. After thanking the mayor for the city's hospitality, there was considerable discussion among members about an article that appeared on the front page of the local newspaper, the *Hobbs Sun-News*, describing Mr. Gallagher's appearance the previous day. There were a lot of inaccuracies in the story, several members asserted. Senator Kernan agreed and said that the concept of the county's one-eighth percent gross receipts tax and indigent funding is very complex and that she would be happy to discuss it in detail with the newspaper. In no way did Mr. Gallagher say that the county was going to raise taxes, she said.

Hunger in New Mexico

Cindy Jackson, a community advocate, described New Mexico as being number one in the nation for child food insecurity. In Lea County, 20% of children are hungry but do not qualify for government aid, she said. That means that parents are working, but do not make enough to keep their children from going hungry. Ms. Jackson works with a group of volunteers who pack lunches into backpacks for 250 kids to eat over the weekend.

Kathy Komoll, executive director of the New Mexico Association of Food Banks (see handout), told members that "food insecurity" has replaced the word "hunger" but she thinks food insecurity is an insulting term. If a child is not eating, that is hunger, she said. People are hungry for many reasons (see handout), with unemployment or underemployment at the top of this list. A medical crisis or breakdown of a car can mean that meals must be skipped. In rural areas, it might be a 60-mile round trip to the nearest grocery store. The high cost of living, especially housing, can mean there is little money left over to buy food. The association's five food banks serve a network of more than 40,000 New Mexicans weekly, Ms. Komoll said. Seniors are among the most physically vulnerable to hunger and often lack access to nutritious food.

One in five New Mexicans suffers from food insecurity, Ms. Komoll said; 30% of children and 21% of seniors in New Mexico are food insecure. A lot has been said about SNAP, the federal Supplemental Nutrition Assistance Program, she said, which will undergo enormous cuts under the farm bill passed recently by the U.S. House of Representatives. "We have great concerns that with these cuts, the volunteer private sector will not have the resources to meet the needs."

Jaron Graham, pastor of the Church of the Nazarene in Lovington, organized a group of churches and community leaders to form the Lovington Food Coalition in 2012, after looking around and seeing that hunger needs were not being adequately met. The structure involves two

food pantry locations, one open every Tuesday from 4:00 p.m. to 5:00 p.m., and the other on Thursdays. There also is a mobile drop-off once a month, Mr. Graham said. The truck, which brings fresh vegetables, comes at 10:00 a.m., but people are lined up at 6:00 a.m. The coalition wants to provide high-quality, healthy food and dignity as it distributes this assistance. Mr. Graham said that a grocer and local restaurants and businesses also are involved in the coalition.

There are three food banks utilized by the Lovington Food Coalition: Roadrunner Food Bank, Brick and Mortar Food Bank and Cornerstone. The backpack program works with the schools to help identify children who appear to be hungry and sometimes are observed hoarding food. Parents are contacted to get approval for participation, and the use of the backpacks is an unobtrusive way to get healthy lunches and snacks home for the weekend. Answering a member's questions about who gets food from the pantries and why do they need it, Mr. Graham said that most of them are families, and contributing factors are underemployment, lack of job skills, one parent is in jail or has left town and seniors struggling on fixed incomes. The cost of living in Lovington is high, he said, and many renters are struggling.

Ruth Hoffman, director of Lutheran Advocacy Ministry, told committee members it is the thirtieth anniversary of her organization, whose goal is to witness and minister to people in poverty in New Mexico. Ms. Hoffman said her work is in policy, but there is no silver bullet. "We do the work individually, but we work together", she said. Congregations in New Mexico are answering the call to feed the hungry. Without SNAP, every congregation in America would each need to spend \$50,000 a year to fill the need, she said.

There are 444,000 New Mexicans who receive some kind of SNAP assistance now — this is one-fourth of the state's population. Some people — the elderly and disabled — get \$16.00 a month, but with the state SNAP supplement, that is raised to \$25.00. Ms. Hoffman would urge the legislature to add \$1.2 million to the general fund supplement and restore that amount to \$30.00 a month, which is where it was before the recession. Other actions that could help reduce hunger in New Mexico include increasing state funding to the Fresh Produce Initiative, increasing the minimum wage, encouraging economic development that provides well-paying jobs, providing early childhood education, improving public transportation, providing stronger enforcement of wage theft laws and many more suggestions that are found on page 15 of her handout. Ms. Hoffman urged every member of the committee to visit a food pantry in his or her district. The challenge of meeting the needs is more than the private sector can handle, and everyone has to continue to work together, she said.

Questions/Concerns

A committee member expressed enthusiasm for the emphasis on fresh produce and asked if what is used is grown in New Mexico. Most of it is, Ms. Hoffman said, but federal and state funding for fresh produce needs to be broadened so that supplying fresh produce becomes part of economic development. The need for cold storage, especially in rural areas, was discussed, including the possibility of using portable cold storage.

A member addressed Mr. Graham, saying his lesson is a good one for the state: You do your work without any judgment, which is very important, the member said. How people come to this situation of not having enough to eat needs to be identified. Adult education, job training, early childhood education, an increase in the minimum wage, all of these are important, the member said, adding that he hoped everyone would listen to people in the trenches who work from the bottom up to effect change.

Ms. Hoffman was asked by a member to supply the committee with a spreadsheet of her policy recommendations for the legislature, along with the dollar amounts requested. Mr. Graham was asked if he thought his consortium was meeting the hunger needs in Lovington. He responded that "we are always going to need more than what the private sector can do, but I think we can come close".

Every year the numbers seem to grow larger, especially for seniors and transportation issues, said another member. Two hundred families receiving food is a drop in the bucket, she said. Outreach is needed in communities to put money into adult education and to utilize public schools and spaces that already exist for this in communities. There is much work yet to be done, she said.

There was discussion of the fact that schools are still throwing away food, and a member made the motion that the LHHS send a letter to the Public Education Department asking that it notify all school districts that it is legal to give leftover food to local food pantries. The motion was seconded and passed with no objection.

Alzheimer's Task Force Presentation

Alzheimer's disease is a public health crisis in New Mexico, said Gino Rinaldi, secretary of the Aging and Long-Term Services Department (ALTSD). In response to House Memorial 20 calling for development of a state plan to deal with Alzheimer's, his agency convened a broad-based task force in 2012, and today Secretary Rinaldi, along with Myles Copeland, ALTSD deputy secretary, and Agnes Vallejos, executive director of the New Mexico chapter of the Alzheimer's Association, presented the results: the New Mexico State Plan for Alzheimer's Disease and Related Dementias (see handout).

Alzheimer's has surpassed all other diseases as the most costly in the nation, Secretary Rinaldi said, and New Mexico now joins 30 other states that have already published plans for dealing with the disease. A PowerPoint presentation of steps taken to develop the state plan was presented to committee members (see handout), starting with the selection of 60 members representative of the entire state. Included were participants from state government, providers, caregivers, tribal organizations, educators, researchers and persons with Alzheimer's disease. The New Mexico Alzheimer's Association co-facilitated meetings and provided technical information and support. Five work groups addressed quality of care, caregiver needs, research, health care system capacity and public awareness, and developed recommendations and goals that were then presented to the full task force for consideration. The plan recognizes the unique elements of

New Mexico (rural character, high poverty and cultural and ethnic diversity), and is a "living document", Secretary Rinaldi said.

Deputy Secretary Copeland described the effect of aging baby boomers, and said that by 2025, New Mexico will have the fourth-largest population in the nation over 65 years of age, and, it has been estimated, 43,000 residents suffering from Alzheimer's. There is a link between Alzheimer's and general health, he said, and age (over 65) is the biggest risk factor. Most care is being given within the home, Ms. Vallejos said, resulting in significant stress on the family caregiver, who may not know where to turn for help. There is stigma and isolation associated with the disease, as well as financial strain for the family, who may not involve a physician until there is a crisis. Deputy Secretary Copeland said the task force found that a lot is being done by organizations, but much of it is not connected. Caregiver training with evidence-based classes not only helps families, but also provides a direct financial benefit for the community at large with urban and rural course delivery, including a Spanish language program.

The plan recommends the establishment of an Office of Alzheimer's Disease within the ALTSD, Secretary Rinaldi said, to serve as a one-stop shop for information and for caregivers who may qualify for services. There are two universities and two national laboratories in new WICHE slots that could be invaluable for research, collecting reliable data and broadening public education about Alzheimer's, he said. Other recommendations include reestablishing a geriatric center at UNM HSC and adopting the Alzheimer's Association dementia care practice guidelines as minimum standards for all providers in New Mexico.

Questions/Concerns

A member asked if treatment for dementia is different than treatment for Alzheimer's. Ms. Vallejos said yes, but as people become more cognitively impaired, physical health becomes more important and the approaches tend to be the same. Project ECHO has an Alzheimer's clinic, she said, and this has really elevated everyone's understanding as far as distinguishing different forms of dementia. The member also suggested that, given estimates of one in three New Mexicans eventually developing Alzheimer's, state government might be wise to get ahead of the curve by adapting senior centers to provide adult daycare facilities instead of mini-gyms. Secretary Rinaldi commented that there is a correlation between lifestyle and dementia, and perhaps there needs to be a balance of both. Minimizing risk factors for Alzheimer's can potentially delay onset, Ms. Vallejos added. "What is good for your heart is good for your head."

A tsunami is coming, said another member, whose mother died of Alzheimer's, and not just in New Mexico but across the country. Rural New Mexico does not have senior centers. It is critical to figure out what to do about respite care for caregivers in rural communities, where people do not know where to go or who to call. It is heartbreaking to see what families are going through, the member continued; the challenge will be to collaborate and spread resources.

Public Comment

Pastor Choice commented that the plan needs to include tri-cultural considerations, not just those of Native American and Hispanic residents. A photograph on page 19 of the plan shows an African American couple, he pointed out.

Robert Rohr, J.D., corporate director of human resources for Haverland Carter Lifestyle Group, an organization that provides home health care in Albuquerque, said that despite geriatrics being a fairly affluent area of health care, recruiting BSNs with geriatric experience is very difficult. He said that residents are coming to his organization at an older age and with more acute needs, requiring more time and expertise from staff. Mr. Rohr urged that skilled nursing care in senior communities should be important to the state; it is not all about hospitals, he said.

Ending Homelessness in New Mexico

Hank Hughes, executive director of the New Mexico Coalition to End Homelessness, described the annual one-day point in time count of the unsheltered homeless in Albuquerque, which was conducted on January 28, 2013. That number was estimated to be about 2,800, Mr. Hughes said, and has been reduced because state and federal funding have increased the number of beds for the homeless to 1,600. It is estimated that 20,000 New Mexicans have or are experiencing homelessness, he said. For homeless children, the numbers have gone up to 13,000, perhaps due to the poor economy. The Public Education Department's definition of homelessness includes sleeping outside or living with friends or in hotels.

People who are disabled and homeless need subsidized case management and subsidized permanent housing, Mr. Hughes said. Housing is the first line of treatment, and it is cheaper to provide it than to just leave people on the street, he said. Mr. Hughes provided a report (see handouts) from the UNM Institute for Social Research that examined in depth Albuquerque's Heading Home initiative. The study found a net cost benefit of nearly \$13,000 per person from fewer emergency room and hospital admissions, incarcerations, inpatient mental health treatments and other services. The homeless fund and linkages are two sources of state funding; the federal government matches funding 4:1 for supportive housing. An additional \$1 million is being sought this year from the legislature to support transitional housing, Mr. Hughes said, and \$1.2 million for the state's current homeless population.

Pamela Angell, co-chair of the New Mexico Coalition to End Homelessness and development director for the Community of Hope at St. Luke's Health Care Clinic in Las Cruces, said that when she began working with the homeless 12 years ago, she had a \$5,000 grant to put veterans in hotel rooms. The nonprofit clinic campus where she now works has five agencies on 15 acres, including a soup kitchen, a food bank serving 5,100 families, daycare that serves 184 children and a clinic with free medications that sees 22,000 patient visits per year. It also provides financial and other medical assistance to the homeless. Ms. Angell said that she is excited about the Housing First model, which provides housing as a first line of defense. Once consumers feel secure, she said, they can address other issues such as alcohol dependence or drug abuse. It is cheaper to provide housing than to provide services (medical, dental and behavioral) to people

who have been living on the streets, she said. Three-fourths of the clinic staff are nurses; the rest are volunteer physicians. The clinic has a Medicaid provider application pending.

Questions/Concerns

In response to a member's question about how much money the program in Las Cruces is saving the state, Ms. Angell said she does not exactly know. There is not a lot of staff funding, so data are hard to come by, but she is working with a statistician at New Mexico State University. Another member asked how many units were needed — 7,000, Ms. Angell estimated — and noted that the cost of building supportive housing would also have to include ongoing maintenance and continued supportive services. It would depend on the degree of disability of the consumer, Ms. Angell said. People can heal and become empowered just by having a roof over their heads.

Another member said she was sponsor of the Affordable Housing Act, which takes care of the state's antidonation clause problem as long as there is a public benefit. The city of Las Cruces donated a building, the member said, and funds from a foundation were used to fix it up for chronically homeless women. The member suggested that a comprehensive study of buildings throughout the state be conducted to identify those that might be suitable for this type of initiative. Ms. Angell speculated that if 2,000 four-plexes could be built — 100 a year for 20 years — the need would be solved. "This is doable if we just put our heart and soul into it", she said.

Ms. Angell was asked by a member if OptumHealth had offered any funding to help with programs. Behavioral health has been handled outside of the campus, she said, but she would like to see behavioral health integrated with primary care on-site. When her program becomes a Medicaid provider, it will be able to take care of 98% of its homeless under the expansion.

Services for Victims of Human Trafficking

Lynn Sanchez, M.A., L.P.P.C., is executive director of The Life Link in Santa Fe, founded 25 years ago. Today, it is a licensed nonprofit community mental health center with more than 50 employees and is the only program in the state providing comprehensive after-care for rescued human trafficking victims (see handout). In keeping with federal recommendations, The Life Link initiated the textable 505 GET FREE in March. Since its inception, it has received nearly 300 texts and 72 calls.

Human trafficking victims are among the most vulnerable in the population, Ms. Sanchez said. Trafficking is not about prostitution; it is about coercion and loss of liberty. People think that trafficking is only in other countries, but people are being trafficked throughout the U.S. for work in domestic service, agriculture, construction, food service and many other industries. A lot of money is being made, and there is very little public awareness of it, Ms. Sanchez said. Victims need immediate safety and shelter, and require food, clothing, housing and extensive long-term care in order to become stabilized. Most of The Life Link's referrals come from the Albuquerque vice squad, but Ms. Sanchez urges communities to do outreach to identify victims of trafficking instead of relying exclusively on law enforcement.

Michael DeBernardi, Psy.D., director of behavioral health services at The Life Link, referred members to the handout to explain why the services for these victims are very expensive but absolutely necessary. There is no identified funding stream, and the only state funding for human trafficking victims is through the Crime Victims Reparation Commission, the federal Violence Against Women Act of 1994 and the Victims of Crime Act, amounting to about \$40,000 annually. In order to provide appropriate services, The Life Link presented a budget asking the legislature to appropriate \$470,000 for 2014 to provide comprehensive services to an estimated 25 rescued trafficking victims. There were seven trafficking cases tried in New Mexico last year with a 100% conviction rate because victims were in good shape to testify, Dr. DeBernardi said.

Susan Loubet, executive director of New Mexico Women's Agenda, says her group has supported human trafficking legislation with a focus on victims. There is a need to support these victims so they are emotionally able to testify against the trafficker, she said. Trafficked minors should not be treated as juvenile offenders, but as the victims that they are, and they should be provided with a lawyer and services. Another provision supported by the New Mexico Women's Agenda is sealing the records of trafficked victims.

Questions/Concerns

A member noted that the legislature cannot appropriate funds to a nonprofit agency and suggested that funds might be provided out of behavioral health funds. Another member asked about the concerns with traffickers and how to protect the victims. Dr. DeBernardi said that victims need a safe house and that safety issues are paramount. There is concern for staff as well, he said. He described many victims as suffering from what is known as Stockholm syndrome, which is a form of traumatic bonding by the victim with the trafficker. It is important to break that cycle, he said, and help victims understand why they are drawn to these types of people.

Another member asked what percentage of the victims served are male, and Dr. DeBernardi said about 10%. None are minors, as the program is for adults, he said. Sometimes victims are local, sometimes they are from out-of-state, but virtually all of them have said there are other victims. Substance abuse is present 100% of the time, he said. Native American victims have difficulty reintegrating into tribes, said another member. It is still considered prostitution, and there is shame, the member said. Human trafficking was discussed at the Navajo Nation Tribal Summit and is considered a serious problem for the tribes. The member suggested perhaps some funding could come from the Indian Gaming Compact being negotiated right now.

Postnatal Screening for Congenital Heart Defect

Sheridan Gluff spoke to the committee about the birth of her son, and how, according to all standard screenings, he was beautiful and healthy. But her son died suddenly not long after birth, and Ms. Gluff and her husband were told their baby had a heart murmur, but in fact it was a birth defect of the heart, and it would have required immediate intervention to save the baby's life. Since losing her son, Ms. Gluff has become involved with the March of Dimes and agreed to appear here today as a spokesperson for the proposed legislation, Ryan's Law. "No parent should have to find out about a defect from the coroner", she said.

Kathy Cooper, a registered nurse who works at Lovelace Regional Hospital in Roswell, described the heart defect that affects three out of every 1,000 babies born in New Mexico. There is a test, she said, that is so simple and so inexpensive, it should be mandated in newborn screening. Ms. Cooper demonstrated the simple, noninvasive device used in the test, which has been strongly recommended by many pediatric and hospital associations. If a problem is suspected, an echocardiogram is next, she said. This test has been performed routinely at Lovelace in Roswell for about a year, and it usually is done at discharge. Every hospital in the state already has this equipment, Ms. Cooper said, so nothing new needs to be purchased, and it does not require any extra staff. Most states already do this test (see handout), she said, but there are 11 states that do not mandate it, and New Mexico is one of them.

Ron Reid, Ph.D., is state director of program services and governmental affairs for the March of Dimes, New Mexico Chapter. This special group is a team from the March of Dimes, Dr. Reid said, motioning to Ms. Gluff and Ms. Cooper; they are ambassadors. There are about 130 babies who die annually in New Mexico because of this easily detected defect, he said. This is one test that can save many lives.

Questions/Concerns

A member asked about collaborations, and whether the New Mexico Medical Association or the obstetrics and gynecology group had endorsed it. There has not been any opposition, Dr. Reid said. During a 30-day session, if everyone is not on board and if the governor is not on board, the chances of this initiative being enacted into law are nil, the member cautioned.

A member motioned for the committee to write a bipartisan letter of support for Ryan's Law. There was no further discussion and no objections, and the motion passed unanimously.

Dr. Reid provided members with a folder of information (see handouts) on prematurity and its economic impact. There are many things that can be diagnosed and prevented in utero, he said.

The meeting recessed at 4:35 p.m.

Friday, October 4

Call to Order and Introductions

The meeting was reconvened at 8:45 a.m. by Representative Madalena, who yielded his gavel to Senator Kernan. It was noted by Senator Kernan that former state representative Donald L. Whitaker, who was from Eunice, had passed away early that morning. Senator Kernan and other members and guests recalled Representative Whitaker's many contributions to Lea County and New Mexico Junior College and his many years of effective and generous service in the state legislature.

Members and staff were asked to introduce themselves, and it was announced that the agenda had changed; the afternoon presentations had been canceled and would be rescheduled for the next meeting of the LHHS in Santa Fe in November.

Behavioral Health Services Discussion

Daniel J. Ranieri, Ph.D., is president and chief executive officer (CEO) of La Frontera Arizona and La Frontera New Mexico. La Frontera Arizona was founded in 1968, and Dr. Ranieri joined the nonprofit organization in 1995, coming from several positions in the for-profit corporate health care world. When he started at La Frontera, there was great system upheaval in Arizona, with many providers on the brink of bankruptcy, and Dr. Ranieri said he had to hire and implement a business structure. The transition took eight years, he said, and at that time, La Frontera had an income of \$11.5 million and 225 employees, "but we were broke". Over time, La Frontera expanded statewide, primarily by friendly acquisitions of other nonprofits that approached it. About three years ago, La Frontera rebranded and redefined its mission as being a community problem-solver working with community partners in public safety, economic development, suicide prevention, senior living and prevention of violence. La Frontera Arizona, now the largest affordable housing provider in the state and a leader in organizational cultural competency, has 930 employees, he said.

Dr. Ranieri said that when La Frontera came to New Mexico, the task before it was huge; it grew and became more complicated, he said. There are a lot of things that he does not know about the transition — Dr. Ranieri insisted he has had no private conversations — but he will tell the committee what he does know. He invited members to contact him at any time with further questions.

Dr. Ranieri said he was first contacted in late November by a friend, Andy Sekel, CEO of OptumHealth Behavioral Solutions, who asked if he knew about "the Carlsbad situation" and said that OptumHealth might need some help. His friend asked if he could give Dr. Ranieri's contact information to the HSD. In January, Dr. Ranieri said, he got a call from Diana McWilliams, and he invited her to visit La Frontera in Arizona. On February 28, the first day of the Public Consulting Group (PCG) audit of the 15 providers, Ms. McWilliams met with him in Arizona for several hours, he said. She was accompanied at this meeting by Thomas Aldridge, who was in charge of the PCG audit, Dr. Ranieri said. In mid-May, Dr. Ranieri said he was again contacted and told that the preliminary audit results were showing problems much deeper than expected, and the HSD was probably going to need help, but the HSD would not know until the audit results were presented. Contract negotiations began at the end of May, and after the contracts were in place, La Frontera started to put together a transition team composed of approximately 20 employees and contractors. This team met regularly, he said, and like a special forces unit, had to be prepared to be deployed. They had an exhaustive list of things to do, he said, and on June 24, when pay holds were initiated on the 15 New Mexico providers, his team was told to be ready. Once directed, the team needed to be "on the ground" in 72 hours. On Friday, July 19, Dr. Ranieri said he received a directive to be on the ground the following Tuesday to transition Southwest Counseling Center in Las Cruces. The HSD wired \$160,000 to

cover the center's operations that week, he said, and La Frontera hired 106 of the 112 employees at Southwest and leased all of its facilities, phones and vehicles. Of the 106 hired, three have left, to his knowledge. Dr. Ranieri was then told that La Frontera would be transitioning Families & Youth, Inc. (FYI), in Las Cruces, The Counseling Center in Alamogordo, TeamBuilders Counseling Services, Inc., in Santa Fe, Border Area Mental Health Services in Silver City and Southern New Mexico Human Development in Anthony. Dr. Ranieri said La Frontera retained a total of 418 staff and actively reached out with each community, with "pretty good" reception.

Dr. Ranieri said there have been many rumors, some inaccurate, some gross exaggeration. He addressed just a few, saying that the ACT team in Las Cruces has not been shut down; it was restructured and updated. It is not true that La Frontera is not providing transportation for the ACT consumers. La Frontera acquired the original 20 vehicles that were being used, and it has purchased nine more. He also addressed rumors that Arizona providers were being hired. La Frontera is not hiring Arizona people, Dr. Ranieri said; there are between two and five Arizona people (from his organization) working permanently in New Mexico.

Questions/Concerns

Committee members had numerous questions for Dr. Ranieri, which have been grouped into the following categories.

How are issues with billings being addressed? New Mexico has changed its behavioral health oversight entity every four years, and providers have not been given the opportunity to adjust their billing problems, one member noted. Dr. Ranieri said that in Arizona, the same regional authority has been in place since 1995. Medicaid rules on billing and reporting have changed repeatedly over that time, and it took La Frontera the better part of five years to set up its system for proper and accurate billing. In Arizona, services have been modified to be in line with Medicaid rules, he said, and the clinical delivery system has been modified to match what Medicaid pays. Over time, as technology improved, billing has become increasingly more complex, Dr. Ranieri said. Everything must be correctly charted, with the proper diagnosis code, initials of the provider and notes that correspond. In New Mexico, providers did not catch up in the transition, he said. Some of the billings in the agencies La Frontera took over were awful, he said, but by teaching them from scratch and with monitoring, it will soon become evident whether the agencies are generating enough billings to survive. "Where did we drop the ball in the state of New Mexico?", another member asked. Dr. Ranieri said he feels it is a shared responsibility. In Arizona, all providers had to learn to bill properly, he said. If there were sanctions, the state would be sanctioned, as well as the regional entity and the providers.

Questions about provider trainings. The majority of New Mexico providers are currently being trained by La Frontera's team, he said. The training is extensive and involves all new computers and software, electronic recordkeeping and billing as an integrated process with checks and balances, Dr. Ranieri said. Also, the providers have access to online training. With the new billing system, there is a monitoring component and a compliance component, and many

ways to report suspicious patterns. It is a big task, he said, and it adds to the cost, but it has to be done. He estimated that training will be complete within the next 30 days to 90 days. A member noted that if the HSD had come to any of the state's nonprofit providers and challenged their billing systems, the providers could have built in the costs to fix them, but they were not offered any of the opportunities that La Frontera was provided.

Who controls medical records? A member said she thought medical records belong to the patient; another said that they belong to the contracting agency, i.e., Medicaid, but that the patient has to consent to a transfer of records. Dr. Ranieri said that this is an area of dispute. There are a series of contracts in place, he said. La Frontera contracts with OptumHealth, OptumHealth contracts with the HSD and the HSD contracts with the Centers for Medicare and Medicaid Services, and the service agreement states that the entity that contracts for services has access to the information in the records. La Frontera is taking the most conservative route to protect client confidentiality, he said.

Time line and scope of La Frontera contracts. "Are you temporary management?", a member asked Dr. Ranieri. No, his organization is not temporary, he said. La Frontera has signed contracts with all four MCOs under Centennial Care. Asked if his company has other contracts with the State of New Mexico, Dr. Ranieri said that La Frontera has been asked to look into other possible contracts for non-Medicaid dollars, with justice programs and with some county agencies, but for now, the focus is on behavioral health. The member asked him if he would provide the committee with a list of other potential contract areas, and he agreed to do so.

Committee members had been provided with a copy of the contract between La Frontera Arizona and the HSD, signed June 18 and finalized on June 25, and had more questions. An earlier contract between the HSD and La Frontera was for services from March 11 through December 31, 2013 and was signed on February 25, 2013. Dr. Ranieri said that this was for earlier work, with minimal billing to cover time and expenses. There was very little done before mid-May, he said, just license certifications, nonprofit corporation filings, etc., nothing substantial. There were things that needed to be done for which La Frontera would be reimbursed, he said. A member read a list of La Frontera employee names from its 2012 Form 990, and then pointed to the hourly rates listed on Exhibit A attached to the contract, and asked if employees or contractors received any other taxable income from any other entity of La Frontera Arizona, Inc. Dr. Ranieri said they did not, although the company does provide incentives and periodic bonuses. The C corporation is an umbrella company, he explained, and it does not provide any services. Asked if he was receiving his rate of \$300 per hour to appear here today, he answered yes. The member asked why the umbrella company is separate and is not a nonprofit. He did not know, and he said it was set up this way on the advice of La Frontera's attorney and auditor. The member asked if Dr. Ranieri was asked by the HSD to reveal his organization's corporate structure. He himself was not asked, he said, but maybe its attorney was. The billing rates in Exhibit A were not the result of negotiation, he said; these rates were presented to La Frontera, and La Frontera accepted. Dr. Ranieri estimated that he will probably

have around 250 billable hours total for his part in the transition and that he intends to remain headquartered in Arizona.

Issues with Centennial Care. Dr. Ranieri said he is cautiously optimistic about Centennial Care and that critical behavioral health services will not be marginalized. He said La Frontera will be negotiating assertively for behavioral health, focused toward measuring outcomes. He does not know yet what the battles will be, but he expects it to be a challenge, given how tight funding is going to be. Dr. Ranieri said he understands the concerns about implementing Centennial Care, which certainly will not be eager to pay bills if they have not been correctly submitted. A member expressed concern about Centennial Care, because the primary care system has spun off behavioral health and she thinks it will not be dealt with by Centennial Care.

Why La Frontera was willing to take on such risk. A member asked if La Frontera considered doing some consulting first, rather than taking over. La Frontera would probably have preferred to do this in a more measured way, Dr. Ranieri said; it did think long and hard before moving forward. The transition team was working 15 hours a day to make sure services would not get interrupted and that employees would get paid. The member continued, asking why, when told to be ready in 72 hours and with all the unknowns, was he willing to take on this huge responsibility? His organization had the experience and the ability to go get the talent that was needed, he said. La Frontera had developed enough capacity that it felt it could transition without injuring the Arizona operations. Another member commented on the "special forces" language used by Dr. Ranieri in his opening statement. It seems like somebody instilled this combat mentality, and that there was a war being conducted behind the backs of the 15 targets, who had no idea of the coming trauma that would be instilled in providers and clients.

Empathy for colleagues. When Dr. Ranieri met with several of the CEOs of the organizations that were being transitioned, he said he felt badly. These folks had spent their lives building their careers and their companies, just like himself. A CEO has the ultimate accountability, Dr. Ranieri said, and if anyone is going to jail, it will be him, but he will not be going alone. Innocent mistakes can come from lack of sophistication or carelessness. Self-monitoring needs to take place continuously, he said, and La Frontera does its own evaluations on an ongoing basis.

Dr. Ranieri requested written follow-up regarding what information has been requested by the committee.

Many members of the committee thanked Dr. Ranieri for his willingness to appear before the committee and for his straightforward testimony. Several members lamented the fact that OptumHealth has never appeared in front of the committee despite four different requests. It was suggested that the LFC, which has powers of subpoena, may be able to help with this issue.

Public Comment

Roque Garcia, former CEO of Southwest Counseling, said that every four years, providers have been subjected to a change in the MCO, and that all of the changes have come on the backs of the providers. OptumHealth has been the very worst of them, Mr. Garcia said. OptumHealth had never before had a public sector contract; it had only worked in the private sector, Mr. Garcia said, and it had absolutely no responsibility. The year 2009 was the worst, he said. "We could not get paid."

Rio Grande Behavioral Health was organized in 1990 in response to a request for proposals from the state to form a regional system, similar to one in Tucson, Mr. Garcia said. It is a great model, and providers have a lot of input. As health maintenance organizations came in to the system, everything changed. In 2000, with capitation, this was the first time that providers were able to purchase a software system to improve billing, he said. Mr. Garcia advised the committee to consider the advantage that La Frontera has: no real responsibility, and it is being funded to develop information technology and infrastructure. Copies of emails from OptumHealth telling Rio Grande how to bill ACT have been sent to the Attorney General's Office, Mr. Garcia said. There is no intention of any fraud anywhere. The state has just spent \$20 million to eliminate 15 CEOs. Mr. Garcia said he would have resigned, but he wants due process and a presumption of innocence.

Krista Scarson, a former nurse practitioner for Southwest Counseling who was employed with La Frontera for two weeks before quitting, told committee members that some of the things she had heard today are not true. She said much of Dr. Ranieri's information is inaccurate because it was provided to him by Larry Heyeck. There was a hostile takeover, she said; these plans had been in place for a very long time. Although she was assured by the HSD that the Arizona company would be ready, there were no computers, no paperwork, no authorizations, no access to charts, she said. The basic elements for a clinical transition were missing. Ms. Scarson wrote letters to U.S. Senators Tom Udall and Martin Heinrich about her concerns. On Monday, at the Behavioral Health Subcommittee meeting in Albuquerque, Ms. McWilliams discussed her "audit" of Southwest Counseling's ACT services. Ms. Scarson said she does not know who conducted the audit, because no one talked with her or her former CEO. Ms. Scarson disputed Ms. McWilliams' assertions item by item. What Ms. McWilliams was reporting simply is not true, she said. Ms. McWilliams is not a clinical prescriber, and her assertion that using telemedicine with this vulnerable population is "an innovative method" is actually just a way to cut costs.

Role of County and Tribal Health Councils in New Mexico's Public Health Infrastructure

Ron Hale, coordinator of the New Mexico Alliance of Health Councils, represents 30 active tribal and county health councils that mobilize communities to identify local health needs and plan and coordinate solutions to those needs (see handout). New Mexico is one of just a few states that do not have county-based public health offices, Mr. Hale said. The coalition, created in 1991, was funded by the DOH until 2010, when funds were cut. New Mexico has huge health problems rooted in poverty, he said, and health care access is an enormous challenge. The councils have been able to attract millions of dollars in grant funding over the past decade, Mr.

Hale said, resulting in an investment of \$4.00 for every \$1.00 invested by the state. A recent three-year evaluation of the health councils by UNM found that the councils established new programs, influenced policies, developed coalitions and networks and accomplished other outcomes leading to improved health in their communities. Mr. Hale said the health councils are asking \$900,000 from the legislature this year to continue their work.

Jane Batson, coordinator of the Chaves County Health Planning Council, described the council membership as being broad-based and representative of the community (see handout), including consumers, clergy, public schools, city and town governments, agencies and senior groups. Accomplishments include creation of a dental services program in 1999 that has evolved into a full-scale dental clinic and the creation of The Open Door free women's health program that includes case management and home visitation. Other accomplishments include a pharmacy program, a school-based health center, a free outreach clinic for the homeless and uninsured, a health impact assessment funded by the W.K. Kellogg Foundation and annual health fairs, among others. The complete loss of funding in 2010 challenged the health council's ability to maintain this coordination, Ms. Batson said, and program stability was challenged.

Patty Collins, former coordinator of the Lea County Health Council, spoke about the loss of funding for staff who can provide the detailed work on the specific health disparities in the community (see handout). Membership, which represents five different communities, has been able to share services and resources and to work toward common goals.

Dick Mason, co-chair of the Sandoval County Health Council, said the council is fortunate to have representation from numerous other boards, councils and citizens groups (see handout). The broad-based nature of the council helps for implementing environmental strategies. Among its accomplishments are a health commons in Bernalillo for low-income county residents, development of a transportation system to provide transport to essential services for residents of rural Sandoval County, conducting a health needs survey every two years and development of a directory of county resources.

Yolanda Cruz, health councils and community coordinator of the New Mexico Health Equity Partnership (see handouts), described the many activities of the partnership, which is funded by a grant from the W.K. Kellogg Foundation through the Santa Fe Community Foundation. The project intends to give local leaders the data, tools and skills to address social, economic and environmental conditions in their communities that shape health outcomes. Ms. Cruz said the Health Equity Partnership will have particular focus on racial, environmental and economic inequities related to higher infant mortality, higher rates of disease and disability and shortened life expectancy.

Committee members thanked the presenters on health councils for their worthwhile work. One member suggested that the committee should consider supporting this funding request or come up with a formula for the local county to be matched.

Motions for Various Letters

Following discussion, a motion was made, seconded and passed for the draft letter to Secretary of Human Services Sidonie Squier to ask specifically for C9 reports for behavioral health from January 1 to the end of September. Regarding a letter to the congressional delegation, another member suggested the emotional tone be removed from it to make it a factual request. Others agreed, and a motion was made, seconded and passed with no objections. A third letter, this one to the attorney general concerning a possible breach of notification requirements with unencrypted data being sent via email, was discussed. A motion to send the letter was made, seconded and passed with no objections.

The meeting adjourned at 3:30 p.m.

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

**November 6-8, 2013
State Capitol, Room 307
Santa Fe**

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on November 6, 2013 at 8:45 a.m. in Room 307 at the State Capitol in Santa Fe.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza (11/6, 11/7)
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan (11/7)
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Absent

Advisory Members

Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto (11/6, 11/7)
Rep. Sandra D. Jeff (11/7, 11/8)
Rep. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. Sander Rue (11/6, 11/8)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson
Sen. Lisa A. Torracco (11/6, 11/7)

Rep. Phillip M. Archuleta
Rep. Paul A. Pacheco
Rep. Vickie Perea
Sen. William P. Soules

Guest Legislators

Sen. Michael S. Sanchez (11/6)

Rep. Christine Trujillo (11/7)

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

Staff

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

Shawn Mathis, Staff Attorney, LCS

Rebecca Griego, Records Officer, LCS

Nancy Ellis, LCS

Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Wednesday, November 6

Welcome and Introductions

Representative Madalena welcomed guests to the meeting and asked members and staff to introduce themselves.

Centennial Care Update

Julie Weinberg

Julie Weinberg, director of the Medical Assistance Division (MAD) of the Human Services Department (HSD), gave committee members a presentation on plans for implementation of Centennial Care simultaneous with Medicaid expansion (see handout), which begins January 1, 2014. Ms. Weinberg said that the MAD has been working with Centennial Care's four managed care organizations (MCOs) since early spring, with attention to testing of claims processing and payments, provider network adequacy and care coordination. She assured members that the MAD is very focused on correct and prompt provider payments, as well as members' access to care. Medicaid recipients have until December 2 to select their MCO, she said. Those who do not select one on time will be auto-assigned. All members will receive notices in December confirming their MCO selections, but they still have a 90-day period to select a different MCO. The MAD has been doing "road shows", with more than 250 separate events attracting nearly 10,000 people. Along with program and education staff, representatives from the four MCOs also have attended every event. As of this report, Ms. Weinberg said, nearly 23,000 individuals had selected an MCO. Information about adult Medicaid expansion also was presented at these events. Most new applicants for Medicaid expansion will now receive just one notice of the opportunity to enroll, and if a Medicaid applicant does not qualify for Medicaid, the individual's

application will be sent to the New Mexico Health Insurance Exchange (NMHIX) for evaluation. From October 1 through 26, 2013, 19,000 persons applied for Medicaid, Ms. Weinberg said. The HSD will automatically enroll nearly 70,000 individuals who are currently enrolled in the State Coverage Insurance (SCI) program and who qualify for Medicaid coverage in 2014. Notices will go to those on the SCI waiting list informing them how to apply for Medicaid or NMHIX coverage.

Beginning in early 2014, hospitals, the Indian Health Service, tribal health facilities, urban Indian health centers, state prisons and county jails also will be allowed to conduct presumptive eligibility determinations for expanded Medicaid.

The newly enrolled adult group will receive a slightly different benefit package than other Medicaid members, the Alternative Benefit Plan (ABP), which includes preventive, mental health, substance abuse and dental services. The ABP will have some limitations on some services, such as physical therapy, and there will be some minimal copayments. Exempted from copayments will be members with household income up to 100% of the federal poverty level (FPL) and all preventive, behavioral health, prenatal and postpartum care and family planning services. Native Americans are not subject to copayments of any kind, Ms. Weinberg said.

Pregnant women and medically frail individuals are exempt from the ABP and can choose either the ABP or the SCI. Those persons on the SCI waiting list will be notified about Medicaid expansion. There really is no wrong door here, Ms. Weinberg said.

Ellen Pinnes

Ellen Pinnes, attorney and health policy consultant, told committee members that Centennial Care combines Medicaid into a single program through a new Section 1115 waiver approved by the federal Centers for Medicare and Medicaid Services (CMS) (see handout). Almost every part of the Medicaid program and almost every Medicaid enrollee will be affected, said Ms. Pinnes, resulting in both positive and negative changes and a lot of unknowns. Ms. Pinnes stated that her presentation was intended to highlight concerns and issues behind the changes that will happen all at once and affect up to 500,000 enrollees. There will be fewer MCOs, and there are questions about whether all four MCOs will have the experience or ability to administer all services.

Ms. Pinnes wondered whether "carving in" behavioral health to physical services actually integrates health care services. While care coordination is a key element of the new Centennial Care, Ms. Pinnes stated that it is not exactly clear how it will work or whether it will improve on the current system. Picking a new MCO can be a complicated process, Ms. Pinnes said, and the HSD is not offering assistance regarding plan selection. Income eligibility for family planning and breast/cervical cancer treatment without copayments has been reduced to 138% of the FPL. On the positive side, 12-month continuous eligibility reduces the "churn" in and out of the Medicaid program and reduces administrative burdens, she said. Originally, the HSD wanted mandatory enrollment for all Native Americans, but the tribes opposed this and the CMS

disapproved it. The devil is in the details, Ms. Pinnes concluded, and many of the details have been shrouded in secrecy. Development of the program has not been transparent, details are still emerging and much is still unknown, she said. Implementation work groups were internal to the HSD, Ms. Pinnes said, and there was limited opportunity for stakeholder input or participation.

Jim Jackson

Jim Jackson, executive director of Disability Rights New Mexico, addressed concerns about Centennial Care for elders and persons with disabilities (see handout). The key feature of Centennial Care is that the MCOs are to provide nearly all services to nearly all populations, Mr. Jackson said, including elders and people with disabilities needing long-term services, behavioral health services, including mental health and substance abuse, and service coordination and case management for people with higher levels of need. The only exception, he said, is that MCOs will not provide developmental disabilities waiver services but will provide health services for this population. There will be increased access for community-based long-term services, as the Medicaid expansion will cover people up to 138% of the FPL. Services now available only through the coordination of long-term services "c" waiver will be available to everyone who is income eligible and needs "nursing home level of care" through the "community benefit", he said. There is, however, a built-in barrier in the community benefit, Mr. Jackson noted. Services that any individual can receive will be capped at nursing facility cost, discriminating against persons with more severe disabilities and higher levels of need. These individuals may be forced into nursing facilities if they can find a facility that will accept them.

There will be greater opportunities for self-direction with many community-based services, Mr. Jackson said, with MCOs financially responsible for those services and for providing consumers with support and assistance for self-direction. The new CMS waiver required the HSD to submit an "Independent Consumer Support System" (ICSS) plan for individuals receiving long-term services, but that has been delayed and will not be in place until January 2014, too late to help current beneficiaries who must choose an MCO by December 2, Mr. Jackson said. With no help from the HSD or the ICSS program, more than 10,000 consumers will have to choose a new MCO on their own, with little information about what providers are in each network. Regarding behavioral health services, it is unclear how the coordination of care will be delegated to "core service agencies", since New Mexico's current system has been turned upside down, Mr. Jackson said. How the desired "holistic" integration of behavioral health with physical health will be achieved following the transfer of the behavioral health system to Arizona companies is also unclear, he said. The Medicaid expansion will extend health coverage, including added service benefits, to large numbers of currently uninsured adults with mental illness, Mr. Jackson said, but it is not clear how this will be accomplished.

Dorianne G. Mason

Dorianne G. Mason, staff attorney at the New Mexico Center on Law and Poverty (NMCLP), provided an overview (see handout) of the Medicaid expansion, the enrollment process, coverage and benefits and new opportunities for data collection. More than 170,000 adults between the ages of 19 and 64 are eligible for the expansion, Ms. Mason said, but at least

45% of these uninsured individuals do not even know about it. Significant and positive steps have been taken by the HSD to spread the word, but more than 90,000 individuals have not yet been brought into the system. Ms. Mason urged partnership with community groups and schools, "going where the people are", she said, and the provision of clear, accurate information from the HSD's Income Support Division workers, who need more training. She also urged improvements to the HSD web site to make it clearer and more user-friendly, and she recommended printed materials that are accurate, clear and easily digestible. The Medicaid expansion is funded 100% by the federal government for the first three years, Ms. Mason observed, and its rollout should not be administratively burdensome. Comments on the "alternative benefits package" for new Medicaid enrollees are due by December 6, 2013, Ms. Mason said, adding that she is pleased that dental benefits will be covered. Questions remain about how the HSD will track whether people are getting needed medical services, she said, and whether the provider network is adequate to provide them. Finally, Ms. Mason emphasized the importance of transparency in tracking and in public reporting data, including coverage disparities by race, ethnicity, gender, age and location.

Questions/Concerns

Committee members had numerous questions for the presenters, grouped as follows.

Clarification of MCO financial processes. One member had specific questions about MCO contracts and payment processes. When a provider makes a mistake in billing, what is the time line for correction and rebilling and payment? The situation with previous behavioral health providers has created concern about this, the member stated, adding that it has been rumored that some providers have had their contracts extended with no fee schedule attached. Ms. Weinberg said she did not know if this was true but that it is routine practice when a new program is created.

Behavioral health care coordination. A member asked for clarification of the behavioral health model within the MCOs. Ms. Weinberg said it is a fully integrated care model with care coordination. There is only one point of contact, one plan, one phone number and one place to submit claims. There are stringent call center requirements for the MCOs, Ms. Weinberg continued, and a consumer searching for services will be directed to an assigned care coordinator. The member expressed concern about a fragile population having to navigate through a bureaucracy. MCOs are not allowed to subcontract management, so they are responsible for the delivery of services, Ms. Weinberg said. Some MCOs have brought in expertise on behavioral health services, but they cannot contract these services out.

Concerns about OptumHealth's contract extension. Matt Kennicott, HSD external services director, responded to a member's question about the OptumHealth contract, which has been extended to June 30, 2014. The new contract is for management of the non-Medicaid side of behavioral health services. A request for proposals (RFP) for a new contract beginning July 1 will be sent out by the department soon, Mr. Kennicott said. The member pointed out that OptumHealth's original contract said it could not be extended more than four years, and it was signed July 1, 2009. The member believes that the contract has expired and the extension is

illegal. Ms. Weinberg explained that the extension, executed through the office of the HSD's general counsel, is for six months only and that it did not make financial sense to go through a full procurement process in order to cover that short time frame. The member asked that the HSD take another look at the validity of this contract and report back to the committee; \$350 million is a lot of money.

Concerns about the gap in family planning services. Ms. Weinberg said the program for women who qualify for the breast and cervical cancer program will continue through October 2014, but family planning services for approximately 10,000 Medicaid consumers whose incomes exceed 138% of the FPL will cease as of December 31, 2013, and they will need to go to the NMHIX to obtain coverage. Another member asked about the purpose of the HSD's decision to eliminate family planning benefits; delaying or impeding reproductive exams and birth control could cost more in the long run, the member pointed out. It is not possible to be all things to all people, Ms. Weinberg replied, adding that there are many alternative ways to access contraceptives and family planning services.

Clarification of reimbursement for licensed mental health clinicians. A committee member told Ms. Weinberg about testimony at the previous day's Behavioral Health Subcommittee meeting that only independently licensed clinicians would be reimbursed by Medicaid, creating a shortage of mental health providers and placing a vulnerable population at risk. Ms. Weinberg asserted that this information was not correct. Current regulations do allow services to be delivered by nonindependents who are affiliated within a facility, she said; those nonindependent services are still covered within the proper setting, Ms. Weinberg said. The state agrees that there are concerns about access to care and whether there is a sufficient work force.

Reasons for adding ABP copayments. Another member commented that the Medicaid expansion is funded 100% by the federal government for the next three years and asked why the HSD added some copayments to beneficiaries of the expansion. Ms. Weinberg responded that the department tried to make this look more like a commercial plan, and it wanted the expansion population to have an experience like those who are not on Medicaid. It is adding complexity to the ABP without much benefit, the member countered.

Concerns about coverage for individuals in jail. Several members expressed concern about the large number of individuals in detention who would be primary beneficiaries of the Medicaid expansion, and one member urged that Medicaid be automatically reinstated upon the individual's discharge. Jails do not collect information like hospitals, nor do they perform discharge planning like hospitals, Ms. Weinberg said. The information technology involved for reinstatement is expensive. The median length of stay in jail for a person determined to be incompetent is 500 days, a member observed, and the state needs to take care of this population.

Approval of Minutes

A motion was made and seconded for approval of minutes for the committee meetings of September 4-6 and October 2-4; the motion passed unanimously.

Tobacco Use and Cost Task Force Report: Senate Memorial 22

Heather W. Balas, president and executive director of New Mexico First, presented a comprehensive final report and recommendations (see handout) to committee members from the Tobacco Use and Employer Costs Task Force. New Mexico First, a public policy organization that offers town hall meetings and public forums to help develop ideas for policymakers and the public, was contracted by Presbyterian Healthcare Services to manage the task force and its reports, Ms. Balas said. Task force membership included representatives from a wide range of commercial and insurance businesses, Native American tribes, health care facilities and associations, the tobacco industry and the University of New Mexico (UNM). Co-chairs were Senator Ortiz y Pino, sponsor of the memorial, and Senator Moores. Also serving on the task force were Representatives Thomson and Monica Youngblood.

According to statistics from the Department of Health (DOH), one in five New Mexico adults and one in four youths smoke, and there are higher rates of smoking among people who are unemployed or have lower incomes. The purpose of this task force was to explore the relationship between tobacco use and employer costs and to recommend changes in the law to decrease costs incurred by employers and employees due to tobacco use. Diane Snyder, executive director, Greater Albuquerque Medical Association, and chair of the task force's law and policy committee, along with Dr. Dona Upson, an internist at the UNM Health Sciences Center and chair of the health and workplace committee, presented the recommendations of the task force. After extensive review of data and considerable discussion among task force members, recommendations included the following:

- modify the Employee Privacy Act to revoke protection of smokers' rights so that businesses can choose whether to hire smokers;
- modify the Employee Privacy Act so that certain sectors for which smoking is particularly inappropriate (health care and education) are allowed to choose whether to hire smokers and to decide whether to prohibit smoking off-premises during work hours;
- require all health insurance plans to include comprehensive treatment for tobacco dependence in benefit packages;
- task the appropriate legislative committee to evaluate wellness programs, with particular focus on smoking cessation, to assess best practices;
- fund tobacco use prevention and cessation programs at levels recommended by the federal Centers for Disease Control and Prevention (currently \$23.4 million) and reinstate cessation and prevention funding for collaborative work with tribes and the Indian Affairs Department;
- increase excise taxes on cigarettes and non-cigarette tobacco products, including electronic cigarettes;
- provide tax credit incentives to employers offering evidence-based tobacco cessation programs;
- encourage voluntary policies to expand smoke-free workplaces, including outdoor spaces; and

- encourage employers and unions to collaborate in efforts to decrease tobacco dependence.

Ms. Snyder and Dr. Upson referred committee members to detailed information contained in the task force report, including pros and cons for each recommendation and the percentage of task force members' agreement with each, which ranged from 100% to 42%. In summary, the issues and policy responses are complicated and controversial, but despite the complexity, the task force was able to identify concrete reforms for consideration by the legislature and the private sector.

Questions/Concerns

The excise tax on cigarettes in New Mexico is \$1.67 a pack. Tribes have a \$.75 tax, and they keep it, one member noted. Tribal entities have a monopoly, noted another, and collaboration with them is needed. There was some funding available to tribes for cessation, but that has been reduced; now tribes are asking that it be increased, Ms. Snyder said. A committee member who served on the task force said the charge of the task force was to figure out the cost of smokers to employers. It is better, the member said, to deal directly with smoking by providing cessation and wellness programs and taxing cigarettes rather than punishing smokers through reduced employment opportunities. Committee members discussed the popularity of e-cigarettes, which are being heavily marketed, and the fact that they are not regulated or taxed.

Liver Transplant Facility Update: House Memorial (HM) 48

Winona Stoltzfus, M.D., medical director of the Health Systems Bureau, DOH, reported to the committee progress on HM 48, which directs the DOH and UNM hospitals to conduct a feasibility study to determine steps necessary to create a liver transplantation institute in New Mexico. After careful consideration of specific criteria, an RFP was developed and sent out in August. There were five respondents, Dr. Stoltzfus said, all from out of state, and an award was made to Transplant Management Group in October. A site visit is planned in November, and completion of the study is expected by the end of December.

Older Adult Falls Task Force: House Joint Memorial (HJM) 32

Senator O'Neill and Representative Thomson sponsored HJM 32, which brought together representatives from the DOH, the Aging and Long-Term Services Department (ALTSD), the Pueblo of San Felipe, the Indian Health Service, UNM Hospital, the Veterans Administration Medical Center, hospice and several nonprofit organizations and a private citizen with a history of falls.

New Mexico leads the nation in deaths from unintentional injuries, and falls are the leading cause of injury-related deaths, hospitalizations and emergency room visits among older adults, according to the executive summary (see handout) of the HJM 32 task force report. The task force was formed to evaluate New Mexico's current approach to community-based fall prevention and to develop evidence-based strategies for effective change. Presenters of the task force recommendations included Michael Landen, M.D., state epidemiologist, DOH; Janet Popp,

physical therapist and gerontologist, Brookdale Place and UNM; and Spanda Bhavani Johnson, wellness director of the Good Samaritan Society, Manzano del Sol Village in Albuquerque.

Dr. Landen served as chair of the task force and described the burden of fall-related injuries and deaths among New Mexico adults ages 65 and older with a series of graphs and charts detailing hospitalizations, medical costs, lost wages and death rates. Older adult falls are in the top three causes of injury, with a rate of 100 out of every 100,000 of that population falling annually and 75 to 85 of them dying from their falls. Even if the individual recovers from the fall, Dr. Landen said, it can herald a major change in someone's lifestyle. Fall injuries can make it hard for older adults to live independently, and many older adults who fall, even when not seriously injured, develop a fear of falling.

Ms. Johnson told the committee that falls can be prevented and that health professionals can refer patients to a program. Exercise interventions are not yet available in all communities, but the DOH has trained 65 instructors in Tai Chi for Better Balance, an exercise program recommended by the CDC that has been gaining traction nationally. Older adults need safe, effective classes taught by experienced and certified fitness instructors, Ms. Johnson said. In a survey of New Mexico senior centers, three are currently offering fall awareness programs, while 43 are not.

Ms. Popp presented the task force findings and a plan to reduce falls in New Mexico by increasing public awareness about modifiable fall risk factors, increasing health care provider awareness to help clients be more proactive and increasing access to evidence-based fall prevention programming. The task force is requesting a \$1 million appropriation from the general fund to the DOH for fall prevention activities and to add a staff person to expand programming and education statewide, form collaborations, collect data and evaluate the impact of prevention programs. Falls are not a normal part of aging, Ms. Popp asserted; they can be prevented.

Questions/Concerns

Asked if other states have instituted a similar statewide fall prevention program, Ms. Popp said that there is not a lot of information available, but Connecticut has done so. Ms. Popp agreed to get budget information from Connecticut. One member was pleased with the task force's emphasis on reaching people in senior centers. Over the next decade, the legislature is going to be spending nearly \$1 billion in capital outlay for senior centers, the member noted, and now is the time to help convert senior centers into wellness centers. MCOs need to be brought into this, as well. Another member noted that there were no representatives from the AARP on the task force and suggested that this organization, with its large membership, might be helpful. Another member praised the idea of a collaboration between the DOH and ALTSD.

Discussion of Dates for Final Meeting

Representative Madalena called the committee's attention to the fact that the scheduled dates for the final meeting of the LHHS (November 25-26) put many members in conflict with

other previously scheduled meetings, and he suggested new dates of December 19-20 instead. A motion to change the dates was made and seconded and passed unanimously.

Thursday, November 7

Welcome and Introductions

Representative Madalena reconvened the meeting at 8:45 a.m., welcomed attendees and asked legislators and staff to introduce themselves.

Health and Working Conditions of New Mexico's Agricultural Workers

Gail Evans, attorney and litigation director of the NMCLP, presented results of the center's 2012 survey on New Mexico field and dairy workers (see handout). The report maintains that many of New Mexico's agricultural workers labor in difficult, dangerous and abusive working conditions, perform backbreaking work in unsafe conditions and are paid extremely low wages. New Mexico's agricultural industry is no longer composed of the small family farms of the past, Ms. Evans said. While there are more than 20,000 farms in New Mexico, 10% (about 2,000) generate 90% of the industry's income from farming and employ almost all of New Mexico's 15,000 to 20,000 agricultural workers. Laws of the past, which were meant to support small family farms, are now used by large agribusiness to maximize profits, Ms. Evans said, such as the following:

- exclusion of dairy workers from the state's minimum wage;
- exclusion of all agricultural workers from federal and state overtime protections;
- exclusion of all agricultural workers from the right to participate in collective bargaining; and
- exclusion of many agricultural employers from enforcement and oversight of the New Mexico Occupational Health and Safety Bureau (OHSB).

New Mexico farm workers' average household income, according to this survey, is \$8,978, while the national average is \$17,500 to \$19,999. Wage theft is rampant, according to survey respondents, with 67% reporting being victims of working off the clock, being assessed illegal deductions or not being paid at all. Nearly 20% said employers had failed to report their income to the Social Security Administration. Ms. Evans and Maria Martinez Sanchez, staff attorney at the NMCLP, presented a video that detailed the stories of farm workers in New Mexico, including individuals who had been injured on the job. Farming has changed in New Mexico over the last 20 years, Ms. Evans said, with the large farms bringing in a lot of profit. She listed cattle, dairy, pecans and hay as the top four categories of agricultural production. When the NMCLP's efforts to change state minimum wage laws to include these workers were rebuffed in the state legislature, the group went to court, Ms. Evans said, asserting that the exclusion was discriminatory and thus a violation of the Constitution of New Mexico. In 2011, the court struck down the exclusion, Ms. Evans said, and now the Workers' Compensation Administration (WCA) is waiting for a higher court to agree. In the meantime, the NMCLP also proposed that state funding be appropriated to allow the OHSB to go into smaller farms to

investigate dangerous conditions and pervasive exposure to pesticide poisoning, Ms. Sanchez said.

Recommendations of the NMCLP study include the following:

- amend the state's Minimum Wage Act to include dairy workers and overtime protections of all agricultural workers;
- pass new laws that give agricultural workers the right to participate in collective bargaining, allow the OHSB to enforce health and safety laws on farms with less than 11 employees and to mandate breaks and shade for field workers; and
- support comprehensive immigration reform to allow undocumented farm workers and their families to earn legal immigration status and citizenship.

This has been a five-year campaign, Ms. Evans said. The NMCLP is requesting that the committee send a letter to the governor and to the WCA, asking them to enforce the court ruling on the minimum wage.

Questions/Concerns

One committee member wanted clarification on current dairy worker protections. Ms. Evans said that dairy workers are covered by the federal minimum wage, but because of exclusions in state law, they are not entitled to overtime, which is a regular feature of dairy work. The member asked for copies of Arizona, California and Colorado worker compensation laws, which have more protections written into them. Workers' compensation insurance is based on payroll contributions into the system, Ms. Evans said. The \$5 million to \$10 million it would cost to cover New Mexico workers is one percent of the industry's reported annual profit, she said; this cost is not in dispute. Workers' compensation only applies to employers of three or more people, regardless of whether they are family members, Ms. Evans said; the minimum wage applies to seven or more full-time employees during a quarter. Another member asked why this has not been passed in the legislature. The agricultural lobby has prevailed, Ms. Evans answered.

One committee member who represents a district with a number of dairy farms said she knows how narrow a dairy farm's profit margin is and that before supporting a letter to the governor, she would want to hear from the other side. Several other members agreed that there are two sides to every story. A motion was made to send a letter to the New Mexico Legislative Council asking that a subcommittee of the Water and Natural Resources Committee be formed to examine this issue and reach some kind of consensus. Ms. Evans informed members that there was a memorial several years ago and a task force formed that met for two years. The NMCLP is not asking the legislature to amend the provision to conform to the court ruling, but rather to provide dairy workers shade, overtime, a minimum wage and the ability to organize. These are things that could be done now. The other side of the story has been told, Ms. Evans asserted. A member expressed empathy for these workers, stating that on tribal lands, there is a tradition of working in the field all day long. Tribes do not hire anyone from outside but do it all themselves, and it is very hard work. He thinks forming a subcommittee to explore this issue is a good idea.

The member's motion to ask the New Mexico Legislative Council to establish a subcommittee was then seconded and passed.

Parkinson's Disease and Pesticide Exposure: HM 42

Heidi Krapfl, M.S., chief of the Environmental Epidemiology Bureau, DOH, provided the committee with a handout summarizing data that eight epidemiologists from her bureau extracted from published studies and peer-reviewed journal articles on Parkinson's disease and pesticide use. This report is in response to the literature search requested in HM 42 (2013). Ms. Krapfl also presented the final report of HM 42, including the appendices with detailed information about specific chemicals and their uses (see handouts).

Representative McMillan, M.D., told the committee that he introduced HM 42 to ascertain whether science supports the general assumption that there is a connection between pesticide exposure and Parkinson's disease.

Data were summarized into two main categories, Ms. Krapfl said, pesticide exposure with genetic interactions and pesticide exposure without genetic interactions. The total number of articles selected for review was 1,577, and 104 studies were included for full review and analysis. Pesticides were categorized, and it was determined as best as possible how the exposure occurred. With agricultural use of pesticides, six results demonstrated statistically significant association with Parkinson's disease and eight did not. With other occupational uses of pesticides, nine results demonstrated statistically significant evidence of an association and seven results did not. With residential use of pesticides, including gardening, there were six results, three demonstrating statistically significant evidence of association and three that did not. In the category with use not specified or mentioned, there were nine results demonstrating statistically significant evidence of association and 16 that did not.

Ms. Krapfl said the New Mexico Department of Agriculture does not have data on the use of pesticides and where they are applied and thus does not allow a determination of risk of pertinent populations. Conclusions included the following.

In pesticide exposure without genetic interactions, evidence suggested an association between Parkinson's disease and pesticide exposure, but other factors were stronger predictors of Parkinson's disease than pesticides, including family history, head trauma and absence of smoking. There is good epidemiologic evidence for the association between general pesticide use and the development of Parkinson's disease, Ms. Krapfl said, but inconclusive evidence for the following specific uses: agricultural, including farming; residential use, including gardening; and other occupational uses. The report then listed recommendations regarding the use of pesticides and how individuals could protect themselves and others from exposure. Under the federal Worker Protection Standard, agricultural workers and pesticide handlers must be trained and informed about pesticides used on the establishment, and violations should be reported to the U.S. Department of Agriculture.

Questions/Concerns

There appears to be evidence of a connection, one member commented, but apparently New Mexico does not have historical data about where and in what amounts pesticides were used. Ms. Krapfl agreed, adding that dose and length of exposure also are important, but it is difficult to assess exposure retroactively. She advised that education and caution in the use of pesticides might be the most appropriate ways to help residents in the future; constituents can control the home environment, she said, and they can work with the New Mexico Department of Agriculture to find out what pesticides are being used where they live. During further discussion about the possibility of developing a Parkinson's disease registry, Ms. Krapfl said that it might be more useful if it included other diseases with a greater incidence that also are associated with environmental exposures such as metals and other non-pesticide toxic substances.

Dan Lorimier, a member of the Rio Grande Sierra Club and the HM 42 committee, said that this report is a major step in the ongoing effort to understand the relationship between pesticides and Parkinson's disease. He recognized Representative McMillan and the DOH for producing this exhaustive report.

NMHIX Update

Jason Sandel, vice chair of the NMHIX appointed by Speaker of the House of Representatives W. Ken Martinez, played a song for committee members, "Be Well", which is the name and theme of the NMHIX's advertising and public relations campaign to get New Mexicans to sign up for health insurance through the exchange. Mr. Sandel is a current two-term city council member in Farmington, where he also is the owner of Aztec Well Servicing. He provided members with a history of the legislation that established the NMHIX (see handouts), signed by the governor at the end of March, and the framework for implementation of the federal Patient Protection and Affordable Care Act (PPACA). The first meeting of the exchange board was in May, when key staff positions were filled and a plan of operation was passed and implemented. Since then, the NMHIX has contracted for a project manager, a technology partner and a communications partner, and Native American collaboration is staffed and under way, he said. The statewide web site, www.bewell.com, has been successfully launched. A statewide advertising campaign is on hold pending resolution of problems on the federal web site, Mr. Sandel said. As of October 31, 294 employers have completed the Small Business Health Options Program (SHOP) enrollment process, and a total of 925 employers have created an account in the SHOP. Individual enrollment remains unknown, since all individuals are passed directly to the federal site, HealthCare.gov. The transition from the NMHIX to Medicaid (and vice versa) has remained disjointed in that computer integration has not been clearly defined as yet, he said. According to the Kaiser Family Foundation, there are 193,000 people who might look to a state marketplace for health care coverage, with at least 118,000 of these likely eligible for tax credits or other assistance if enrolled through the NMHIX, Mr. Sandel said. The goal of the exchange is to enroll 84,000 within the first year, but delays in the use of the federal portal could hamper the state's potential for success. Board meetings are open to the public and generally held the third Friday of each month, Mr. Sandel said, with the next meeting scheduled in Roswell on November 15 and a board retreat planned in Taos in January.

Paige Duhamel, staff attorney with Southwest Women's Law Center, appeared at the meeting with Mr. Sandel and praised the considerable accomplishments of the NMHIX's "heavy lifting" in such a short time frame, but she wanted to provide remarks about needed improvements (see handout). Ms. Duhamel said that New Mexico ranks second in the nation for the rate of uninsured (448,000) and that approximately 229,000 of these are exchange-eligible, so there is a lot of work left to do. Ms. Duhamel is especially concerned about the apparent reluctance of the NMHIX board to appoint a stakeholder advisory committee, as charged in its enabling legislation. The NMHIX had proposed an advisory committee made up solely of its contractors, which would exclude many of the voices that the legislature intended to include, she said. Also of concern is the amount of funding for enrollment activities and outreach: out of the total \$6,593,500 that is allocated, 65% is being spent in hospitals and health care clinics, meaning only those currently needing or seeking medical services are being reached. Ms. Duhamel said that the NMHIX must do better in funding outreach to healthier New Mexicans in order to better balance its enrollment. She also disagrees with the amount of funding dedicated to public relations and marketing: \$7.5 million is already contracted and another \$5 million is being sought from federal funding, bringing the total to \$12.5 million — twice the level of in-person outreach and enrollment assistance. That extra \$5 million would be better used to fund the state's community health worker programs to do education and outreach in communities, she said. Lastly, Ms. Duhamel urged the legislature to fund an actuarial value study to establish a basic health plan option for the exchange, since health insurance may not be affordable to many individuals even at subsidized rates.

Questions/Concerns

Mr. Sandel was asked about the \$1.5 million for a Native American service center. The HSD was not able to tell him where those funds are, he said. A member asked if the funds had been expended elsewhere; Mr. Sandel did not know. Another member made a motion to send a letter to the HSD regarding accounting for the grant funds intended for a Native American service center and to request an answer prior to the final meeting of the committee on December 19. The motion was seconded and passed unanimously. A member noted that the NMHIX had received \$100 million in grant funding and wondered why the Procurement Code was not being used. Mr. Sandel said that the NMHIX was specifically exempt from the Procurement Code because of limited time lines, but that it was following the intent. Another member had concerns about accounting at the NMHIX. Mr. Sandel said the NMHIX board is now expecting a monthly check register with details of each expenditure, so all of that information will be available. Queried about the Native American Advisory Commission, Mr. Sandel said there has been a lot of conversation about how to move forward because the NMHIX is not a state agency and cannot engage with tribes in a government-to-government manner, but it has Native American consultants and the NMHIX is pleased with the collaboration that has occurred since August. Nominations for the commission have been received, he said.

Lack of integration of the NMHIX with Medicaid enrollment is a continuing concern for several committee members. Ms. Duhamel said that HSD outreach events were focused on Centennial Care and not on Medicaid enrollment. The HSD has dragged its feet on Medicaid

enrollment, she asserted, so it has no funding available for this; but, fortunately, a lot of the navigators are also familiar with Medicaid eligibility. A committee member noted that the "elephant in the room" was Public Consulting Group (PCG) and asked if there was not a single New Mexico company that could have done this job. Tony Kerk of PCG, sitting next to Mr. Sandel at the presentation table, was introduced by Mr. Sandel. PCG, based in Boston, has a contract with the NMHIX to provide logistical services. It is the same company that conducted an audit for the HSD on 15 behavioral health providers. Mr. Kerk said that he has no knowledge of his company's other practices but that PCG does have a great deal of experience with insurance exchanges. PCG was chosen through an RFP, Mr. Sandel said.

A member asked Mr. Sandel about the New Mexico Medical Insurance Pool, which has about 10,000 members, many of whom will be moved into the NMHIX. Approximately 1,500 of these individuals will be covered by the federal government through the PPACA; 3,500 will probably be eligible for Medicaid expansion, and 5,500, many of whom are seriously ill but cannot be denied coverage, will go to the exchange, Mr. Sandel said. They will be moved progressively over time through December 2015 so as not to "crater" the NMHIX, he said.

Chiropractic Physician Primary Care Delivery

Steve Perlstein and Robert Jones, both chiropractic physicians, made a presentation to the committee (see handout) regarding allowing advanced chiropractic physicians to become team players in alleviating the shortage of primary care physicians. Dr. Perlstein cited a Legislative Finance Committee (LFC) report to the DOH describing the aging population and the growing shortage. Among other recommendations, it stated that health care service delivery models must evolve to adequately address New Mexico's health care needs. What Drs. Jones and Perlstein are seeking, on behalf of the New Mexico Chiropractic Association, is a change in the scope of practice for advanced chiropractic physicians to give them limited prescriptive authority as primary care providers.

There are nearly 500 licensed chiropractors in New Mexico, Dr. Perlstein said, and about 30% have undergone the advanced practice certification program, which involves 90 hours of additional training. He said the drugs that they are interested in being able to prescribe are those most commonly found in primary care, such as those used by a physician assistant: codeine in cough syrup, a drug for back pain, headaches or strep. Right now Dr. Perlstein may see a patient with any of these symptoms but would have to refer the patient to a colleague in order to get a prescription. Chiropractic physicians do not just do adjustments anymore, Dr. Perlstein said. He has to make sure that low back pain is not cancer or a prostrate problem, and diagnosing this is within his current scope of practice. He would then refer the patient for treatment.

In an exchange of ideas with a physician who is also a member of the committee, Dr. Perlstein asserted that most in his profession are moving more toward an evidence-based practice, and he agreed that expanded prescriptive authority would need to be evidence-based. Treatment plans involve visits several times a week, and a patient will start treatment but then stop. It is like not taking an antibiotic for its full course, he said.

Dr. Michael Pridham is an evidence-based chiropractor who is also licensed to teach. The health insurance industry has placed chiropractic in a separate category, he said, and patients are sometimes paying more in copayments than the chiropractor gets paid under the contract. Private insurance companies set the copayment, and high copayments are discouraging people from getting the care they need.

Ms. Johnson said that a bill was brought to the legislature in 2013, but it got tabled in committee, and talks with the superintendent of insurance stalled. "We are trying to create more access", she said.

Prospects for a School of Public Health

Deborah Helitzer, Sc.D., professor of family and community medicine and associate vice chancellor of research education at UNM, showed committee members a film made by students from New Mexico State University (NMSU) and UNM who want a school of public health. Public health is population health, interventions that make a difference to a large group of people, such as seat belts and school lunches (see handout). It has a lot to do with keeping people healthy, Dr. Helitzer said. Her handout included numerous examples of current public health initiatives in nutrition, diabetes prevention, substance abuse and mental health, multiple projects for tribal populations and domestic and sexual violence prevention. The College of Public Health at UNM is proposing a collaboration with NMSU to create a school of public health, which would broaden course offerings and increase capacity for public health research.

Access to Medical Marijuana

Dave Schmidt, director of the Drug Policy Alliance, announced to the committee that the DOH and Medical Advisory Board had recommended the addition of Parkinson's and Huntington's diseases and traumatic brain injury for inclusion for medical marijuana use, and the recommendations have been sent to Secretary of Health Retta Ward for approval.

Jessica Gelay, policy director of the Drug Policy Alliance, provided information to committee members (see handouts) about the "Freedom to Choose" campaign for veterans' access to medical marijuana. Employment discrimination against users is a problem, she said, and the need for physician education is huge. This program pays for itself, and it is the most regulated group there is, said Ms. Gelay, who brought several guests with her to tell their stories to committee members.

Staff Sergeant (Ret.) Mike Pell, a disabled U.S. Army veteran with posttraumatic stress disorder (PTSD), chronic pain and depression, was on 38 pills a day when he had been separated from his wife, was involved in a stand-off with police and was locked up in the psychiatric ward for three days. At that point, he decided to try medical marijuana, and he credits it with giving him his life back. Ms. Gelay said there are now 4,000 New Mexicans on medical marijuana for PTSD, and it reduces their need for pharmaceuticals and allows them to function in society and to regulate their own medication.

There are 23 licensed producers in New Mexico, and the number of plants they can grow is regulated. Now that New Mexico is reaching 10,000 registered users, there is a point where people will be forced into the black market, she said. An expansion of the number of plants can be done by regulation by the DOH. Ms. Gelay then introduced two professional producers that she brought with her to speak to committee members about their businesses.

Doug Speigel was licensed three years ago. The first year, he delivered for free, and during that time, one of his clients was a young man whose wife was dying of cancer. He got to know them both and saw that medical marijuana made her feel so much better. If her husband could not get it from Mr. Speigel, then he would have gone to the street. Eli Goodman, owner of New Mexican Natural Medicine, said there is an obvious safety factor involved with going to the streets, but just as important is the quality of the medicine. Mr. Goodman offers different strains, he said, and considers testing to be very important. Quality is unknown on the street; a tested material is much more controlled. It is no longer necessary to smoke marijuana because there are teas and many different edibles. No one here is promoting smoking, he added.

Public Comment

Fonda Osborne, president of the National Union of Hospital and Health Care Employees, urged committee members to reintroduce HB 445 from the first session, which failed by only one vote in the House Appropriations and Finance Committee. It would have required hospitals to have nurse staffing committees and develop plans based on patient acuity and ancillary staff. In June, her organization filed an official complaint against Christus St. Vincent Hospital regarding staffing. The DOH claimed it did not find any problems in four days of investigation. Staffing was increased to levels unknown in previous years, then the levels dropped again, Ms. Osborne said. Even though the state did not fault the hospital on staffing, it did cite the hospital for bedsores and falls. The intensive care unit at Holy Cross Hospital in Taos has gone from six to two beds, Ms. Osborne said. Safe staffing legislation would require the "bean counters" to consider patient care as well as profits. Representative Trujillo, the sponsor of HB 445, said she will carry this legislation again but will amend it to include release of information on staffing levels as a condition of state funding. Christus St. Vincent is a nonprofit and claims that, under the PPACA, it had to lay people off, Representative Trujillo said, but there is nothing in the PPACA that requires this. Senators Lopez and Rodriguez also indicated their support for this legislation.

Recess

The committee recessed at 5:45 p.m.

Friday, November 8

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:00 a.m., welcomed guests and asked legislators and staff to introduce themselves.

Corrections Health Care

Eric Chenier, fiscal analyst with the LFC, accompanied by Ruby Ann Esquibel, principal analyst, LFC, presented committee members with a PowerPoint presentation (see handout) describing the exponential growth in costs of medical treatment for New Mexico's prison population. Today's total expenditures are five times what they were in 1980, Mr. Chenier said, and with an aging prison population, costs are two to three times higher for prisoners 55 and older. There is also a higher incidence of behavioral health and substance abuse issues and chronic and infectious diseases. Mr. Chenier described details of the Corrections Department's contract with its health care provider, Corizon, Inc., chosen through a competitive RFP. Corizon is an out-of-state company, he said, but it uses all New Mexico providers. The Corizon contract cost \$40.6 million in fiscal year (FY) 2013 and will cost \$43.7 million in FY 2014 and FY 2015, a 7.6% increase.

Ms. Esquibel reported to the committee members that there are significant opportunities for savings due to Medicaid expansion. Many of the behavioral health services currently covered by the Adult Probation and Parole Division of the Corrections Department will now be 100% covered by federal funds, saving as much as \$2 million annually, she said. In addition, Medicaid now will pay for inmates' inpatient hospital care after the first 24 hours, which could save the state as much as \$30 million over the next decade. Expanding the use of telehealth services and geriatric parole in New Mexico could lead to additional savings, Ms. Esquibel said. UNM's Project ECHO is conducting work in prisons via telehealth, and the DOH's Public Health Program is providing some services in detention centers in Albuquerque and Dona Ana County, including screening, treatment of sexually transmitted diseases, prevention screenings, family planning services, opiate replacement therapy counseling and laboratory testing for HIV and hepatitis A, B and C.

Aurora Sanchez, deputy secretary of corrections, said that the annual cost per inmate is down now to approximately \$5,000. The prisons have been using telepsychiatry for the past nine years, and they have seen savings from this, Ms. Sanchez said. Once an inmate is released, there are contract services available with the Interagency Behavioral Health Purchasing Collaborative through OptumHealth. These services will end on December 31, and the collaborative would like to extend them. Any savings will be redirected toward residential reintegration, Ms. Sanchez said; no one wants these folks to return to prison. There will be rough spots as the expansion is rolled out, she said, but, hopefully, lessons learned can be applied throughout the state. Brent Earnest, deputy secretary of the HSD, described Corrections Department efforts in pre-release Medicaid eligibility determinations and in training on presumptive eligibility. Being able to access Medicaid after release from prison could reduce the recidivism rate, he said.

Questions/Concerns

One member noted that geriatric release is complicated; often the inmate has nowhere to go, and it is important to provide whatever help is possible before the inmate leaves the system. There are many issues, but these folks deserve a chance, the member noted. Mr. Earnest said that leadership in corrections is embracing the same vision, but it will take a paradigm shift in

thinking for some people. Another member told Mr. Earnest that some legislators are interested in seeing all prisoners pre-qualified for Medicaid before release, and there probably will be a new bill introduced this session. If this does not get worked out, the member said, legislators will find the information technology (IT) funding to create a system for suspension of benefits.

Suspension was an IT challenge during the rollout of the HSD's new ASPEN system, Mr. Earnest said, but the HSD is now able to achieve the goals of suspension through other approaches. The problem is not with prisons, the member said; presumptive eligibility can take place only once a year, and this is not workable for anyone who goes in and out of the corrections system.

Another member asked if treatment teams are being used for all prisoners who are being released. Ms. Sanchez said that they are. The release teams look at medical and behavioral health needs, jobs or education and social service needs. She then described a particular inmate who could be released today. The Corrections Department has tried diligently to place him, she said, but his family does not want him, no nursing home will take him and he is not sick enough to be in the hospital. He is being taken care of in prison because there is nowhere else for him to go.

Tasia Young, lobbyist with the New Mexico Association of Counties, described the issue of redirecting the counties' second one-eighth percent gross receipts tax to the HSD because sole community provider funding for hospitals ends on January 1, 2014. Counties object to this because it is an autonomy issue — local government is closest to the people — and an equity issue; there are winners and losers, and the funding will not come back to the local level in the same proportion. Mr. Earnest said that the HSD's proposal is a way to replace funding that is going away. He said he hopes there can be some kind of resolution between the counties and the HSD.

End-of-Life Choices

Barak Wolff, M.P.H., a former public health director, is co-chair of the executive council of Compassion and Choices. Dying is one of life's few certainties, he said, and it is not easy but is very important to discuss. Surveys show that 70% to 80% of people who are asked say that they would like to die at home, but only 30% actually do, Mr. Wolff said. Five percent of Medicare beneficiaries die each year, but 30% of the entire Medicare budget is spent on their last few weeks of life. Mr. Wolff provided a PowerPoint presentation to committee members (see handouts), starting with an overview of his organization, which is based in Denver. Compassion and Choices is the largest nonprofit working to improve care and expand choice at the end of life. It helps people plan for and achieve a good death, he said, and works to change attitudes, practices and policies so that everyone can have more control and comfort at the end of life. Compassion and Choices provides counseling, help with advance planning and state-specific advice, and its legal casework brings attention to end-of-life issues that affect everyone, Mr. Wolff said.

The Compassion and Choices presentation included detailed information about aid in dying in the State of Oregon. Aid in dying involves a physician providing a prescription to a

mentally competent, terminally ill adult who may ingest it to achieve a peaceful death if suffering becomes unbearable, Mr. Wolff said. In Oregon, during the 15 years since statute has allowed it, only 673 patients chose to secure the medication, and more than one-third of those did not consume it. The vast majority of patients were white and college-educated, had insurance and were dying of cancer or Lou Gehrig's disease. Mr. Wolff also provided background on federal and other state challenges to right-to-die legislation and details about the state's *Morris v. New Mexico* lawsuit, scheduled to go to trial on December 9.

Kathryn L. Tucker, director of advocacy and legal affairs for Compassion and Choices, is a graduate of Georgetown University Law Center, an adjunct professor of law at Loyola Law School and co-counsel for the plaintiffs in *Morris v. New Mexico*. Ms. Tucker provided extensive remarks about the case (see handout), her professional background and a history of the statutory and constitutional claims involved in this case. The suit has been brought by two physicians who treat cancer patients and a patient who has terminal cancer asking the court to recognize that physicians who provide a prescription for aid in dying to patients who request it should not be subject to criminal prosecution. In fact, the terminally ill patient, Asa Riggs, who is now in remission with advanced uterine cancer, was present at this meeting with Ms. Tucker and introduced herself to committee members. Saying she was a naturally shy person, Ms. Riggs nonetheless asserted that when she dies, she wants to be at home with her loved ones and wants her medical team to have every option available for her, including aid in dying. Ms. Riggs said she does not know if she will use it, but she wants it as an option. Ms. Tucker explained that aid in dying is not "assisted suicide", but rather a way to empower terminally ill individuals to have control over their manner of death. It is likely that the trial court decision in *Morris v. New Mexico* will be appealed, Ms. Tucker said, and that the case will ultimately be decided by the New Mexico Supreme Court.

Questions/Concerns

One committee member whose spouse is a physician encouraged broader education about palliative care. Physicians generally refuse all treatment when given a terminal diagnosis, the member said, adding that this is a good discussion that everyone should have. Ms. Tucker agreed that palliative education is very important, and when aid in dying is available, physicians are more eager to refer to hospice and to take additional training. Asked about support for aid in dying from physicians, Ms. Tucker said that many are supportive, but the American Medical Association is still opposed. Another committee member said that he had changed his opinion over the last several years about end-of-life choices and that he is supportive of the right to refuse further treatment. As a former pastor, he said, he cannot make that leap to support aid in dying. Ms. Tucker agreed that these are very personal, often religious, decisions. In Oregon, the state requires certification of terminal illness (an estimated six months or less to live) and mental competency. There are a lot of data from Oregon, Ms. Tucker said, and her organization does not know of any case where a terminally ill patient who chose to take the medication did not die quickly and peacefully. Typically, the patient is surrounded by family and self-administers the drug, then goes into a deep sleep with no signs of struggle. The patient is empowered to make this choice, and family members show none of the adverse mental health effects of a suicide.

Another member questioned whether physicians can "opt out" of participation in aid in dying if it is against their beliefs. Absolutely, said Ms. Tucker, and it is important to remember that no patient can do this through a surrogate; it is very clearly limited to the patient. Subtle pressure might be exerted on an individual to ingest the medication, another member speculated, and Ms. Tucker said that this was a concern at one time in Oregon, but there has been no evidence to indicate that this has happened. A member also brought up the possibility that the terminally ill patient might have a change of heart — that taking the medication might be a mistake. There are absolutely zero data that anyone who did this did not have full capacity, Ms. Tucker said. Some patients did live longer than six months, but there is no rush to make this choice, the most profoundly personal choice that anyone can make.

The ban has been raised, Ms. Tucker said, and the landscape of aid in dying is rich with data; none of the "parade of horrors" has come to pass. Those who are swayed by evidence can feel comfortable with the data, she said.

Peer-to-Peer Counseling: HJM 12 Report

Toby Rosenblatt, bureau chief of the Injury and Behavioral Epidemiology Bureau, Epidemiology and Response Division, DOH, presented the committee with a letter from Secretary of Health Ward regarding HJM 12, which requests that the DOH and the HSD incorporate peer-to-peer approaches into existing substance abuse efforts. Secretary Ward said that she regarded this approach as a diversion of resources for reducing substance abuse. There is no evidence-based scientific support for the efficacy of peer-to-peer prevention, the letter stated. It is an intervention, but not prevention.

Economic Development and Health Care Work Force

Dick Mason, chair of the legislative committee of Health Action New Mexico, presented information (see handouts) to the committee about the economic development potential related to expansion of New Mexico's health care work force. Mr. Mason also handed out summary of recommendations of the 2013 LFC report, "Adequacy of New Mexico's Health Care Systems Work Force", along with several other reports documenting the shortage of health care workers in New Mexico that will be exacerbated by the number of people who will now have health insurance under the PPACA. Mr. Mason said he is a corporate planner and industrial engineer, and he views this as an enormous opportunity for economic development. The expansion could create as many as 3,000 new jobs in the first year of implementation, he said. Senator Candelaria has drafted a senate joint memorial that requests the secretary of health to convene a health care work force working group to make recommendations to the governor and the legislature regarding development of the state's health care work force.

Senator Candelaria passed out copies of his proposed memorial, and several members had questions. One member asked why Senator Candelaria wants to ask the DOH to be in charge of this; perhaps another entity, such as a subcommittee of the LHHS, would have fewer issues of protecting its turf and could look at the issues in a more holistic and uniform way. Another member said that she supports the memorial but feels the proposed group should include

additional participants who do not work in state government. Senator Candaleria said that he would visit with the DOH again and possibly have a revised memorial ready for the last meeting of the committee in December.

J. Paul Taylor Early Childhood Task Force Report: HM 75

Kim Strauss, manager of the Brindle Foundation and chair of the HM 75 task force, said the group was made up of passionate advocates for children and included six members with Ph.D.s, many clinicians, four representatives of the military and numerous other stakeholders. The meetings began in April, and Ms. Strauss said she knows that the creation of this task force came with a certain amount of controversy, since New Mexico was deemed last in the nation for child welfare in the latest Annie E. Casey Foundation survey. Ms. Strauss presented the executive summary (see handout) and recommendations of the task force, but she also asked that its existence be extended by the 2014 legislature so that it could work cooperatively with state agencies and other advocates to develop details for execution of the early childhood mental health and child abuse prevention plan. The task force also requested that it serve to oversee the plan's implementation and identify areas unfunded that will require reallocating existing dollars or securing new funds for recommendation to the 2015 legislature.

Susan Burke, executive director of PB & J Family Services and vice chair of the task force, told committee members of critical cuts to the most vulnerable children, such as the 2009 cuts of up to 90% for at-risk children to the Family Infant Toddler program and 50% cuts for mental health programs. Families that end up costing the most to the state do not make it into the program, she said. There is no unified strategic plan with these cuts. Another task force member, Karen Armitage, M.D., associate clinical professor of family and community medicine at UNM, said there are people and teams and agencies that work on early childhood programs, but they are not connected, and, therefore, there are no referrals. The task force looked at a model where, if a child enters a place where the child is normally seen, but there are other risk factors, a provider can find out how that family is doing right now, fully utilizing already existing resources.

Following is a brief summary of HM 75 task force recommendations:

- establish community and state networks;
- identify at-risk children and families;
- increase linkages between primary and behavioral health;
- support comprehensive work force training;
- substantially increase the availability of high-quality, outcomes-based mental health services;
- promote programs that are evidence-based and meet standards for best practices;
- collect and make widely available critical data and support rigorous evaluation of programs; and
- decrease child abuse and neglect.

A second task force, this one an ad hoc working group convened jointly by Senator Ortiz y

Pino and Rachael Gonzales, a survivor of childhood abuse, and which met throughout the summer and fall of 2013, also presented its recommendations, which included the following:

- increase home visitation programs for young families;
- utilize unsubstantiated child abuse and neglect referrals as a portal for voluntary participation in services;
- improve interagency collaboration to end a "silo" effect;
- change the focus from punishment to rehabilitation;
- improve availability and usability of data and assessment of outcomes;
- create an early childhood committee as a component of every county health planning council;
- create a directory of successful, evidence-based approaches to prevention for expanding and replicating services;
- provide better-funded family planning, marriage and parents preparation programs;
- provide more effective drug and alcohol treatment programs;
- reduce the number of young people sent to juvenile corrections through a "probation subsidy" model;
- emphasize efforts to reduce poverty;
- establish an annual high-profile statewide summit on prevention of child abuse and neglect called by the governor; and
- create and support initiatives to foster children's awareness of physical, emotional and sexual abuse.

Volunteers who served on the ad hoc committee included several physicians, several private practitioners and representatives of nonprofit and faith-based family service organizations, community health and abuse prevention groups, UNM's Child Abuse Prevention Partnership and New Mexico Voices for Children.

Public Comment

Stewart Duban, a professor and pediatrician at UNM, said there is a need to keep the players together for this work force. "We check vision and hearing, but we do not screen one child on issues related to abuse and neglect", he said. There are 175,000 children under the age of five in New Mexico; 16,000 of them are served and 80,000 need the service. There needs to be a list of questions asked routinely at screening, he said, and it will not take a lot of time. These questions need to be asked at home visitation and by anyone who comes into contact with those children. The link between physical problems and abuse is a straight line, Dr. Duban said. Outcome data are absolutely essential but totally lacking.

Adjournment

There being no further business before the committee, the sixth meeting of the LHHS for the 2013 interim adjourned at 4:25 p.m.

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

**December 19-20, 2013
Room 307, State Capitol
Santa Fe**

D

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, at 8:40 a.m. on Thursday, December 19, 2013, in Room 307 of the State Capitol in Santa Fe.

Present

Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Mark Moores (12/19)
Sen. Benny Shendo, Jr.

Absent

Sen. Gay G. Kernan
Rep. Terry H. McMillan

Advisory Members

Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff (12/19)
Rep. Linda M. Lopez (12/20)
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen (12/19)
Rep. Vickie Perea (12/19)
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

A

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Rep. Paul A. Pacheco
Sen. Lisa A. Torraco

F

Guest Legislators

Rep. Eliseo Lee Alcon
Rep. Thomas A. Anderson
Sen. Carlos R. Cisneros

T

Sen. Timothy M. Keller (12/19)

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Thursday, December 19

Welcome and Introductions

Representative Madalena welcomed guests to the meeting and asked members and staff to introduce themselves.

Approval of Minutes

A motion was made and seconded for approval of the minutes from the November 6-8, 2013 meeting of the LHHS. Representative Perea offered one point of clarification: she had not yet been appointed to the legislature as of November 6-8, 2013, and her name was mistakenly included among those marked "Absent" in the minutes for those dates. She asked that her name be stricken from the "Absent" column of advisory members. With this correction, the motion of approval of the minutes passed unanimously.

Another motion was made to approve the minutes of the Disabilities Concerns Subcommittee meeting on November 4 and the Behavioral Health Subcommittee meeting on November 5. This motion was seconded and passed with no objections.

Computer Adaptive Testing — Mental Health Suicide Prevention Solution

Steve Trubow, a medical engineer with Olympic Behavior Labs in Port Angeles, Washington, introduced Robert Gibbons, Ph.D., a professor of biostatistics at the Center for Health Statistics, University of Chicago, and Jan Fawcett, M.D., a professor in the Department of Psychiatry at the University of New Mexico (UNM) Health Sciences Center (HSC). The panelists discussed a new screening tool, computerized adaptive testing for mental health (CAT-MH)(see handout). Providing a live demonstration for committee members, Dr. Gibbons showed how a brief screening of approximately two minutes can identify individuals who are severely

depressed and at high risk of suicide. The program, which has been the focus of a 10-year National Institutes of Health grant in New Mexico and West Virginia, is a simple diagnostic screening that can be used with accuracy and precision anywhere there is an internet or smart phone connection, Dr. Gibbons said. New Mexico and West Virginia were selected for the project because both states have a high number of medically underserved areas, high populations of veterans, challenges in geography and a lack of technical innovation, he said. Untreated, undiagnosed depression is the biggest risk for suicide, and the combination of anxiety and depression is particularly deadly.

D With the federal Patient Protection and Affordable Care Act's (PPACA's) emphasis on the use of primary care to improve health outcomes, this brief screening set up in a primary care provider's office can become an important tool, Dr. Gibbons said. The severity of the score determines whether that individual should be further screened for risk of suicide. Being able to identify those persons at highest risk means that they can be more quickly referred for specialized mental health services. The CAT-MH will, in the long term, not only save lives but save millions of health care dollars by reducing hospitalizations and emergency room visits, he said. There is a Spanish version of the screening, and a child's version is under development. Cultural differences that would be critical among Native American populations are being explored through another grant at the University of Chicago, Dr. Gibbons said. Plans are under way to implement this testing in a pilot project in Taos.

Questions and Comments

One committee member asked about the possibility of using this screening in other care settings. Dr. Gibbons agreed that this may hold promise, such as in detention centers, but the model is designed to be used in partnership with states through Medicaid and Medicare. In New Mexico, the project has formed a partnership with the UNM HSC Department of Psychiatry. When a problem is identified in an individual, Dr. Fawcett said, it needs to be in a setting where immediate intervention can take place. Another member suggested using the test to screen for posttraumatic stress disorder among veterans, and Dr. Gibbons said that his team is actively pursuing this possibility and has been talking with the New Mexico National Guard. Mr. Trubow said there have been meetings in Gallup and San Juan County, where there is a high population of young Native Americans who have the highest suicide risk. The screening might be given through the schools, Mr. Trubow said. Dr. Gibbons suggested the possibility of having a kiosk in Navajo Nation chapter houses; internet would not be needed, he said; only an electrical outlet is required. A member noted that overcoming the stigma of seeking mental health help is a big problem culturally among Native Americans. Dr. Fawcett agreed, noting that this problem was beyond the scope of the project.

A member asked if anything could be done about the continuing problem of suicide jumpers at the Rio Grande Gorge bridge just northwest of Taos, which is very costly to the county's emergency and technical response teams. Dr. Fawcett responded that physical barriers might be helpful, but in the long run there probably is not much that can be done about people who drive from out-of-state to commit suicide at a specific location. The key is to implement

earlier diagnostic intervention with those individuals, before they have reached the decision to drive to Taos.

Native American Suicide Prevention Clearinghouse

Panelist Sheri Lesansee, program manager of the Native American Behavioral Health program at the UNM Center for Rural and Community Behavioral Health, introduced herself and the Honoring Native Life program, a Native American Suicide Prevention Clearinghouse and Technical Assistance program established in 2011 by Senate Bill 417 (see handout). Senate Bill 447 in 2013 created a Native American Suicide Prevention Advisory Council with 11 voting members who will assist in developing policies, rules and priorities for the clearinghouse. Ms. Lesansee reported that great progress has been made, with eight voting members of the council's appointments having been approved and three others pending approval. The web site, www.honoringnativelife.org, has been redesigned. A community summit was held in May and planning is in place for a statewide youth and family coalition to be formed, Ms. Lesansee told the committee. Community engagement activities have included participation in training with the Albuquerque Area Indian Health Service and the Inter-Tribal Council on Substance Abuse and contact with the Albuquerque Indian Center, the All Indian Pueblo Council, Acoma Behavioral Health Clinic, Circle of Life — Eight Northern Pueblos, Inc., the Dine Ba Hozho Coalition in Shiprock, the Navajo Nation and the Mescalero Apache Tribe.

Ms. Lesansee was accompanied at the committee presentation by Doreen Bird, M.P.H., a community-based research specialist with the UNM Center for Rural and Behavioral Health; Caroline Bonham, M.D., a psychiatrist and director of the center; and two students: Kaylee Pesina of the Pueblos of Isleta and Laguna and Kateri Daw of the Navajo Nation, both members of the newly formed Honoring Native Life Youth Council. The youth council was established to broaden and deepen communication between youths and adults, she said, and to develop training and strategies for suicide prevention. Members of the youth council developed a video that can be seen on the web site and are planning to host a statewide Youth Council Summit in 2014. The youth group will address gun safety, anti-bullying efforts and ways to overcome stigma, among other related topics.

Health Care Procurement and Transparency Legislation

Senator Papen and Ms. Mathis directed the committee members' attention to Item 29 (202.195404.1) in the list of bills for endorsement consideration for the 2014 legislative session (see Appendix A). Ms. Mathis explained that because of recent changes to Human Services Department (HSD) rules that go into effect January 1, 2014, any right to an adjudicatory hearing for a person who is the subject of a referral to the attorney general for a credible allegation of fraud (CAF) is unequivocally eliminated. What this bill does in Section 2 is amend the Medicaid Provider Act by adding a definition to CAF in terms of the process used by the HSD, not in terms of what the provider is alleged to have done. Section 3 of this bill makes a CAF determination by the HSD a final decision from which a provider can immediately appeal in district court under Section 39-3-1.1 NMSA 1978. What this does, Ms. Mathis said, is offer judicial review of the integrity of the process that was used to make the determination of a CAF. Section 4 of this bill

adds language from federal law and guidance that, in the absence of evidence to the contrary, mere errors found during the course of an audit, or billing or processing errors, do not constitute Medicaid fraud.

Questions and Comments

In response to a member's question about injunctive relief being denied to the behavioral health providers who were subject to the HSD audit conducted by Public Consulting Group (PCG), Ms. Mathis explained that the behavioral health provider's claims were brought in federal court alleging lack of due process and that process is continuing. A committee member stated his opinion that this bill does not go far enough. The providers who were referred by the HSD have gone out of business and no longer have the finances to pursue their interests in court, he said. The resulting disruption of behavioral health services should not have been allowed, the member continued; the HSD should have been required to attempt other remedies before choosing the "nuclear option". Several other committee members thanked Senator Papen for this legislation, and one member added that he hopes the debate this legislative session will be centered on the principle that, before the state can take away a person's pursuit of life and liberty, due process must be provided.

A motion was made for committee endorsement of this bill; it was seconded and approved by a majority of voting members.

Health Care Procurement

Senator Keller presented Item 3 (202.194655.2) in Appendix A, which would eliminate the health care exemption to the Procurement Code; clarify that an investigation of alleged health care overpayments or fraud is not an emergency condition justifying an emergency procurement; require a public body to contract through normal procurement procedures for audit services to investigate alleged overpayments or fraud and to contract for temporary on-call health care or other services necessitated by a suspension of payments pursuant to a determination of a CAF; and give the attorney general, state auditor and the Legislative Finance Committee standing to seek judicial review of certain purchasing practices. The bill also makes an appropriation of \$100,000 from the general fund to the Office of the State Auditor to compile and maintain a list of audit firms approved to conduct audits of state and federal health care programs, and the bill declares an emergency.

One member commented that, over time, the legislature has allowed increasing authority to the executive branch and should not be surprised when things like the HSD's emergency contracts for the PCG audit, and its subsequent hiring of Arizona agencies, happen that bypass the Procurement Code. Another member asked why, if the HSD knew about the need for supplemental providers back in November, it was deemed an emergency in March.

A member moved that this legislation be endorsed by the committee; the motion was seconded and endorsed with a majority vote.

Health Care Cost Commission Amendment to the Constitution of New Mexico

Senator Keller also presented Item 22 (202.195269.2) of Appendix A, a Senate Joint Resolution proposing to amend Article 5 of the Constitution of New Mexico to create a Health Care Cost and Quality Transparency Commission to promulgate and enforce standards and regulations to ensure transparency of health care costs and other financial and quality data for use by consumers, taxpayers and policymakers. A motion was made to endorse the legislation; it was seconded and passed with a majority vote.

Medicaid Disability Services Oversight Council

Senator Keller then presented Item 5 (202.194697.1) of Appendix A, a senate joint memorial that would direct the New Mexico Legislative Council to establish a Medicaid Disability Services Oversight Council. Senator Keller was joined at the table by disabilities advocate Noni Sanchez, who told legislators that she has long advocated for just such a council that would bring stakeholders together, and she urged endorsement of the memorial. A member moved that the memorial be endorsed by the committee; the motion was seconded and passed with a majority vote.

Brain Injury Services

Senator Keller also presented Item 4 (202.194686.4) of Appendix A. This bill would enact new sections of the Group Benefits Act, the New Mexico Insurance Code, the Health Care Purchasing Act, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law to require coverage for services related to brain injury.

Glenn Ford, advocate and former board member of the New Mexico Brain Injury Alliance (see handout), spoke in favor of this legislation, describing his own difficult recovery following a brain injury. After being sent home from the hospital, Mr. Ford said, he continued to struggle, eventually losing his job, his insurance (most coverage is nonexistent beyond the acute stage of treatment, he said) and the support of family to the situation. Eventually, Mr. Ford was accepted by an acute care facility out of state where he was treated in a group setting for six months. During the past year, Mr. Ford said, three individuals with brain injury that he knew through the alliance have been lost to suicide. He advises anyone in New Mexico with a brain injury to leave the state for treatment.

Mark Quigley, chief executive officer (CEO) of Mentis Neuro Rehabilitation in Houston, also spoke in favor of this legislation. Mentis Neuro Rehabilitation treats brain injury patients with a multidisciplinary approach that addresses many of the behavioral and communication issues that often accompany brain injury, Mr. Quigley said. Without this kind of comprehensive treatment, most patients will be placed in a nursing home, regardless of age, he said. With dedication and advanced treatment, many patients are able to return to their former lives. These are rehabilitative services, Mr. Quigley said; they are not custodial or assisted-living services. The legislation being proposed has similar language to laws that have been passed in Texas and Ohio, Mr. Quigley said.

A member moved to recommend the legislation for endorsement by the committee; the motion was seconded and passed with a majority vote.

New Mexico Dental Association (NMDA) Update

Thomas J. Schripsema, D.D.S., chair of the NMDA Council on Government Affairs, presented his organization's "Oral Health Focus 2020", a comprehensive approach to resolving barriers that challenge good oral health in New Mexico, where tooth decay is the most common chronic disease among children. This approach identifies issues and creates policy, practice and funding objectives that will provide long-term savings to the state and to individuals, Dr. Schripsema said. The NMDA plan has four "areas of vision", he said: 1) prevention and public health; 2) effective funding; 3) education; and 4) practice and work force changes. The plan urges a statewide incentive program for community water fluoridation, a phase-out of the gross receipts tax on dental services and a phased plan to establish a dental school in New Mexico. Grant funding should be increased for all New Mexico students accepted into dental schools, he said, and loan repayment scholarship programs should be expanded in exchange for practice in highly underserved areas. The plan urges more training of community dental health coordinators (CDHCs) and suggests that a demonstration project on alternative mid-level work force models be undertaken for use in underserved communities. Dr. Schripsema also described to committee members the success of a pilot project at Hidalgo Medical Services in Grant County that utilized a CDHC and another project funded by the American Dental Association (ADA) that is collaborating with Indian tribes to improve the oral health of Native Americans. On the latter project, Stephanie Poston of the Pueblo of Sandia described the progress of prevention and education efforts currently under way.

Questions and Comments

A member asked why it is so difficult to get dentists to serve in frontier communities. Dr. Schripsema said that Medicaid does not pay enough to support a dental practice in these areas, and recent graduates of dental school have so much debt that they have to establish a reliable cash flow elsewhere. Another member asked for clarification on what a CDHC does in comparison to a dental therapist. A dental therapist performs irreversible procedures, whereas the CDHC's tasks are largely preventative and palliative, Dr. Schripsema said. A member asked what point there is in having a CDHC if there are no services to coordinate. Dr. Schripsema said the barrier to accessing dental care is lack of funding, and the assumption that there are not services available is not true — if the demand is there, the services will follow.

A committee member who is a former governor of the Pueblo of Jemez said he is looking for a long-term solution to the problem of so many children living with dental pain, which interferes with learning. The Alaska model of utilizing mid-level dental therapists is a native solution to a native problem, the member continued, and when the ADA sued the tribes in Alaska to try to prevent the dental therapy model, it also insisted on changes in the federal Indian Health Care Improvement Act and the PPACA. Now tribes cannot do what they want on their own lands and need to ask permission, the member said.

Dental Therapist-Hygienist Legislation

Pamela K. Blackwell, an attorney and project director of Oral Health Access for Health Action New Mexico, described the state as being thirty-ninth in the nation in the number of dentists per 1,000 residents. Other factors also point to an accelerating crisis, she said, including the fact that only one-half of the state's dentists accept Medicaid patients and the recent Medicaid expansion promises dental services for as many as 170,000 additional New Mexicans. Ms. Blackwell provided a PowerPoint presentation (see handout) and other support material (see handouts) regarding revised dental therapist-hygienist legislation being proposed by her organization. The dental therapist-hygienist model builds on the strengths of New Mexico's work force, Ms. Blackwell said, and provides an exceptional opportunity to invest in the community. Existing resources can be utilized at schools that are already located where the need exists, Ms. Blackwell said, and federal funds would be available for training. This is a health issue that demands a solution, she concluded.

Kristen Christy, executive director of the Union County Network in Clayton (see handout), described her organization's unsuccessful efforts to recruit a dentist. The network's extended rural community of approximately 4,000 people has been without a dentist or a dental hygienist for 12 years, she said, and currently, individuals must take an entire day off work to drive many hours for dental care in Dalhart or Amarillo, Texas, or Raton, New Mexico. Many people delay oral care, she said, and end up in the emergency room with septic conditions. The community has received a \$500,000 grant for a health and dental clinic, but cannot find a dentist. Ms. Christy said that the dental therapist model being proposed is one that would work in her community; patients could keep their dental records locally and the network could nominate local students to attend dental therapist programs. This is a long-term solution for the community, she said.

Mary Altenberg, executive director of Community Dental Services (CDS) in Albuquerque and former chief of the Health Systems Bureau of the Department of Health (DOH), told committee members that the current system of dental care in New Mexico simply is not adequate. The CDS operates three clinics that serve more than 11,000 persons throughout the state (see handout) and is one of only a few that will serve low- and no-income patients. The need is huge, she said, and it only continues to grow. To meet future demand, the state will need mid-level providers for routine treatment. The dental therapist model being proposed for New Mexico could become part of the dental team at the CDS, Ms. Altenberg said, and CDS clinics could become training and education sites for students from underserved communities. Dental therapists could be employed at the CDS after graduation, she said, generating cost-savings for the clinics and helping to increase access to services for the growing number of patients. It is not a question of "if", Ms. Altenberg asserted, but "when".

Questions and Comments

A committee member asked Ms. Blackwell what has changed in the dental therapist-hygienist proposal from the original one put forth several years ago. The hygiene-based model is new, Ms. Blackwell said. Apparently, there is a glut of hygienists in Albuquerque who cannot practice in outlying areas because they must be supervised, she said; this dental therapy model

would expand the geographic area that a hygienist could serve. The legislation provides for a new code, not an addition to the existing dental code, and requires student sponsorship by a community and emergency training, which would allow practice in schools and at Indian Health Service sites. Ms. Blackwell disparaged a member's suggestion that dental therapy be rolled out in the form of a pilot project or on tribal lands only; to segregate it would be slowing a much-needed solution for the rest of the state, she said. Responding to another question about possible collaboration with the NMDA, Ms. Blackwell said her understanding is that the NMDA opposes any kind of dental therapist model in New Mexico. Sometimes, organizations need to agree to disagree, offered another member, adding that it is going to take political courage to move things forward.

Public Comment

Barbara Webber, executive director of Health Action New Mexico, told committee members that with the PPACA and the expansion of Medicaid in New Mexico, there is a whole shift in the way health is perceived. The momentum must continue, she said, in oral health and in behavioral health, and she is looking to this committee for leadership, Ms. Webber said.

The committee recessed at 5:15 p.m.

Friday, December 20

Welcome and Introductions

Representative Madalena reconvened the meeting at 8:40 a.m., welcomed guests and asked members and staff to introduce themselves. He also told the day's presenters that their time for presentations would be limited to no more than one hour.

Hospital Funding and County Indigent Funds

Brent Earnest, deputy secretary of the HSD, described the Sole Community Provider (SCP) program, which historically provided additional hospital funding through county contributions, matched by federal funds, to support the principal or sole provider of hospital services in a particular area for uninsured or indigent patients (see handout). Mr. Earnest said that at the end of 2012, the state faced a reduction of more than 70% (from \$246 million to \$69 million) in the program. Recognizing the severe impact that this would have on SCP hospitals, the HSD proposed a "bridge" payment structure in 2013 that resulted in payments of \$159 million. For 2014, the HSD negotiated with the federal Centers for Medicare and Medicaid Services (CMS), through the Centennial Care waiver, a replacement program for this same set of hospitals that includes the following two pools of funding:

- Safety Net Care Pool (funding for uncompensated care and hospital quality care improvements) at \$68.8 million for 2014, focused first on smaller hospitals; and
- rate increases for former SCP hospitals.

These changes will alter the distribution of funds based on the amount of services provided by hospitals, Mr. Earnest said. Individual payments to hospitals can no longer be tied

directly to the amount contributed by counties, but instead will be tied more directly to the amount of care provided by those hospitals. To put these payments into effect, the HSD needs a consistent, dedicated revenue stream, and has proposed dedicating an existing one-eighth gross receipts tax (GRT) increment, or the equivalent amount, to this program, Mr. Earnest said. In addition, new general fund appropriations may be necessary to make up the difference, he said. Medicaid expansion should significantly reduce the burden on the county indigent fund programs, he said, as well as reduce uncompensated care at hospitals.

Steven Kopelman, attorney and executive director of the New Mexico Association of Counties, told the committee that counties have always entered into partnerships with their community hospitals, and that the one-eighth GRT increment has always been dedicated to indigent patients who are residents of the county. There are dwindling revenues for counties across the board, Mr. Kopelman said, affecting law enforcement, detention, county roads — everyone is having to make do with less, he said. If the HSD intercepts these county funds, counties could no longer pay for services such as substance abuse programs and ambulance and inmate services, and many counties would have to lay off employees. Counties understand that the HSD needs specific dollar amounts, Mr. Kopelman said, referring committee members to a list of county GRT local option increments as of January 1, 2014 (see handout), but this could be done on a voluntary basis. Part of the problem with the HSD's plan is that it contains a lot of inequities among counties, he said, with some being short-changed and others getting more. But most important is the issue of county autonomy, Mr. Kopelman said. The concept of "intercept" is not acceptable; discretion needs to be given to the counties.

Jeff Dye, president of the New Mexico Hospital Association, provided members with a copy of an editorial by Rich Umbdenstock, president and CEO of the American Hospital Association (see handout), which appeared in the *Wall Street Journal* describing the changing, and challenging, landscape for hospitals of the future. Mr. Dye said the economic impact of downsizing and layoffs in New Mexico's hospitals, which are moving toward providing more primary and outpatient care, is significant. There has been a huge turnover among hospital administrators (39%) during the last year, Mr. Dye said, and lower reimbursements and sequestration have dramatically affected the bottom line. Medicaid reimburses at approximately 58% of the cost of delivering services, he said, and the SCP program has traditionally filled that gap. Finding a new method to make this work will require statutory change, Mr. Dye said. He provided members with a chart of estimated pool and rate increase revenues by hospital (see handout). "We are all in this together," he said, "and we hope we can count on our stakeholder partners".

Questions and Comments

One committee member suggested that instead of asking county programs to "bite the bullet" with an intercept of their funds, the state should create a consistent revenue stream by eliminating corporate tax give-aways and tax breaks for the wealthy. A guest legislator said he asked to be invited to this committee because the two counties in his district are facing a 25% cut in funding for their indigent programs if the one-eighth GRT increment is intercepted. Compared

to the rest of the state, the individuals in his district are very poor, he said, and he has a problem with county dollars being taken away and distributed elsewhere. Another member pointed out that hospitals can enroll new patients in Medicaid at the time of service, and while Mr. Dye agreed that this was so, the process can be time-consuming and cumbersome, he said.

Mr. Earnest agreed with another committee member's comment that the new HSD formula has disparities and that smaller counties benefit more. A member who was a county commissioner before becoming a state legislator told Mr. Earnest and Mr. Dye that the committee recognizes the predicament, and that something reasonable must be done for all involved. Counties today are willing to give more for a reasonable request, the member continued, stating that working together as a team is the only way to accomplish this goal. Santa Fe County alone would lose at least \$8 million, the committee member said, and all of its indigent programs would be eliminated. Mr. Earnest responded that he had met with the counties dozens of times, and the HSD is constrained as well, and there is no ability to change much of this. It was the counties who originally created the indigent fund, the member countered, and they have managed it well. Essentially, the HSD is asking for a repeal of the indigent fund, the member stated. Another member asked what will happen to people not poor enough to be on Medicaid but burdened with huge medical bills. Counties are a safety net, Mr. Kopelman responded, and that is why they need to retain these indigent services. At this point, the counties are willing to dedicate a certain amount to the fund, he said. Another member asked for more information about the charts in the handouts, asking for a county-by-county matrix. Mr. Kopelman said that his association has that information, and he will provide it to committee members. Mr. Dye said that the numbers on his handouts were "very soft estimates". Mr. Earnest confirmed that the nature of these numbers only lend themselves to estimates rather than hard numbers. The only hard number is the \$68.8 million determined by the CMS, he said.

Community Health Workers

Secretary of Health Retta Ward presented a handout to committee members on the governor's health care work force initiative to create and implement a training program and certification process for community health workers (CHWs). A 2003 senate joint memorial tasked the DOH with a feasibility study of developing a community health advocate program and, in 2006, the New Mexico CHW Advisory Council (see handout) was formed. In 2008, the DOH Office of Community Health Workers was established by executive order, but no funding was allocated for the office. This new initiative to create a certification board and statewide CHW registry includes a request for a recurring \$500,000 general fund appropriation, Secretary Ward said. Although CHWs have been serving New Mexico communities for decades, there has been no certification process to ensure basic skills and knowledge. Among the many advantages of competency-based training and certification of CHWs is that many services now will be eligible for reimbursement, she said. CHWs serve as an extension of professional health care providers in frontier and other underserved areas. CHW activities include outreach, community education, informal counseling, social support, referral and advocacy; and CHWs can play a crucial role in reducing health disparities and increasing access to care. There currently are 800 to 900 CHWs (including tribal community health representatives) working in New Mexico, Secretary Ward said.

Questions and Comments

Several members asked about the possibility of inclusion of behavioral health and oral health under the umbrella of CHWs. Christina Carrillo, program manager in the DOH Office of Health Promotion and Community Health Improvement, who accompanied Secretary Ward to the committee hearing, said that the addition of these competencies is being considered, as are other additions. One committee member gave an example of a study he read about where CHWs were utilized in a hospital emergency room and were able to save nurses and physicians a lot of time and save hospitals a lot of money by helping to direct patients to other services of which the patients were unaware. A committee member was concerned that current CHWs be grandfathered into the new program, and Secretary Ward assured the member that this is the case. Ms. Carrillo said the DOH hopes to support the CHW profession as a pathway to other health care careers, as well.

International Community Health Specialists

Francisco Ronquillo, a physician assistant and community health advocate who came to New Mexico from Cuba, spoke to committee members about a work force that exists in New Mexico that currently is vastly underutilized. Mr. Ronquillo was accompanied by a nurse, who also came from Cuba, and a pharmacist who is from Mexico. There is a shortage of health care professionals, Mr. Ronquillo noted, and even though the three cannot practice in their professions in the United States, they would like to at least be able to use their knowledge to help with illness prevention. Jerry Harrison, executive director of New Mexico Health Care Resources, explained that health care professionals such as these are unable to become licensed in New Mexico because, in many cases, they cannot verify their education. Mr. Ronquillo said he has a list of 43 health care professionals in Albuquerque right now. The state could waive certain prerequisites, and credit could be given for those with previous work experience, he said. There are a lot of barriers to licensure here. Mr. Ronquillo said his group has met with the CHW Advisory Council and that UNM has agreed to help with some kind of training program.

Representative Garcia has prepared a house memorial directing UNM HSC to convene a task force to study the potential of using community health specialists for unmet health care needs in New Mexico, and he has asked for the committee's endorsement of Item 25 (202.195349.2) of Appendix A. A motion was made for endorsement; it was seconded and passed with a majority vote.

New Mexico Health Insurance Exchange (NMHIX) Update on Native American Service Center

Mike Nunez, CEO for the NMHIX, provided members of the committee with a written response to questions posed by the committee in a letter dated November 13, 2013 regarding the progress of NMHIX plans for a Native American Service Center (see handout). Mr. Nunez' response provides details of the original grant application to the federal government asking for \$1,288,000, broken down as follows:

• tribal support center director	\$110,000
• tribal support center program managers (2)	\$150,000
• "fringe benefits" for the positions above	\$ 78,000
• tribal consultation	\$337,500
• tribal outreach/education	\$265,000
• assistance to tribal individuals and small businesses and coverage for appeals and complaints	\$347,500.

The initial grant was received by the HSD, the letter states, but the funds were not transferred to the NMHIX until November 13, 2013, less expenses for information technology, some minor HSD salary and operations expenses, contracts with the New Mexico Health Insurance Alliance and board start-up activities. Prior to this transfer, no funds had been spent on NMHIX matters related to Native Americans, Mr. Nunez' letter states. In August 2013, following a request-for-information process, a contract was awarded to Native American Professional Parent Resources (NAPPR) to develop a comprehensive outreach, education and enrollment system and to get trained health care guides into the field to do aggressive outreach and enrollment activities, the letter states. As of the end of October 2013, contracts had been developed with all tribes and pueblos, but the Navajo Nation contract is still pending. An additional \$1.4 million for Native American Service Center activities and marketing has been requested in a second federal grant submitted on November 15, 2013. To date, funds being spent on Native American activities in 2013 and including those requested for 2014 is \$4,441,496. While there is not yet a physical Native American Service Center, Mr. Nunez assured members that these services are being provided by the NMHIX.

Questions and Comments

A member asked Mr. Nunez if the HSD deducted funds from this grant that were not listed as part of the initial grant application. Mr. Nunez said that funds were spent by the HSD in broad classes. The member said that this is of concern to her. Asked about the lack of Navajo participation, Mr. Nunez said there has been some progress through NAPPR outreach, and some chapters are close to an agreement on how outreach and education will occur. Asked how many Native Americans had enrolled in the NMHIX, Mr. Nunez said that two had enrolled through the exchange as of the end of November. Asked about a target goal for Native American enrollments, Mr. Nunez said that number is 2,600. The NMHIX has been greatly hindered by problems with the federal web site, he said.

Another committee member commented on the budgeted salaries for the center director and program managers. Stating that she had been involved in a recent executive director search for another nonprofit entity, these numbers seem out of line for New Mexico. The member also asked for a breakdown of costs for "tribal consultation", and for more detail on the grant budget. Another member asked for details on the fringe benefits, as well. Asked about the vendor selected to build the individual exchange, Mr. Nunez said it is the same vendor that did the Small Business Health Options Program (SHOP), which is doing well. "Get Insured" is the name of the vendor.

Senate Memorial (SM) 94 Task Force Report

Jim Jackson, executive director of Disability Rights New Mexico, and Fletcher Catron, a Santa Fe attorney, provided a detailed report of task force findings (see handout) related to SM 94. Mr. Jackson and Mr. Catron were joined later by John Block III, new executive director of the Developmental Disabilities Planning Council (DDPC). SM 94, sponsored by Senator Ortiz y Pino, requested the DDPC to convene a work group to consider potential changes to the Uniform Probate Code to address issues related to guardianship or conservatorship of incapacitated adults. The issues to be addressed included possible changes to the Uniform Probate Code that would allow greater access by family members to information about decisions and actions of guardians or conservators that could be used to evaluate performance; provide greater accountability to family members for those decisions; and clarify decision-making authority and notice regarding decision-making upon the death of a protected person.

According to the executive summary, task force members generally agreed that, while there may be problems or concerns at times with the way the Uniform Probate Code is applied or administered, it is based on a well-respected national model, and, therefore, amendments should be approached with caution. After careful review of the privacy provisions for the protected person, the task force concluded that confidential information about the protected person should not be automatically provided or available to others simply because they are related to the protected person, as such disclosure may not be in the best interests of the protected person. The task force did recommend that additional funding be provided to the state courts, earmarked for monitoring and review of required annual reports from guardians or conservators, but did not recommend that the Uniform Probate Code be amended to make guardians or conservators more directly accountable to family members. Regarding decision-making authority upon the death of a protected person, the task force recommended that the legislature narrowly amend the code to require that a guardian provide notice of the protected person's death to immediate family members and to provide them with basic information about the process of becoming a personal representative.

The task force's final recommendation was to amend the Uniform Health-Care Decisions Act to allow a health care agent or surrogate, in the absence of an appointed personal representative, to obtain medical records related to the decedent during a 30-day window after an incapacitated person's death.

Questions and Comments

A member asked whether all reports are kept confidential, and was told by Mr. Catron that they are, unless the family members are litigants or there is an order of the court granting access to such records. A family member could petition the court for access if that individual felt it necessary in order to protect the ward, he said. Another member asked Mr. Block what happened in the past when several guardianship contracts were cancelled by the DDPC. Mr. Block responded that the director previous to his directorship sent out a request for proposals (RFP), and later determined that four or five of the responding contractors did not meet contact criteria. There were protests, and another RFP was issued and still no contracts were awarded. After the

director left the council, the Attorney General's Office verified that these contractors did, in fact, have proper qualifications, and they were notified and were allowed to keep the clients they had. Mr. Block, who has been executive director of the council for two months, said his tenure has been a "rocky road" but that things are starting to settle down.

Senator Ortiz y Pino asked the task force members if efforts to amend the Uniform Probate Code and Uniform Health-Care Decisions Act could just as well be postponed until the next session; they agreed that a delay would be fine.

Public Comment

D Marcia Southwick, who maintains a Facebook page called Boomers Against Elder Abuse, gave committee members her written statement regarding the need for transparency of the guardianship industry. Virtually every professional involved in a guardianship proceeding stands to benefit financially if an elder can be deemed incapacitated, Ms. Southwick said. In all 50 states, guardianship courts are riddled with these same conflicts of interest, and these courts are referred to by elder advocates as kangaroo courts. Furthermore, as it turns out, there are guardians on the task force who make money off of elders' nest eggs, she said. This is not playing fair when it comes to the most vulnerable members of our society, Ms. Southwick said. In the future, she hopes national advocates will be offered a seat at the table.

Endorsements

See Appendix A for a complete list of all legislation endorsed by the LHHS for the second session of the 2014 legislature.

Adjournment

There being no further business before the committee, the seventh meeting of the 2013 interim LHHS adjourned at 4:45 p.m.

BEHAVIORAL HEALTH SUBCOMMITTEE MINUTES

**MINUTES
of the
FIRST MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

July 9, 2013

**Eastern New Mexico University, Campus Union Building, Multi-Purpose Room 110
43 University Blvd.
Roswell**

The first meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Benny Shendo, Jr., chair, on July 9, 2013 at 10:16 a.m. in Multi-Purpose Room 110 in the Campus Union building on the campus of Eastern New Mexico University (ENMU) in Roswell.

Present

Sen. Benny Shendo, Jr., Chair
Rep. Stephen Easley, Vice Chair
Rep. Phillip M. Archuleta
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Gay G. Kernan
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent

Sen. Sue Wilson Beffort
Sen. Howie C. Morales
Sen. Sander Rue

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Tuesday, July 9

Introductions

Senator Shendo asked members and staff to introduce themselves.

Welcome

Dr. John Madden, president of ENMU, welcomed the subcommittee and described the university as a community of 4,000 to 5,000 students enrolled in a wide range of degree and certificate academic programs, including a special services program for the disabled and one of the only air traffic control programs in the United States. (See handout.)

Update from the New Mexico Rehabilitation Center

Janie Davies, administrative services director of the New Mexico Rehabilitation Center (NMRC), told the subcommittee about NMRC's Chemical Dependency Unit, which provides addiction treatment. The program, she explained, is not an intensive one-on-one program. (See handouts.) It lasts 21 days, and "there is only so much we can do" during that time period. There is one psychiatrist and multiple facilitators on staff. The program works with other interventions of the patient's choosing, such as Alcoholics Anonymous, Narcotics Anonymous and other faith-based programs.

There are 43 beds at the NMRC; 15 in the medical wing and 28 in the chemical dependency wing. Most admissions — at least 80% — are court-ordered, the majority coming from Albuquerque. Ms. Davies said that many court-ordered admittees have a negative attitude at first, but they show appreciation for the program after three weeks. Individuals who have not had a job in 10 years because of chemical dependence are able to focus for the first time, and they do not want to be there. Included in her handouts is a copy of the letter that admittees have to sign.

Ms. Davies stated that the NMRC treats an average of 18 to 20 individuals who are admitted to the substance abuse treatment program every day. The program must accept all court-ordered admittees but screens other applicants for admission to ensure that the individuals have already gone through withdrawal. Team conference happens once a week with doctors and counselors and a progress report is completed for each client.

Questions/Concerns

Funding source. The NMRC's chemical dependency program uses about \$2.5 million in Department of Health (DOH) general fund dollars. The staff at the NMRC are all DOH employees. However, the NMRC accepts reimbursement from private payers as well. The chemical dependency program is currently not eligible for reimbursement through Medicare or Medicaid. It has not been able to meet the staffing or facility requirements under those programs but is "actively working" toward certification. As of July 1, it employs a psychiatrist. It is difficult, Ms. Davies explained, to obtain the staff the facility needs, such as psychiatrists, psychiatric nurse practitioners and registered nurses. The NMRC provides services on a sliding-

fee scale for everyone who walks through the door, accepting county indigent funding and private insurance and Medicaid. Anyone of either sex over the age of 18 may be admitted.

Population treated in the Chemical Dependency Unit. The unit accepts all addictions, though it cannot offer suboxone/buprenorphine treatment and cannot admit patients who are recovering through these opioid-replacement therapies. Alcohol detoxification presents dangers, so the NMRC requires five days' withdrawal from alcohol before admission. Nurses are difficult to hire, and detoxification is not feasible at the NMRC.

Post-release follow-up. The NMRC does 30-day, 60-day, 90-day and one-year follow-ups with patients, contacting them at telephone numbers they provide. However, many are not reachable later; many are admitted after being homeless; and most are from outside the Roswell area. It is difficult to gauge the success of the individuals because there is no way to ascertain whether an interviewee is telling the truth over the telephone.

Evidence-based therapy. The NMRC uses a "conglomeration" of approaches, including faith-based and 12-step programs; patients need to be in a support group. A patient chooses the approach the patient will take.

Discussion of chemical dependency treatment facilities in New Mexico. Ms. Davies stated that she knows of only three inpatient chemical dependence treatment facilities in the state. She said she believes that the DOH's Turquoise Lodge will be opening an entire wing for adolescent chemical dependence. Fort Bayard has a small program. She said that if the NMRC had the option, it would expand to offer intensive outpatient therapy. The NMRC also could use an outpatient program through counseling associations to provide support to those back in the community. This would allow the NMRC to serve more people more effectively.

In rural and semi-rural areas of the state such as Roswell, it is difficult to find the personnel necessary to staff many facilities. The Los Lunas facility is a state facility, but it does not provide chemical dependence therapy. For detoxification, patients in Roswell will be sent to Sunrise at the ENMU Medical Center. The NMRC does not provide outreach counseling after discharge. It does have a list of resources throughout the state to provide to patients upon discharge, connecting them with the NMRC and with Narcotics Anonymous and Alcoholics Anonymous. The number of repeat admittees fluctuates greatly, according to Ms. Davies, and the rate of recidivism is high. A subcommittee member observed that, with at least one-third of the patients coming from Albuquerque, the legislature may wish to expand the chemical dependency treatment resources that are available in the Albuquerque area.

Working with Native American people. The NMRC treats many Native American patients. Often tribal governments support the cost of care. Those individuals who have the support of their tribes in recovery will have the most success, Ms. Davies said. As patients direct the type of care that they receive, it depends on the patient whether they receive care that is aligned with a particular cultural heritage. There was discussion about the closure of the Nizhoni Center, an

important chemical dependency treatment facility in Gallup. It was observed that the need for such programs is great and resources are few.

Panel: Community-Based Behavioral Health

Jane Batson, interim assistant vice president for external affairs at ENMU, informed the subcommittee that she has been working with a large group to address homelessness. (See handout.) In 2011 and in 2012, the group has used point-in-time surveys to identify homeless people, which has been done routinely in Albuquerque. This has provided an idea of the number of homeless people in the area. These numbers have increased in the past few years, though housing has not kept up with demand. The group found that people living with disabilities are twice as likely as non-disabled individuals to be living in homeless shelters. At least 40% of these individuals are likely to have a mental illness or chemical dependence issue.

Ms. Batson shared her and her group's disappointment that the state-owned rehabilitation facility, which has been abandoned by the NMRC, was not made available for homeless services. The group had assembled a large coalition of agencies that intended to establish a nonprofit to provide services for homeless people. The coalition had been in negotiations with the Martinez Administration, but were then informed that a donation of the NMRC facility would violate the Anti-Donation Clause of the Constitution of New Mexico. The building has now been condemned and destroyed.

Questions/Concerns for Ms. Batson

Youth services. The Roswell nonprofit, Assurance Home, operates the James Ranch Youth Shelter, which provides housing and support for teens, including short-term homeless housing for teenagers, with a capacity to serve 20 individuals, Ms. Batson said. It is funded by the Children, Youth and Families Department (CYFD), and private funding flows through Assurance Home and other donations. It is co-educational, with an even male-to-female ratio. The facility is always full, with "extras" sleeping on sofas. The majority served are homeless adolescents under 19 years of age who have conflicts at home. They may have been living in tents, boxes and on the streets for a time. Many end up in a CYFD home for children who cannot be placed in foster homes. They are primarily from Chaves County.

New Mexico has the second-highest rate of child homelessness in the country, Ms. Batson said. It is a problem afflicting both rural and urban areas. Children at the James Ranch Youth Shelter go to school in the Roswell Independent School District. They have counselors and activities. The children remain at the shelter, which is supported by a foundation and operated by Assurance Home, for 30 to 45 days.

There was further discussion about the dearth of facilities to accommodate homeless youth in the state.

Anti-Donation Clause. Some subcommittee members suggested that a constitutional amendment to provide for easier state support of nonprofit welfare activities may be in order.

Some of the exceptions to the Anti-Donation Clause, including welfare purposes, were discussed.

Jessie Chavez, a former state liaison to Local Behavioral Health Collaboratives 5, 9, 10 and 12, next addressed the subcommittee. (See handouts.) Mr. Chavez explained that local collaboratives are a way for localities to provide input in the behavioral health system statewide. Members are people receiving behavioral health services, family members of consumers, providers, public education and law enforcement — whoever is involved in behavioral health services in the state. Mr. Chavez discussed the history of the collaboratives.

According to Mr. Chavez, local collaboratives are able to obtain total-community-approach funding for youth substance abuse prevention and treatment. He discussed intensive outreach programs through schools and elsewhere. Reports show a significant improvement among participants, as compared to nonparticipant teens. This work has had an impact on teen drug use. Local Collaborative 5 members realized suicide is a big issue. They developed a subcommittee of the local collaborative to work with teens in high schools. The school system, Counseling Associates, Inc., (CA) and others developed an approach based on *More Than Sad* videos. Local collaborative members went into high school freshmen health classes to provide suicide prevention training. The group consisted of independently licensed providers, who used video and discussions. Local Collaborative 3 has exported this intervention model to other collaboratives.

Mental health first-aid training. Mr. Chavez explained that this program provides "first aid" to individuals having a mental health crisis. It is intended for use by service employees who may come across people in mental health crises. It provides a protocol that may serve as a more helpful alternative than calling the police to intervene.

Local collaboratives have the umbrella of LifeLink in Santa Fe. Thus, they are able to provide members' travel, training and related expenses. Affordable housing has disappeared, according to Mr. Chavez. "We had some federal funding; 24 units in Eddy county," he said, "but costs have increased: \$2.3 million needed and \$1.8 million found". Roosevelt and Curry counties' Local Collaborative 9 has been doing work with core service agencies to provide anti-stigma (for receiving mental health services) awareness and fundraising. Local Collaborative 12, in Lincoln and Otero counties, has been focused on consumer involvement and has established hotlines for people to call when someone is in crisis. Local Collaborative 10 in De Baca, Quay and Harding counties cites a lack of adequate transportation, a lack of services and a lack of professionals to serve its population.

Questions/Concerns

Gangs in Chaves County. Mr. Chavez stated that gangs continue to present a challenge in Chaves County, although the incidence of gang-related activity has decreased in recent years. Several community groups have become involved, and programs have been established to provide mentoring, a youth center and community gardens. There also are programs that

promote collaboration between seniors and youths, an intergenerational connection that Mr. Chavez stated seems to be dissolving in society.

Collaborative functions. Mr. Chavez stated that local collaboratives have no involvement with monitoring expenditures of behavioral health funds. The Interagency Behavioral Health Purchasing Collaborative (IBHPC) is operated by state agency executives, he noted, and it is supposed to be looking at utilization and providing oversight.

A subcommittee member stated that the statewide behavioral health entity, OptumHealth of New Mexico, and the IBHPC have failed in their responsibilities.

Marti Wright Everitt, chief executive officer of CA, next made her presentation. (See handout.) She stated that CA provides behavioral health services in Chaves and Eddy counties. The landscape has greatly shifted recently, said Ms. Everitt, with the decision of the Human Services Department (HSD) to issue a pay hold against several behavioral health service provider entities whom it has accused of fraud. "CA's offices will be closed within the next two weeks unless something happens", she stated.

Ms. Everitt informed the subcommittee that she has been a resident of Roswell for 34 years and has served as director for CA for the past 27 years. CA provides behavioral health services to more than 4,000 individuals each year who are the most needy and vulnerable — adults, young mothers, homeless and at-risk people. Ms. Everitt said that she and 14 of her colleagues, plus 204 employees, have been branded by the HSD as criminals and liars. Ms. Everitt stated that this is untrue and that the HSD's fraud investigation is an "erroneous, dubious and fundamentally flawed process". Since 1996, CA has contracted with managed care organizations (MCOs) that the state has designated, changing every four years to work with a new MCO. Since 1996, there have been four different MCOs, with differing rules and expectations and "non-working billing and payment systems", she stated. The new Medicaid waiver program, Centennial Care, will be another change, with four separate MCOs to deal with at once. The state's public behavioral health system is, in Ms. Everitt's opinion, "chaotic, inconsistent [and] administratively overburdened" and will collapse under its own weight. She stated that she partly believes that the HSD is, in fact, intending to start anew rather than fixing a "broken" system. CA has had to pass rigorous audits repeatedly and has passed these audits and reviews at a 90% or 100% pass rate, she said. MCOs bring major problems around a billing system, and then refuse payment to providers for six months at a time or longer.

Ms. Everitt described what she characterized as many difficulties with OptumHealth and described a claims system that has "never worked", payment from incorrect payer sources and incorrect aberrant claims identification. One direct service provider agency gave her a stack of emails between OptumHealth and that agency regarding billing problems, and the stack she displayed appeared to be about six inches thick. Ms. Everitt stated that the HSD and OptumHealth failed to communicate effectively with provider entities about claims anomalies and published the names of the 15 provider entities. These provider entities have been told to

continue services without pay until Arizona provider entities take over management of the New Mexico provider entities' operations. CA did take the opportunity to submit a request for a lifting of the pay hold for "good cause". Ms. Everitt stated that Southwest Counseling would be closing and that the consequences would be "tragic" for thousands of consumers if the HSD does not lift pay holds imposed upon these provider entities.

The auditor employed by the HSD for the provider entity investigations is Public Consulting Group, Inc., (PCG) from Boston. PCG has audited programs in North Carolina, and Ms. Everitt reported that PCG had been placed on a corrective action plan in North Carolina due to complaints regarding its audit. North Carolina's state auditor found that PCG had committed great errors in its audit, Ms. Everitt said. Provider entities in North Carolina were allowed to address the deficiencies alleged in the audit. Ms. Everitt said that she questions the HSD's claim that it had no discretion but to turn over the alleged provider entity practices for criminal investigation immediately upon receiving PCG's audit results. Ms. Everitt stated that she wants the HSD to continue its investigation, but only after reestablishing payment to all of the provider entities. She also wants OptumHealth's software system to be investigated to ascertain the types of anomalies identified.

Questions/Concerns

HSD actions and PCG audit. Subcommittee members expressed a great deal of concern about the ongoing HSD fraud investigation and pay holds. They stated that medical recordkeeping is "not an exact science". Members questioned the speed with which the HSD turned over the PCG audit findings as "credible allegations of fraud" (CAFs) and what the federal regulations actually require. A member expressed frustration that a meeting with the HSD and the IBHPC had "gone nowhere", with the HSD refusing to reveal any information about the ongoing investigation and pay holds. It was suggested that PCG audit the Arizona provider entities before they take over.

Request to state auditor. Members suggested writing a letter to the state auditor requesting that he investigate the actions of the HSD, the IBHPC, PCG and OptumHealth, just as the North Carolina state auditor had. A motion was made and seconded, and the motion passed.

July 3 LHHS meeting. Some members discussed the July 3 meeting of the LHHS in Albuquerque. Secretary of Human Services Sidonie Squier, IBHPC Director Diana McWilliams and Attorney General (AG) Gary King were all present. Secretary Squier was questioned about the hiring of PCG through a "single-source contract" and her claims that referral to the AG was required upon the CAF finding. Yet, a member argued, the HSD had the discretion to make a CAF finding, and nothing required the HSD to make a CAF finding within four days of receiving the results of the PCG audit.

A member stated that AG King had expressed disagreement with Secretary Squier at the July 3 hearing, in that he had made no determination of fraud whatsoever, that the CAF was

made by the HSD, but a determination of fraud in the criminal or civil sense could only be made after the AG had had an opportunity to investigate each case.

PCG's audit in North Carolina. A subcommittee member raised several issues regarding what the member had learned about PCG's audit in North Carolina. PCG was paid something in excess of \$2 million. Its earnings were contingent upon the amount of fraud PCG reported, even if none of that alleged fraud was substantiated. Thus, PCG had an incentive to overreport allegations of fraud. The member wondered whether the HSD's contract with PCG had similar provisions for contingency.

Discussion with Al Lama, assistant AG. Mr. Lama emphasized the distinction between a CAF and the AG's investigation of possible criminal or civil causes of action. He said that the CAF standard was an "easy threshold". Also, the HSD would face severe penalties for not complying with federal law. However, the HSD had the option of taking as much time as it needed to make a determination of CAF. The AG does not wish to disclose specific information regarding the fraud claims, as disclosure could prejudice the ongoing investigation and any prosecution. Mr. Lama could not give a date when the review of the 15 agencies will be complete; maybe a couple of months, but in these cases, he said, it may take up to a year.

Panel Discussion: Legislative Finance Committee (LFC) Program Evaluation of Behavioral Health Services 2013

Charles Sallee, deputy director, LFC, and Pam Galbraith and Valerie Crespin-Trujillo, LFC program investigators, presented the results of their LFC report to the subcommittee. (See handouts.) Mr. Sallee began the presentation by discussing challenges due to substance abuse. He stated that in New Mexico, prescription drug deaths now exceed deaths due to illicit drugs. Eight of the 10 leading causes of death in New Mexico are at least partially due to substance abuse. Thirty percent of adults receiving services in New Mexico's behavioral health system have co-occurring disorders. Many young people face depression and other mental distress. Maternal depression has an effect upon the cognitive development of youths.

The panel discussed the statutory history and duties of the IBHPC and the Behavioral Health Planning Council, a large advisory body to the IBHPC. The IBHPC is charged in statute with contracting with one or more behavioral health service MCOs. The IBHPC contracted with ValueOptions to serve as the statewide entity (SE), and, later, with the current SE, OptumHealth.

Mr. Sallee reported that the IBHPC is supposed to, but does not, provide a master plan yearly and that reporting provided by the IBHPC is not of good quality and does not allow a real assessment of behavioral health service needs in the state. It is almost impossible to reconcile OptumHealth and HSD reporting. Moreover, the IBHPC has not used the rulemaking authority it has been provided in statute. This rulemaking was supposed to be the mechanism to provide a responsive framework for behavioral health services and an inventory of all behavioral health expenditures.

Before the IBHPC was instituted, a series of agencies funded providers either directly or, as with the HSD, through a third party. The DOH provided block grants to coordinating agencies. Mr. Sallee referred subcommittee members to the LFC report at page 10, which shows how the SE was another layer added to pull together the diverse behavioral health service purchasing among state agencies. The HSD now spends the vast majority of behavioral health dollars. Most of the CYFD behavioral health services funding flows through OptumHealth, but not all of it.

Questions/Concerns

IBHPC reporting. Ms. Crespin-Trujillo addressed the discrepancies between HSD and IBHPC reporting. OptumHealth reporting is often aggregated, she explained. Sometimes data regarding adults are not separated from those pertaining to children, and a reviewer must sift through "layers" of data. Also, there is a lag in paying claims that exists throughout Medicaid: fiscal year (FY) 2012 claims may not be paid until 2013.

A subcommittee member observed that a lack of consistency in reporting is an effective way of obfuscating information. Mr. Sallee stated that the LFC has been raising the "red flag" on the lack of transparency for a number of years.

Nonpayment of direct service providers. Many complaints have been made about SEs failing to pay providers or failing to pay them in a timely fashion. At one time, MCOs had paid only 50% of allotted funds to direct service providers and had failed to provide a proper accounting for how that money flowed. A subcommittee member stated that OptumHealth has yet to settle many of these complaints. Another member observed that problems with financial oversight of public behavioral health expenditures continue, and changes for accountability are still needed.

Mr. Sallee stated that there is almost no systematic approach by the SE or others to find large-scale Medicaid waste, fraud and abuse. Instead, the HSD's Office of Inspector General (OIG) has concentrated on prosecuting allegations of fraud by individual recipients for small dollar amounts. The HSD has recently decided to issue the HSD's OIG report directly to the secretary. The LFC recommends that this reporting role be codified to allow greater independence. Mr. Sallee mentioned Senator John M. Sapien's 2013 Senate Bill 227 (which did not pass) and the State Inspector General Act, which would strengthen the LFC's and state agencies' ability to perform audits and investigations.

Ms. Crespin-Trujillo indicated that \$56 million of the behavioral health budget of \$283 million comes from state general funds and federal grant dollars, not from Medicaid dollars. This \$56 million serves 24,000 residents.

There was discussion of what was characterized as a lack of authority and administration at the HSD for behavioral health services and a "convoluted system" for consumers and providers. Mr. Sallee stated that it is not possible for the IBHPC, the HSD or the legislature to analyze which services are helping consumers and which are not. He reported that contract services

comprise a majority of the behavioral health budget (provider reimbursement for patient services and administrative fees for OptumHealth). Expenditures have increased, as have the units of services, while the number of individuals served has recently declined from 25,000 to 22,500. OptumHealth characterized more than \$1 million in FY 2010 through FY 2012 as "uncategorized". Thus, the HSD does not have the information it needs to monitor services. Performance outcomes have been inconsistent for the past three years. There has not been adequate follow-up after discharge of patients in chemical dependency treatment programs.

Provider audits. Ms. Galbraith said that the LFC performed its behavioral health services program evaluation before the PCG audit's completion. She referred the subcommittee to page 28 of the LFC report, which indicates that OptumHealth and the HSD's OIG are responsible for reviewing program integrity. The HSD's OIG is obligated to audit providers. OptumHealth is paid consideration in its contract with the HSD to do so. Program integrity efforts by the OIG and OptumHealth, according to Ms. Galbraith, should have served as an early warning system for the pending crisis brought about by the PCG audit of the 15 providers. In none of the information received by the LFC investigators, Ms. Galbraith said, was there evidence of any audit performed by the HSD's OIG or by OptumHealth. She stated that the LFC staff performing the behavioral health services audit made a "considerable" number of information requests to OptumHealth. She referred the subcommittee to page 29 of the LFC report.

Ms. Galbraith said that the LFC program evaluation team had difficulty obtaining responses from the HSD during its audit. The team had planned to go into provider agencies, review client files, compare claims processing with documentation of services delivered and examine the providers' use of evidence-based practices, but the HSD claimed that providing LFC staff access to this information would violate federal law — namely, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). The HSD claimed that, under HIPAA, a "health oversight agency" could have access, but the LFC does not constitute a health oversight agency. The HSD disagrees with LFC staff that a health care funding agency such as the LFC should be accorded access under the HIPAA Privacy Rule. The LFC never did obtain the information requested. Referring members to page 23 of the LFC report, Ms. Galbraith said that the program integrity clause of the HSD's contract with OptumHealth is weak, lacking performance measures by which the HSD can evaluate monitoring effectiveness.

Ms. Galbraith observed that behavioral health programs funded by state general fund dollars are "key" for individuals without other access to these services.

Letters of direction. Ms. Galbraith explained to subcommittee members the use of "letters of direction", which the IBHPC issued to the SE to direct how funds should be allocated. The IBHPC issued more than 170 letters of direction during the period under review. Ms. Galbraith stated that the letters of direction are intended to allow the IBHPC to direct the use of funds that had been allocated to the IBHPC but would revert if unused by the end of the fiscal year. The letters of direction direct the SE to do certain things and evade the state's Procurement Code, which would have required a bid process. The LFC, she explained, believes this to be an illegal

practice. Providers, pursuant to provider contracts, are obligated to support operational costs through contractual reimbursement. However, Ms. Galbraith explained, letters of direction allow the program to request reimbursement for a portion of operational costs. These practices raise concerns under the Constitution of New Mexico's Anti-Donation Clause. For example, in 2013, the AG found a violation when fair market rents were not being charged to nonprofits using buildings owned by the City of Las Cruces.

A member asked Mr. Lama to explain what sanctions apply to Anti-Donation Clause violations. Mr. Lama replied that the constitution provides no penalty. If public money is expended, there may be a responsibility to reimburse the general fund. There is no criminal or civil penalty. The AG may be responsible for recovery in cases of Anti-Donation Clause violations.

Questions/Concerns

Letters of direction. It was observed that these letters should be available through public records requests. Another subcommittee member stated that actions ordered through letters of direction should require approval as budget adjustment requests. There was an inquiry into the role of the federal government, which oversees grants that it makes. Ms. Galbraith stated that a significant amount of money is transferred through letters of direction and that the LFC has no idea how money is spent through these letters. Once the money moves to the SE, there is less transparency.

Gene Lovato, a former deputy secretary of the HSD, stated that federal acquisition regulations provide guidance as to how the grant must be evaluated. The state is provided far more authority over these grants than has been heretofore recognized. Mr. Lovato counseled the subcommittee to examine both the relevant federal waiver and federal acquisition regulations.

Contracting. A subcommittee member asked whether it is necessary for state agencies such as the HSD and DOH to contract for management services when there are capable people at these agencies. Ms. Galbraith observed that there is a common practice of contracting with many former agency employees, some of them performing tasks with which they had previously been charged as employees.

Combining behavioral health service and physical health service administration. Referring to slide 5 of the handout, a member asked whether the state was "going backwards" to the previous policies in place in the 1990s, during which behavioral health services were, in name, provided jointly with physical health services, yet administered separately. The member asked whether that previous Medicaid configuration worked well. Mr. Sallee answered that the 1990s configuration did not work out well, according to the 2002 gap analysis. The member asked why the HSD was going back to something that did not work, and how was Centennial Care established? Mr. Sallee explained that the Centennial Care policies were administrative decisions made by the HSD, and the questions as to whether these policies would be an improvement would be good ones to ask the secretary of human services. Centennial Care will

integrate behavioral and physical health care services at the payment and managerial levels, yet Mr. Sallee opined that integration should occur at the provider level and not at payment or managerial levels.

Procurement Code. A member asked whether the HSD had violated the Procurement Code by hiring PCG as an auditor through a "sole-source" contract without bidding. The member asked whether controls could be placed on such procurements to avoid sole-source contracting in such cases. Mr. Sallee stated that he would perform an analysis of state procurement law. Another member stated that the HSD's action in performing a Medicaid audit without using the state auditor might be a violation of state law. There was discussion of the limited emergency basis on which a state agency may seek emergency procurement. Justification is supposed to be made in writing. Mr. Sallee stated that no such justification has been found for the sole-source PCG audit contract.

PCG audit in North Carolina. A member urged that PCG's audit work in North Carolina be carefully reviewed. The North Carolina contract provided contingent payments that would reward PCG for each unsubstantiated finding of fraud. Even in the event that the allegations of fraud are not substantiated, PCG is paid by North Carolina for the unsubstantiated cases. The member asked whether New Mexico's contract with PCG contains an incentive to find fraud, such as North Carolina's contract provides. The member further noted that the HSD refused to attend today's hearing. Mr. Sallee told the subcommittee that the LFC would be analyzing the contract.

Public Comment

Lorraine Freedle, Ph.D., identified herself as a licensed independent social worker and a pediatric neuropsychologist. Her agency, TeamBuilders Counseling Services, Inc., (TeamBuilders), has been in a payment hold due to the HSD's CAF against it. Dr. Freedle said that the HSD has not permitted TeamBuilders to take corrective action to address the HSD's concerns and that the HSD has publicly branded the TeamBuilders' leadership as criminals. Dr. Freedle stated that the Arizona provider agencies that the HSD has brought in to assume management of agencies such as TeamBuilders have not been publicly vetted. According to Dr. Freedle, they are not licensed or certified to provide the services that TeamBuilders has been providing. Seventeen million dollars in taxpayer money will be used to pay Arizona provider agencies. Dr. Freedle and her husband, Shannon W. Freedle, started TeamBuilders 17 years ago and began serving people statewide. TeamBuilders has been a sole provider in many communities and has more than 650 employees and foster parents working with it. It regularly receives audits from state and private entities that have found no problems. OptumHealth has found TeamBuilders to be 95% compliant per its reviews. Dr. Freedle questions the new algorithmic software OptumHealth put into use. She also questions the 24-point audit tool that PCG used, pursuant to which a 96% compliance is a failure. She questions PCG's conflict of interest and the system in which this has happened. Dr. Freedle urged that the HSD immediately approve TeamBuilders' request that the pay hold be lifted for good cause. She believes that if the

Medicaid fraud investigation process is legitimate, all provider agencies should meet the criteria for a good-cause suspension of the pay holds.

Patsy Romero, chief operations officer for Easter Seals El Mirador (ESEM), told the subcommittee that she also represents one of the 15 providers the HSD has identified as criminal and as civilly fraudulent. She stated that ESEM would furlough 120 employees in Raton and Taos (who earn \$13.25 an hour) and that 273 at-risk children and families would not get services as of the day of the meeting. OptumHealth told ESEM that it is in contract violation if ESEM did not serve patients without pay and that OptumHealth would decertify ESEM. New Mexico has intergenerational challenges and "our communities do not want outsiders to serve them", Ms. Romero said. ESEM is not made up of frauds or "tricky" people. "We love our clientele, our employees and our communities."

Former Senator Timothy Z. Jennings spoke next, welcoming the subcommittee to Roswell. He requested that the subcommittee take a look at the job training center in Roswell, which, he said, needs to recruit more children from New Mexico; half of them come from out of state. He also brought subcommittee members' attention to the New Mexico Military Institute lottery scholarship, which provides excellent opportunities through allotments of \$10,000 to \$12,000 per recipient. Mr. Jennings stated that New Mexicans have "begged" for money for behavioral health services, and yet the HSD pays \$3 million for people "to do nothing for it". Mr. Jennings observed that layers of management or contracting for behavioral health services involves each "layer" receiving 10% "off the top". CA has been here for as long as he can remember, Mr. Jennings said. It has picked up the pieces regardless of upheavals in the behavioral health system. The state provider infrastructure has weathered enormous policy changes with the changes in administrations, he said, and "one does not find reliable providers like this just anywhere". Mr. Jennings unfavorably compared Secretary Squier with former Secretary of Human Services Pamela Hyde, J.D., who, he said, appeared at every meeting of the LHHS, even when she strongly disagreed with members' statements. "She showed up, with the courage of her convictions. She did not avoid meetings", Mr. Jennings said. "It's a problem that no one from HSD has shown up for the subcommittee meeting today."

Bridges to Accessing Care: Experiences of the Developmental Disabilities and Mental Illnesses (DDMI) Project

Dr. Alya Reeve introduced herself as principal investigator for the "DDMI Report" on the continuum of services for individuals living with co-occurring developmental disabilities and mental illnesses. Dr. Reeve is a professor of psychiatry, neurology and pediatrics at the University of New Mexico Health Sciences Center. Panelists Kari Hendra, a family nurse practitioner for student health at ENMU, and Nathan Padilla, a licensed master social worker and clinical supervisor for La Familia Mental Health Services, also introduced themselves and echoed some of the comments that they, too, had found the work of these providers to be top-notch.

Ms. Hendra pointed out that health practitioners are never trained on how to bill. She provided the subcommittee with background about student health care at ENMU, stating that typical consumers in ENMU's program are students with developmental delays, including some dually diagnosed individuals. Some are not diagnosed. ENMU estimates that it serves about 100 students per semester, who come from all over the country. About half of New Mexico students have Medicaid. Sometimes, students do not have the psycho-social skills to be on their own right away, she said, and the extreme stress of school can lead them to "self-medicate" with drugs and alcohol.

Mr. Padilla, who has a background as a drug and alcohol counselor, explained that the DDMI project was previously funded by ValueOptions and that it also received a grant through a state fund. The project is trying to meet the needs of patients who might not be verbal or able to articulate their needs, and it is intended to be a collegial consultation model to increase capacity in the community. There are telehealth sites in Taos, Shiprock, Farmington, Roswell and Silver City. Telehealth sessions are interspersed with in-person sessions, building trust through the latter. The values have been about support and valuing clinicians.

Questions/Concerns

Telehealth. Pursuant to a question, a panelist told the subcommittee that telehealth is used to counsel practitioners. The DDMI project provides in-person services for patients for the first visit, and thereafter, it uses telehealth. With their clientele, project practitioners feel it is important to establish trust in person. A particularly useful aspect of telehealth is teleprescribing, which allows patients access to prescriptions without driving long distances, as they have been previously required to do for in-person prescribing. Dr. Reeve said the DDMI project is taking precautions to ensure a secure internet connection that complies with privacy laws using a "telepresence" format such as Skype.

The meeting adjourned at approximately 5:30 p.m.

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

**September 3, 2013
Barbara Hubbard Room, New Mexico State University
1810 E. University, Bldg. 284
Las Cruces**

The second meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Benny Shendo, Jr., chair, at 10:15 a.m. on Tuesday, September 3, 2013, in the Barbara Hubbard Room on the campus of New Mexico State University (NMSU) in Las Cruces.

Present

Sen. Benny Shendo, Jr., Chair
Rep. Phillip M. Archuleta, Vice Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Edward C. Sandoval

Guests Legislators

Rep. Mary Helen Garcia
Rep. James Roger Madalena

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, Contract Staff, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Tuesday, September 3

Introductions

Senator Shendo asked members and staff to introduce themselves.

Welcome

Dr. Tilahun Adera, dean and professor, College of Health and Social Services, NMSU, welcomed subcommittee members and guests and described NMSU's plans for becoming the primary regional hub for social services. Dr. Adera described how the various schools within the College of Health and Social Services — the School of Nursing, the School of Social Work and the Department of Public Health Sciences — are helping to meet the needs of the region and entire state. Special programs include a research center to train graduate students in research methodology, a center for child advocacy, a border epidemiology center, an institute for research into health disparities and a southern area health education center to improve access to primary care. The college ranks high in training Native American and Hispanic students, she said, and maintains a vision of bringing a national work force to NMSU by offering high-quality programs at undergraduate and graduate levels.

Dr. Pamela Schultz, associate dean and director of the School of Nursing, touted the excellence of the school's mental health program. As the only university in the region that trains psychiatric nurse practitioners, the school just graduated its first class in doctorate of nursing practice, an advanced program converted from the master's program in response to changes in national accreditation requirements. Graduate programs focus on family nursing practice, adult health and geriatric nursing, as well as community health. Another area of focus is family violence, she said, and the school would like to plan a workshop for teachers — a two-day event each semester — on sexual abuse of children.

Update on the Status of Behavioral Health Services

Brent Earnest, deputy secretary of human services, described the driving purpose of the Human Services Department (HSD) as assuring access to care and the highest quality of services. Ensuring Medicaid integrity is worthy of investigating, he said, as every dollar misspent does not go to services. There is increased federal emphasis on efforts to catch fraud, and the federal Patient Protection and Affordable Care Act (PPACA) provides new fraud-detection tools.

Deputy Secretary Earnest said that in November 2012, the HSD received a referral from OptumHealth of suspicious billing activity involving 15 provider agencies. The HSD reached out to the Attorney General's Office (AGO), and the AGO agreed that further independent investigation was needed. The HSD then contracted with Public Consulting Group Inc., (PCG) to audit these 15 agencies. In January and February, after receiving the referral from OptumHealth, the HSD started to reach out to other agencies for possible transition, including

three providers from Arizona, Deputy Secretary Earnest said. It was of utmost importance that access and continuity of care be maintained, he said. Early audit results indicated that additional entities might be required for full transition, and the HSD identified two additional Arizona entities. On June 21, 2013, the results of PCG's audit confirmed credible allegations of fraud (CAFs) against the 15 agencies and \$36 million in possible overpayments, Deputy Secretary Earnest said. On June 24, these results were presented to the AGO, the Federal Bureau of Investigation and the United States attorney general for possible criminal prosecution. The HSD suspended Medicaid payments to these providers in accordance with federal guidelines for Medicaid funding, he said. HSD funds totaling \$6.3 million have been expended so far during this transition: \$4 million for payroll of existing agency staff to maintain continuity of care, \$1.4 million for professional costs, \$709,000 for operations and the remainder for office and other expenses.

Larry Heyeck, deputy general counsel, HSD, said that PCG is in 46 other states doing similar audits and that this was not a canned audit; HSD staff worked closely with the auditors on a daily basis. PCG was asked by the HSD to "follow the money" and to examine business relationships that could indicate conflicts of interest. "We found that executives and others were doing extremely well", Mr. Heyeck said. He then distributed a chart (see handouts) with lines connecting behavioral health provider agencies in overlapping business relationships with other entities. "If something appears to be wrong, this is what's wrong," he said, holding up the chart. As an example, the "Rio Grande Seven" providers depicted in the chart all had relationships with Rio Grande Behavioral Health Services, a company that is incorporated in Arizona. Many of the seven providers also had relationships with two other companies. All of the information on this chart came from publicly available sources, Mr. Heyeck said, such as federal nonprofit 990 tax forms, county clerk records, corporate structures, etc., and he urged all legislators and citizens "to look it up". In addition to the PCG audit identifying \$36 million in overpayments, he said, the relationships depicted in the chart need to be examined.

Diana McWilliams, chief executive officer of the Interagency Behavioral Health Purchasing Collaborative (IBHPC) and director of the HSD's Behavioral Health Services Division, spoke about the transition of service providers. She said that three agencies have had some of their funding restored by the HSD, and the other 12 are now transitioning. The new agencies have been reaching out to staff, and there has been an 88 percent retention rate of clinicians and paraprofessionals. There is a process to protect the audited agencies as well as the new agencies, and there is a process to protect consumer information. The new agencies have requested releases of information in order to transfer medical records from the former providers. If a release is not signed, the consumer can have a new assessment or go elsewhere for treatment.

Ms. McWilliams discussed phone calls and other inquiries coming into the IBHPC about the transition. The vast majority of these calls have been questions about the audit or general questions about what is going on, she said. There was a misunderstanding with Albuquerque Public Schools about behavioral health services in the schools, but the HSD is working with the district to get it resolved. Ms. McWilliams said she is collecting "positive transition stories",

including some from employees of the new service providers who have been given raises and who now have health insurance. She also said it is very important that the IBHPC is hearing directly from consumers. She advised subcommittee members to refer any concerns they receive from the public directly to her.

Questions/Concerns

A subcommittee member asked if the contracts for these new providers end on December 31. Their contracts now are with OptumHealth, and if they stay on, Deputy Secretary Earnest said, they will then contract with managed care organizations (MCOs) under Centennial Care. They are not currently being reimbursed through Medicaid, he said. Their billing systems are not up and running yet. There is a lot of training taking place right now to ensure fidelity to billing, he said.

Another member asked if the \$17.8 million in transitional funds is state money. "Yes", Deputy Secretary Earnest replied, "although we will try to get some matching federal dollars for services after the fact". OptumHealth is paid on a monthly basis, and all claims during the transition are being held by OptumHealth in an escrow account for retrospective accounting, he said. OptumHealth is not benefiting financially now. Most of the transition funds are for payroll of former and new agency employees.

A member commented that the amount of valid claims will be greatly reduced because of reduced services during the transition due to lack of access, but OptumHealth still gets the same capitated rate. Several subcommittee members said they felt that the state agencies should be able to oversee the non-Medicaid behavioral health services (costing approximately \$50 million) without paying OptumHealth to be in the middle. "It is a totally unnecessary contract", said one member. Another asked Mr. Heyeck, "Are you [the HSD] discussing a contract with Optum?". Mr. Heyeck confirmed that discussions with OptumHealth are ongoing.

One subcommittee member expressed great concern about reports that hospitals in Las Cruces and Silver City are being flooded with clients who have been turned away by La Frontera, one of the new Arizona providers. Ms. McWilliams said she had not heard this but would look into it. Another member asked if employees were being terminated to go to work for the Arizona agencies and was told that this did happen because of taxes. Another member asked if the Arizona companies rehired everyone. Deputy Secretary Earnest said they were told to rehire all clinical staff and others, and most were rehired, but they were told not to rehire management or administrators, he said.

A member asked whether employees at Arizona companies have been threatened or told that they would be fired if they spoke to anyone or the press about the transition. Mr. Heyeck said that the HSD learned that employees were told by their former employers not to speak to transitional providers.

A subcommittee member expressed great concern about hardships for employees who lost vacation time and personal treatment options (PTOs) in the transition. This is true, Mr. Heyeck said, but the Arizona providers did retain employees' seniority and will provide the same amount of vacation. It is up to former providers to pay for PTOs. "The state torpedoed these former providers and let them go broke", commented a subcommittee member. Mr. Heyeck responded that these nonprofits should have had more cash reserves.

A member asked whether anyone from the HSD had spoken with the Workforce Solutions Department. Mr. Heyeck said that he does not know if any employees from the affected agencies have applied for unemployment.

Based on what he has heard from people at Southwest Counseling, the transition to La Frontera has been chaotic, a member said. "There's nothing smooth about it. We all know it's not going smoothly." He continued, "Are the CEOs of these Arizona companies all male, all Anglo? It's important to me that New Mexico hire from here, not from out of state.". Mr. Heyeck responded that these companies are now New Mexico providers, not Arizona providers, and that there is cultural diversity in the leadership — one chief executive officer is African American. In response to a question about whether the Arizona providers are properly licensed to practice in New Mexico, Mr. Heyeck assured subcommittee members that in spite of some technical hurdles, they are now licensed.

Another member asked why the HSD did not shut down the 15 service providers in December if it had CAFs at that time. Deputy Secretary Earnest said that the HSD had reports from whistleblowers who said that they had been fired for reporting overbilling, billing for services that were never provided and billing without documentation, but OptumHealth's referral alone was enough for a CAF. New PPACA regulations require that a CAF, once referred, requires a suspension of payments. Knowing how disruptive this would be, Deputy Secretary Earnest said, after consultation with the AGO, the HSD took the extra step of hiring an independent auditor. "Our hands were tied", he said of these suspensions. "It was something we had to do."

An extended discussion among members about rights to "justice" for the accused New Mexico providers, given the secrecy of the audit and the frenzy of media attention, followed. "When do you finally get to see that evidence?", one member asked. "It will all be played out in the media before it ever goes to court. It needs to be decided, and charges need to be filed by the AG", she said. Another member said he is incredulous that the accused providers cannot see the charges against them. "Surely you are aware, Mr. Heyeck, of the severity of cutting off funding — putting these people out of business. And what if it turns out they are exonerated?"

A member asked Ms. McWilliams, "How can you paint such a rosy picture of this transition? Clearly, with 27 calls [to a CMS-sponsored forum last week] about problems, there have been many disruptions in service.". Ms. McWilliams responded that it is absolutely not true that a client could not get service. The HSD has been fronting money to cover provider salaries,

she said. "We have a very fragile system here in mental health, and we are very committed to addressing any disruptions. It is absolutely unacceptable for a former provider to tell clients they won't get services. If that means assisting each of these persons on an individual basis, I will take care of it personally.", she said.

Several members referred to the "Behavioral Health Funding Schematic" handout of the "Rio Grande Seven", finding its meaning to be unclear. Another member said she found the chart and the HSD's entire presentation to be "very accusatory" toward the former providers and feels that there are two sides to every story. The chart seems like selective secrecy, observed another member. "How does this not impair the investigation? People are being accused of things in the public sphere and cannot see the charges; it really bothers me." A member added that Secretary of Human Services Sidonie Squier said the provider agencies were all "criminals" at the last meeting of the LHHS in Albuquerque. "Where is Secretary Squier?", another member inquired. Deputy Secretary Earnest informed the subcommittee that her absence was due to recent eye surgery. The absence of La Frontera was noted by a member. "My concern is that we have appropriated tax dollars, and it is disrespectful for them not to appear when we asked." Ms. McWilliams assured the member that La Frontera's absence was an agenda issue. She did not know that La Frontera had been requested to attend the meeting and asked that, in the future, she be included in any invitations to the new vendors.

A member of the audience, Roque Garcia, asked and was granted permission by the chair to speak to the subcommittee about allegations depicted in the chart distributed by Mr. Heyeck. Mr. Garcia is acting chief executive officer of Southwest Counseling Center, a former provider who was singled out by name in Mr. Heyeck's description of the Rio Grande Seven's relationships with other entities. Mr. Garcia defended his network of affiliations and said that it had saved the state more than \$40,000 per year. He asked if members were aware that La Frontera listed 18 different related corporations on its Form 990, one of these even being a for-profit entity. Members asked Mr. Heyeck why he did not provide that information, as well. Deputy Secretary Earnest said that the HSD would follow up on this request.

Subcommittee members had questions about the \$17.8 million in transitional funding and where it came from. Deputy Secretary Earnest said that these funds, included in the budget from the last legislative session, were transferred from a contractual services category. There is a surplus within the Medicaid program budget, he said, so nothing was taken away. Other members expressed concern that Medicaid dollars might be at risk and that the HSD might encounter a situation with the federal Centers for Medicare and Medicaid Services (CMS), whereby millions of dollars have to be repaid, as happened last year with special education funds in the Public Education Department. Another member lamented the high administrative fees being paid out to OptumHealth. Overbilling is one thing, she said, "but these enormous administrative contracts need to be looked at, as well".

The subcommittee chair said he was very sorry that Secretary Squier had walked out during a previous meeting of the subcommittee and now was unable to attend this meeting. "We need to hear from the secretary", he said. "She needs to be here to defend her department."

Information on the costs of the transfer to transitional providers and copies of any lease arrangements were requested by another member, who also was concerned about potential taxpayer losses from lawsuits filed by displaced providers. Another member noted that elections are just around the corner, and this is likely to provide the opportunity for much political grandstanding.

North Carolina Audit

Knicole Emanuel, a partner at Williams Mullen law firm in Raleigh, North Carolina, and a specialist in Medicaid litigation for health care providers and Medicaid recipients, said that the situation in New Mexico is comparable in many ways to the one in North Carolina, where PCG conducted a similar audit. Using a PowerPoint presentation (see handout), Ms. Emanuel explained that preventing fraud is the federal government's overarching goal, and the PPACA puts states in charge of identifying overpayments from Medicaid through recovery auditor contractors (RAC), of which PCG is one. States and RAC vendors must coordinate recovery audit efforts, and RAC vendors are reimbursed through a contingency model. The audit is a three-year look back.

Ms. Emanuel showed an example of a tentative notice of overpayment from PCG to a North Carolina provider and showed how amounts owed are extrapolated, and she described numerous PCG "bloopers", including extrapolation errors, code confusion, no-medical-necessity errors and a lack of training among auditors. Her advice to her provider clients: "Appeal, appeal and appeal". She expressed shock that the New Mexico providers audited by PCG were given no due process for appeal by the state. Under federal law, states must provide appeal rights under state law or administrative procedures to Medicaid providers that seek review of an adverse Medicaid RAC determination, she said. Nationwide, 72 percent of appealed denials are successful. Ms. Emanuel said she often uses administrative procedures instead of state law, and she often utilizes restraining orders to secure a stay of the suspension of payments pending litigation. According to Ms. Emanuel, Section 27-11-3 NMSA 1978 might be relevant to an appeals process for providers.

A subcommittee member asked the chair for permission to bring a guest up from the audience to join the discussion — Thomas Aldridge, Charlotte-based manager with PCG, who is responsible for both the North Carolina and New Mexico audits. Mr. Aldridge denied that his company's auditors are inexperienced and said they have the depth and breadth of experience and have successfully conducted audits in 46 states. PCG maintains six statisticians on staff, he said, and utilizes sophisticated software to do extrapolations. Mr. Aldridge strongly defended the integrity of the North Carolina and New Mexico audits. For the New Mexico audit, PCG auditors obtained and examined, during unannounced visits, a sample of 150 claims from each provider.

During questioning, Mr. Aldridge revealed that, in January, at Ms. McWilliams' request, he accompanied her and other HSD staff members on a trip to Arizona to interview potential new providers. The trip, which took place before the audit began, was paid for by the HSD, he said. Several subcommittee members indicated they were very concerned that this was a conflict of interest. Mr. Aldridge explained that Ms. McWilliams asked him to go because of his years of experience to help determine whether these providers had proper compliance in place. Mr. Aldridge said the audit has been completed, and that he was not being paid to be at the meeting today.

New Mexico Quality Audits of MCOs for Medicaid Requirements

William Boyd Kleefisch, executive director of HealthInsight New Mexico, said his company has been the Medicaid external quality review organization (EQRO) with the HSD since 2005, providing oversight for all Medicaid managed care physical, long-term care and behavioral health contracts. The OptumHealth audit was from July 1, 2011 to June 30, 2012. (See the handout of the PowerPoint presentation.) Its focus was on OptumHealth's compliance with all applicable laws. Because its contract expires on December 31, this will be the last year OptumHealth will be audited.

Margaret A. White, director, EQRO, and Greg Lujan, behavioral project manager, EQRO, joined Mr. Kleefisch for the presentation. They explained that an external quality review means the analysis and evaluation of quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

Mr. Lujan, who designed the audit to HSD and CMS specifications, described his own background and his credentials as a therapist in behavioral health and as an auditor and care coordinator in managed care. Mr. Lujan coordinated all OptumHealth audit activities, providing oversight and monitoring of auditors, and he also drafted the final report. The audits are progressive, he said. The first year, OptumHealth's score was 87 percent, which indicated "moderate compliance", with three areas needing corrective action. OptumHealth's second year was 97 percent, indicating full compliance, with the corrective action plan lifted. Year three was 99 percent, and OptumHealth was found to be in full compliance with all aspects of the quality audit for fiscal year 2013.

One member commented that she failed to see how OptumHealth can have these high scores, and many provider organizations got scores of 90 percent to 95 percent in their audits from OptumHealth, yet now they are being labeled as criminals and frauds. OptumHealth is making huge amounts of money off the state, she said. "What kind of responsibility does this organization have?", she asked.

Public Comment

Becky Beckett, member of the National Alliance for the Mentally Ill-New Mexico, thanked the subcommittee for its work. The most vulnerable people are being used as pawns, she said.

A psychiatric nurse at Southwest Counseling Center explained that she contracted with La Frontera out of loyalty to her patients who are without services. Because La Frontera's medical director admitted that he does not have a license, she is suspended from work.

Douglas Frazier is a consumer who said he does not understand New Mexico any more and would like to move away. He was helped by a TeamBuilders program and said that TeamBuilders personnel are not criminals.

Earl Nissen, member of a number of local nonprofits and currently serving on the board of directors of the New Mexico Alliance for School-Based Health Care, asked legislators to come up with solutions to strengthen and extend behavioral health services in school-based health centers. It would be unconscionable for the new behavioral health managers to cut any services that would negatively affect high school students, he said. Mr. Nissen offered subcommittee members a handout with more details about school-based health centers.

Patsy Romero, chief operating officer of Easter Seals El Mirador, described many problems and huge gaps in service in the northern communities of Taos, Espanola and Raton. Ongoing issues with handling and transfer of medical records have resulted in at least 12 client families filing complaints, she said. The HSD has not paid furloughed employees, Ms. Romero said. She described her employees as intimidated and misinformed by HSD staff about the facts of the investigation. She also said that during the audit, PCG's software program corrupted 97 percent of the files that were being uploaded.

Jim Jackson, executive director of Disability Rights New Mexico, echoed Ms. Romero's comments and assured members that the complaints are real. There are delays in access to medications, ongoing therapy and services. Without behavioral health services in schools, children are being kept home. He described eight years of disappointment, first with ValueOptions, then OptumHealth. He is quite skeptical that things will be better under Centennial Care. Mr. Jackson urged subcommittee members to look into the use of the \$17.8 million that has been transferred. Some of this money is for items other than services, he said, and there could be anti-donation violations by using these dollars for payroll.

Nancy Jo Archer, chief executive officer of Hogares, Inc., said that after 35 years of leading the agency, no one is more concerned about fraud than she is. Ms. Archer characterized the transition of services as a "hostile takeover" and an abandonment of services. "It is un-American", she said. Staff is demoralized and depressed, and services have been negatively affected. The HSD and the Arizona providers have created a traumatized community that is out of balance. "In this business, trust is paramount", she said. "Now that's gone."

Delfina Roach, who works with the New Mexico Brain Injury Alliance, said she is scared about the quality of care for children with behavioral problems. This usually gets attention only when there is a crisis. Quality care is not being looked at as a whole, she said. Out-of-home regulations require placement with in-state providers even if there are not appropriate places for

them to go. Ms. Roach thanked Senator Morales for his earlier statement regarding the potential for loss of matching federal dollars because of mismanagement of Medicaid funds.

Adjournment

The meeting was adjourned at 5:40 p.m.

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

**September 30, 2013
Adelante Development Center
3900 Osuna Road NE
Albuquerque**

The third meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Benny Shendo, Jr., chair, at 9:15 a.m. on Monday, September 30, 2013, at Adelante Development Center in Albuquerque.

Present

Sen. Benny Shendo, Jr., Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Edward C. Sandoval
Rep. Phillip M. Archuleta, Vice Chair

Absent

Guest Legislator

Rep. Miguel P. Garcia

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, September 30

Call to Order and Introductions

Senator Shendo asked members and staff to introduce themselves.

Welcome

Mike Kivitz, president and chief executive officer (CEO) of Adelante Development Center, Inc., welcomed members of the Behavioral Health Subcommittee and the public and described the work of the nonprofit organization, which was founded in 1978. Adelante currently provides a wide variety of services, including employment, vocational and life skills training, residential services and volunteer opportunities for people with disabilities. There are over 1,000 people on Adelante's payroll, including more than 400 in Albuquerque who are disabled, and another 200 at other locations. In serving its role as a community resource, Adelante also operates BackInUse.com, a web site that provides an exchange for rehabilitation and distribution of durable medical equipment.

Native American Behavioral Health Concerns

Maria K. Clark, director of the Pueblo of Jemez Health and Human Services Department, introduced Keahi Kimo Souza, program manager of Jemez Behavioral Health Services. Ms. Souza and Ms. Clark said that federal sequestration has had a huge impact on their delivery of health services, especially on inpatient services, and that they have had to rely more on grants. People are now being put on waiting lists in urgent situations — special needs, domestic violence, assaults, DWI, suicidal ideations — and this has increased utilization of the emergency room, they said. Daily rates have increased, there have been cuts to services and staff layoffs and some clients are being sent out of state in order to receive appropriate care. Restriction of staff training has affected morale, and self-referrals are down because clients fear they will be sent away.

Linda Son-Stone, Ph.D., is CEO of First Nations Community HealthSource in Albuquerque, which was established in 1972 to provide comprehensive medical, dental and behavioral health services to urban Native Americans. Additional services include prevention education to teach people about healthy relationships. The feedback on these classes has been excellent, Dr. Son-Stone said, and there is a critical need to continue them. In New Mexico, a woman is more than twice as likely to be a victim of sexual and/or domestic violence than in other states, Dr. Son-Stone said. Many of these victims are reluctant to seek help, and there is an urgent need to help children who witness domestic violence. Sequestration has eliminated two of First Nations' sexual assault and domestic violence programs, she said.

In response to questions from subcommittee members, Dr. Son-Stone said that her organization has applied for additional grants, but many of the organizations that provide

services have also suffered cutbacks. First Nations treats everybody who presents, she said, and tries to coordinate care with the Native American community from which the client has come. Follow-up is always the goal, she said, but it is also a huge challenge, since many clients do not have a cell phone or permanent address.

Dr. Son-Stone explained that First Nations is Medicaid-certified, and therapy services can be billed, but prevention and care coordination services cannot be billed. One subcommittee member, who said that she has sponsored legislation to obtain funding for tribal domestic violence case training, wants to continue this advocacy, and said that she would like to work with First Nations on this. Another member expressed dismay about case management not being reimbursable. This is wrong, he said; it may save money in the short run but will result in more spending in the long run. Dr. Son-Stone said that in response to the federal Patient Protection and Affordable Care Act (PPACA), First Nations has increased its capacity to enroll for Medicaid and to provide education about available benefits through a Health Resources and Services Administration grant.

Another member asked Ms. Clark about Centennial Care, specifically, why there is push-back against managed care among Native Americans. Working with the state has been a challenge, Ms. Clark told members, and tribal providers have fought hard to retain fee-for-service (FFS). In managed care, participants are locked into one of the four managed care organization (MCO) provider networks. Payment is delayed by the MCO, causing problems with budgeting, she said. With FFS, payment is often made within four days, and an enrolled Native American can go anywhere for service. MCOs get paid "per member per month" (PMPM), and the highest tier is the sickest population — i.e., Native Americans, Ms. Clark said. MCOs are eager to sign up tribal members to get the highest PMPM because they will be paid regardless of whether or not they provide the service. At the Pueblo of Jemez, its program is able to charge the PMPM only if it performs the service. The Pueblo of Jemez is still pushing for reintroduction and passage of House Bill (HB) 376 from the 2013 regular session, which would exempt all Native Americans from mandatory enrollment in Medicaid managed care.

Susy K. Ashcroft, M.A., L.P.C.C./L.A.D.A.C., who is Paiute, is eastern clinical director for the Navajo Nation and has been an advocate for Native Americans for many years. Ms. Ashcroft said she wanted to speak specifically to the interruption in behavioral health services due to the Human Services Department (HSD) audit. Ms. Ashcroft said she knows first-hand that clients are not getting uninterrupted services. The audit, she said, "has destroyed therapeutic alliances that have taken years to build up. It has destroyed the careers and reputations of people I have worked with, and trusted, for many years". Ms. Ashcroft said that there are huge issues of neglect and physical and substance abuse, and that clients can no longer be sent to nearby providers. The pool of providers has been shrinking, she said, and "culturally competent" providers are disappearing. "These changes distress and frighten me", she said. Ms. Ashcroft does not want her health care governed by an MCO whose goal is to save dollars. "We (tribes) have always been sovereign, and you can't tell a sovereign nation what to do."

William Merkle, Ph.D., director of human services at the Pueblo of San Felipe, is a licensed psychologist, and he oversees the pueblo's behavioral health program, which includes several large grants. With the recent addition of a part-time staff psychiatrist and ongoing peer support workers, the Pueblo of San Felipe has established programs for teenagers and for suicide prevention and a new equine therapy pilot project. It is a strong system, Dr. Merkle said, and the concern with MCOs is that the pueblo will no longer be in the driver's seat.

Anthony Yepa, Pueblo of Santo Domingo, director of the behavioral health component of the Kewa Pueblo Health Corporation, said that it was Congress that decided that Native Americans should be treated differently. Many Native American health care organizations are funded by the federal government through the Indian Health Service. Mr. Yepa said that the 15 agencies that were audited were much-needed providers of services. The problem, he said, is that the state has not been monitoring its contractors. If there truly was fraud, why did it take OptumHealth so long to catch up with it? There is a \$5.3 billion contract for Centennial Care and its four MCOs, he pointed out, and who will be monitoring these? Mr. Yepa said his social worker at Kewa wanted him to point out to legislators that they (the tribes) are sovereign, they have their own laws, plus federal laws, and there should never be a need for "prior authorization" from the state. Because the state does not acknowledge tribal court commitments, there often are problems getting patients committed to the state hospital, Mr. Yepa added.

Questions/Concerns

Subcommittee members had questions for panel members on the following topics:

Lack of data on behavioral health needs. One member asked if there were any numbers available on how many people are on the street, in the emergency room or in jail because of the disruption of behavioral health services. Another member asked if prisons are being used to take care of mental health needs. Ms. Ashcroft said she believes that the state has collected some data, but does not use the data. She said when she asked about Native American data gathered by the state, she was told that there is not data for how many people end up in crisis in Albuquerque or in Gallup. There is a lot of health disparity, she said. Recently, she asked Local Collaborative 2 for a \$500 grant to do a census and study of problems, and she was asked why she wanted to reach out to the drunks. The myth is that they came to town to party and then got into trouble, but no one has any idea what has happened to these people, because there is no data. Another member lamented the lack of funding for services in Gallup, where there are so many bars, and the lack of any attempt to address the damage being inflicted upon families from compulsive gambling. Legislators are here to serve constituents, she said, and there is obvious need, but she remains very disappointed in the system.

HSD disruption of therapeutic alliance. A member asked how the alliance can be rebuilt. Ms. Ashcroft said that the HSD has made decisions about clinical matters, and the agency does not have very many trained clinicians high up in the organization. Native Americans deal with the whole person; traditional culture upholds that, she said. Taking the entire system down was just wrong. Ms. Souza added that the audited agencies had people who were the points of

contact, and the disruption of this therapeutic and personal alliance has been detrimental. Trust is always an issue in Indian country, Ms. Souza said, and it took many years to build. Predictability and follow-through are key, she said. There have been many promises, but there is no follow-up.

Problems of veterans and homelessness. One of the strengths of the Native American community is identification with family, Ms. Souza said, but grief therapy and historical trauma cannot be addressed in fewer than a dozen sessions, and there are limits on services and funding. At the Pueblo of Jemez, there are approximately 200 veterans. The Veterans Health Administration in Albuquerque has a lot of resources, but also a wait list for services. There are cuts in services, and people are being put on wait lists there, she said, and they are told that if they are Native American, they should go back to their tribes.

Tribal involvement with Centennial Care. In response to a member's question about tribes' involvement with the state regarding the Centennial Care strategy, Mr. Yepa said that the state has engaged the tribes, but communication has been a struggle. "Our questions addressed to HSD were not answered by HSD. We had to go to CMS to get our questions answered", Mr. Yepa said. Care coordination will require the MCOs to hire Native Americans to communicate with these communities, he said, and the waiver requires culturally competent services. To date, there have not been details on how this is going to be rolled out. Ms. Clark said that the Pueblo of Jemez did inquire about possible involvement in case management.

Update on Behavioral Health Services

Diana McWilliams, director of the Behavioral Health Services Division (BHSD), HSD, and CEO of the Interagency Behavioral Health Purchasing Collaborative, and Larry Heyeck, HSD deputy general counsel, provided talking points (see handout) to subcommittee members.

Ms. McWilliams described a change in early 2012 to OptumHealth's program integrity protocols, with which it had always been in compliance, she said. There was an "enhancement" to OptumHealth's system that changed how it looked at data, a change that would not necessarily have been noticed by agencies, Ms. McWilliams said. The enhanced system compared providers to peers within the state. Prepayment review and analysis are recommended by the Center for Medicare and Medicaid Services (CMS), she said. Mr. Heyeck added that under the PPACA, there is a move away from the "pay and chase" model to one of predictive analytics in order to better protect money before it goes out the door. There has been up to 10 percent fraud identified at the federal level; in New Mexico, this would translate to \$300 million to \$400 million in projected waste and abuse, he said. If something looks like suspicious activity, it must be referred by OptumHealth to the Quality Assurance Bureau (QAB) of the HSD and investigated by OptumHealth with desk audits, claims review and analysis, and on-site file audits, Ms. McWilliams said. From the QAB, information may be sent on to the state Attorney General's Office (AGO).

Ms. McWilliams said that OptumHealth will be retained for six months, through June 30, 2014, to manage non-Medicaid behavioral health funds, allowing time for collaborative agencies to bid for a contract to manage these behavioral health dollars. She discussed third-party oversight of behavioral health services from June 30, 2013 through the end of the first quarter of 2014. The HSD is looking at data points, inpatient admissions and crisis and utilization data for this period, she said. If there are any issues with disruption of services, the collaborative should be informed. She assured members that every report will be investigated. Work is under way within the collaborative to put together web site dashboards that will be available to the public. Ms. McWilliams referred subcommittee members to two web sites for behavioral health providers in Arizona, which provide a dashboard of information and data on how the system is performing (see handout). She said that the BHSD will be putting out a request for proposals (RFP) for technical assistance and for monitoring of New Mexico's behavioral health system and to assist providers statewide with billing and clinical documentation.

Questions/Comments

Members had numerous questions for Ms. McWilliams and Mr. Heyeck, grouped into the following categories.

Professional qualifications of Ms. McWilliams and Mr. Heyeck. Ms. McWilliams said she is not a licensed behavioral health provider. She holds a master's degree in public administration and served as a Delaware state legislator for two terms. Ms. McWilliams said she has also run several nonprofit organizations in child care, Planned Parenthood of Delaware and the Rape Crisis Center in Santa Fe. Mr. Heyeck told members that he is a licensed attorney in New Mexico and that he has been involved in health care in both the private and public sectors. He has served as deputy director of the state's Medicaid program, where he oversaw contracts, fraud and abuse; health care financing; and the "nuts and bolts" of managed care. Last week, he was an invited speaker at a Medicaid program integrity workshop.

What is the executive program integrity special project? That is the name given to the internal audit of the 15 behavioral health providers, according to Ms. McWilliams, who said that she did attend a series of meetings of this group from January 5 through March. The meetings were usually held in the Office of the Secretary of Human Services. Several meetings were held in the offices of OptumHealth, she recalled. The member read a list of OptumHealth employees, including the national head of OptumHealth and various state and regional employees, and asked if they were invited to these meetings as well. Yes, replied Ms. McWilliams, because it was OptumHealth that made the referral. Asked if the attorney general attended, she said no, but that his office was given regular updates. Asked if Thomas Aldridge, manager of the Public Consulting Group (PCG) audit, attended any of these meetings, Ms. McWilliams said she thought he attended at least one, but he participated by phone. The January 11 agenda mentions Southwest Counseling Center and La Frontera by name, the member pointed out. Based on the size of those referrals, the HSD was very concerned about being able to cover services, Ms. McWilliams said, so it had to look at where else it might go for help. The HSD did know in November how large the referral was, she said.

Is OptumHealth getting a percentage of recouped payments? Mr. Heyeck described two new rules under the PPACA: the 60-day rule, requiring providers to report overpayments to the MCO and the state; and the lowering of the bar for credible allegations of fraud. All contracts have been changed to align with the PPACA, Mr. Heyeck said, and if the HSD or the AGO receives dollars on a civil claim, the MCO that identified the fraud will get a piece of that restitution.

Four tiers of findings referred to in the PCG audit public summary. A member asked why the audited agencies were required to change management instead of going with the tiered approach established before the audit. Most of the problems did not even require a change in management, per the executive summary that was made public, the member noted. The HSD chose to end 12 agency contracts that were in a PCG category that would not even justify a change in management, the member said. After reading federal regulations, it is clear that there were many choices and total discretion on the part of the secretary of human services in this matter, the member concluded, and the action taken to freeze all payments was not required by the CMS. Mr. Heyeck said that not only the clinical findings, but the conflicts of interest, justified a change in management. The only discretion Secretary of Human Services Sidonie Squier had was to grant good cause exceptions, he said.

Lack of data regarding progress of service provider transition. Several subcommittee members expressed dismay that they still have not received data from the HSD regarding the transition. They are looking for data that compare service levels from before the transition to the present. Ms. McWilliams said that she does have data and that she wants to put the data into a report. She also said she has data on inpatient admissions, which she said have not gone up during the transition. Based on the reports she has received, Ms. McWilliams said, the transition is going well. The retention of providers, or re-hires, is at 90 percent. These numbers can be documented, she said, because the department has rosters in order to meet payroll. There is a transition update spreadsheet that she has with the roster, and she will get that information to the subcommittee. Although the HSD does get monthly summaries from OptumHealth, these month-to-month reports are not helpful, Ms. McWilliams said. Another member noted that without data, it is very hard to judge what is really going on. The subcommittee has never gotten information about behavioral health beyond the glowing assertions. Another member asked if people are falling through the cracks. "We are not denying services to anyone", Ms. McWilliams said. "We will provide you with numbers. We are working on it now, putting together a dashboard. My team is investigating every report and complaint. Therapeutic relationships are very important; they are our number one priority."

Transfer of medical records and document imaging. In response to questions about document imaging of medical records, Mr. Heyeck said that in stipulations he drafted, imaging companies must be secure, maintain confidentiality and be bonded, and their employees must have federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) training. Two companies were chosen: DATAMARK and Document Imaging of the Southwest, both with many years of experience, Mr. Heyeck said. Obtaining the records sometimes was very

difficult, with some former providers taking the records off site and, in some cases, locking them up. A subcommittee member expressed great concern about an email he received with a copy of a form signed by an Arizona provider. He asked what gave an Arizona provider the ability to sign off on this. He said it was his understanding that those files must have a consent form signed by the individual or guardian. There are names in this email that are not encrypted — 2,000 to 3,000 of them he said — and he is concerned that the state has violated the rights of these clients. Also, there is an obligation under HIPAA to notify all of those individuals whose names have been released.

Clarification of email from the CMS. One member received a copy of an email from some members of the New Mexico congressional delegation to the CMS clarifying that, according to the CMS, New Mexico was not at risk for losing Medicaid funding if good cause was granted to the audited providers. The CMS recommended that consumers report their concerns to directly to OptumHealth. Another member reiterated his earlier stance that the state had total discretion and could have taken other options short of putting the agencies out of business. "Why did you do this four months early and cause all this chaos?", he asked. Mr. Heyeck responded that the decision was not made by himself.

Motion to Send a Letter to the Attorney General

A motion was made requesting that the Legislative Health and Human Services Committee send a letter to the attorney general about the unencrypted email. The motion was seconded and passed without objection.

Behavioral Health in the Criminal Justice System

Dr. Nils Rosenbaum is a psychiatrist who works for the Albuquerque Police Department, and, along with Detective Matthew Tinney, is part of a crisis intervention team (CIT), whose goal is early intervention in situations that have the potential to escalate. Dr. Rosenbaum said that the overarching purpose of the CIT is to protect public safety, to divert people away from incarceration whenever possible and to facilitate people getting the services that they need. It is entirely voluntary, he said. The CIT cannot force anyone to do anything. About 25 percent of Albuquerque police officers have been trained in CIT techniques. When a call comes in to the dispatcher, the sergeant on duty decides which team should respond. A caller can ask for a CIT-trained officer. The CIT finds the person who is having the crisis, talks to the person, talks to family members and takes the person to the hospital, if needed. Sometimes what is required to defuse a situation is as simple as providing someone with a new pair of socks, or perhaps the person needs a ride to get an appointment for help with a problem. The CIT facilitates people getting care, Dr. Rosenbaum said.

Detective Tinney said that the CIT provides short-term crisis management. "We help them get into services. We do not have a budget, and we are not a service provider ourselves, but hopefully we can link someone into services", he said. The team provides the human connection, Detective Tinney said, a one-on-one contact that can allow a person to save face during a crisis situation. It can take months to get an appointment with a psychiatrist, he said, and sometimes

the CIT can facilitate a person getting the needed services earlier. Assertive community treatment (ACT) is similar, but it does provide services, he said. ACT is a team-based service that includes case management and psychosocial rehabilitation provided in the community.

Dr. Rosenbaum described the community engagement team (CET) concept, passed by the legislature but vetoed during the last legislative session, as a hybrid between a CIT and ACT that can help address barriers to treatment. It was never designed to be a forced treatment, he said. A CET, as proposed, could be set up by any group and does not require state funding. A CET member can talk to an individual about available services and link that person to those services, Dr. Rosenbaum said. A lot of people do not want to see a psychiatrist, and there are lots of barriers to getting an appointment. A CET member who is clinically trained can be sent in to talk to a person before he or she becomes hospitalized or jailed. Jail is being used as a hospital, said Dr. Rosenbaum. The same percentage of people who used to be institutionalized are now in jail. Albuquerque has a mental health court, Detective Tinney said, and this has been very effective. If an individual is accepted into a court program and follows up with treatment, then the court case will be dropped.

Questions/Concerns

Several members expressed gratitude to Dr. Rosenbaum and Detective Tinney for the important work that they do. One member said he was formerly a crisis intervention officer himself, and the training he received was invaluable. He knows how important it is to get to someone in crisis before things get really bad. In response to a question about the voluntary nature of the CET proposal, Detective Tinney said the key is not having the treatment forced. He does not think anyone should be involuntarily hospitalized or put into jail if the person is having an episode. In Albuquerque, on average, 300 cases a month are assigned to a CIT; calls for crisis-trained officers are about 3,000 a month. The CIT began as a grant project, Dr. Rosenbaum said, and it reduced calls for service. Now it is part of the Albuquerque Police Department's annual budget. Albuquerque also has three ACT teams, he said, and they can bill Medicaid for services, but then those funds are returned to the city.

Update on the CET Pilot Project

Ms. McWilliams presented information on draft guidelines for the establishment of a CET pilot project. She said the guidelines would be posted on the HSD web site within the next 48 hours. The guidelines are in response to the governor's veto of HB 588 in April. The governor contended that while CETs had merit, the program should not be housed in the Department of Health (DOH), but rather at the HSD. Ms. McWilliams said she has been meeting regularly with clinical service providers and substance abuse experts, as well as members of the HM 45 Task Force, to develop guidelines for good clinical policy.

The CET has to establish clear metrics for desired outcomes, Ms. McWilliams said, such as whether the consumer is participating in outpatient or recovery programs, holding a job or driving a vehicle. Does the consumer perceive improvement, and is there reduced use of the emergency room? Treatment should not be compelled without a determination of incapacity, and

criteria for inclusion or exclusion should be identified. Eligibility should be specified, she said, and clinical and peer leaders should be specified. Peer support workers are paramount to recovery. Ms. McWilliams said that specialized training and protocols for quality improvement must also be included. It is important to know where the levels of care are located within the community, and each community will have its own needs. Quarterly reports should show the cost of services per person and include identified metrics.

Ms. McWilliams described alleged problems with an ACT program in Las Cruces that is for persons 18 years and older who have been diagnosed with mental illness and have undergone repeated hospitalizations. It involves work with an interdisciplinary team. During a recent assessment of former ACT operations by La Frontera in Las Cruces, it reported admission criteria were not available; there was minimal programming on consumer behaviors; punitive measures were being used; there was no access to medical records for 60 clients who are in ACT intensive services; and there were no criteria to move clients to lower levels of care. There is no waiting list for services, and there was significant overstaffing, she said. There was no designated employment specialist, and progress notes were copied and pasted for different clients. There was no discussion of client independence or employment, she said, and clients are being isolated at home. Ms. McWilliams also described licensing issues and poor and inaccurate documentation. She said that a medication audit has occurred. At-risk clients are being medically reevaluated, and clients who are ready to transition to lower levels of care have been identified. Problems that were identified have now been addressed, she said.

Questions/Concerns

One member expressed surprise that the HSD has gone forward with establishing CET guidelines without the accompanying legislation. Ms. McWilliams said that the guidelines, which will be posted very soon for public comment, will help different communities to develop their own guidelines that will meet individual community needs. She was not at the meeting to speak about the legislation, she said. CETs are positive, she said. The BHSD already funds ACT teams and will continue to do this. Another member inquired if all ACT programs are now in compliance with current laws and regulations. ACT teams are all doing the same thing, Ms. McWilliams said. Is she holding the Arizona companies to the same standards?, the member asked. The companies have to use the organizations they are now in charge of managing, she responded, adding that the system needs some technical assistance moving forward for all providers, not just the ones that were audited. Asked how much that will cost, Ms. McWilliams said that the amount is in the current budget request, and this will go out for bid in an RFP. Technical assistance and training are needed to help with the entire statewide network in the transition to Centennial Care, Ms. McWilliams said, but she could not provide the member with the cost because she did not have her budget with her.

Public Comment

Jim Jackson, executive director of Disability Rights New Mexico, spoke positively about CITs and CETs and the emphasis on voluntary services. He also spoke about the 15 audited service providers, insisting that the HSD had discretion before it "pulled the trigger". His

agency's concern is that three months into the transition, the HSD, the collaborative and OptumHealth are failing to live up to their responsibilities to provide services.

Nancy Jo Archer, former director of Hogares, said that the new agencies did offer employment to most of her staff. Afterward, many of them left, so Ms. McWilliams' chart is not accurate. She echoed Ms. Ashcroft's earlier comments about the disruption of trust, and she said OptumHealth's computer system never provided data about the progress of programs and that it was virtually inoperable the first two years and barely any better the next two years. If the HSD could have gone to the AGO with just OptumHealth's audit, why did it spend an additional \$3 million?, she asked.

Valerie Romero, a behavioral management specialist at Casa de Corazon in Espanola, said that there are lots of families in Espanola who want to know how to get services. To say that most employees are still with the agency that took over is wrong, she said. Ms. Romero was accompanied by Rocio Trujillo, who told members that without the help of Behavioral Management Services, for which Ms. Romero worked, he could not have gotten his 15-year-old son back in school. Ms. Romero said that as a youth, she was mentally ill herself and that she has a learning disability. Nonetheless, she earned her GED and then a bachelor's degree and is now working on a master's degree in social work. "I see the potential in these kids", she said, and she thanked the subcommittee for the opportunity to be heard.

Evelyn Blanchard, a social worker and an organizer for the New Mexico Center on Law and Poverty, recalled the difficulty of getting Native Americans admitted to the state hospital in 1962 when she began her career. She said it is no different today. The DOH and the HSD have a poor relationship with the tribes, and an atmosphere of collaboration does not exist, she said. Tribes tried to give input for Centennial Care, but it was rejected. The Pueblo of Jemez probably has the premier health facility in the state. It is tenacious and serious about collecting data to determine the kinds and quality of services needed in the community, Ms. Blanchard said. This was offered to the HSD and refused. The premise of Centennial Care was based on unreliable data, she said, and the services are defined by the data the state insists on imposing in Indian country.

Pat Tyrell, director of the National Association of Social Workers, said he appreciated the subcommittee bringing the focus back to behavioral health. "I was profoundly moved by the testimony I just heard and disappointed that at the beginning of the public comment period, the decision-makers and state agency personnel all left", he said. The crisis shows extremely poor planning, he said, and a lack of respect for New Mexico and its cultural traditions. Mr. Tyrell's field is substance abuse. To measure progress, he said, "you have to break through denial". His information differs from that of the party line.

Arlena Ash is a consumer and said she has actually called adult protective services on herself when she was living in unsafe conditions and did not know how to get out. She does not

have the right diagnosis to qualify for ACT, and because of her employment, she is not eligible for Medicaid and is having a hard time.

Krista Scorsone said she is the nurse practitioner that Ms. McWilliams read about in La Frontera's ACT assessment. No one even spoke with her, she said. La Frontera decided to use telemedicine to engage with the ACT population. People who meet criteria for ACT have comorbidities that cannot be assessed by a television screen, Ms. Scorsone said. If Ms. McWilliams' presentation is so inaccurate, how accurate can the other presentations be?, she asked.

Jamie Campbell is a consumer who lives with schizophrenia and is concerned about access to pre-crisis services. They are not available, there are long wait lists and it can take as long as six months to get an appointment. There needs to be something in between, she said. A person needs a case manager to get into the system, and then there are struggles to get the right services, medications, etc., Ms. Campbell said. She is in favor of peer support workers.

Robert Salazar is a consumer and a representative of the New Mexico's National Alliance on Mental Illness (NAMI). Mr. Salazar wanted to share that recovery is possible. It was very hard for him to accept that he has a mental illness, and it was not until he ended up in the criminal justice system that he finally found the help he needed. During his last incarceration, he was put in a psychiatric unit with treatment and daily support groups. It has been hard to pay for prescriptions, but he finally got a waiver to get his medications for free. Mr. Salazar has had the support of his family, and he feels that this has been extremely important. There are more than 386,000 persons in New Mexico who suffer from mental illness, and a recent study estimates that it costs twice as much to help them inside the justice system as it does outside the justice system, he said. Preventive measures are superior and far less costly than reactive measures, according to Mr. Salazar, who now holds a job with NAMI and is attending school.

Minutes Approved

A motion was made, seconded and passed unanimously to approve the minutes from the July and August meetings. A member noted to the chair that the subcommittee has been promised several different documents by Ms. McWilliams before the next meeting.

The meeting adjourned at 4:30 p.m.

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

**November 5, 2013
Room 322, State Capitol
Santa Fe**

The fourth meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Benny Shendo, Jr., chair, on November 5, 2013 at 8:40 a.m. in Room 322 of the State Capitol in Santa Fe.

Present

Sen. Benny Shendo, Jr., Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Edward C. Sandoval

Absent

Rep. Phillip M. Archuleta, Vice Chair
Rep. Paul A. Pacheco

Guest Legislators

Rep. David M. Gallegos
Rep. Miguel P. Garcia
Rep. James Roger Madalena
Sen. Nancy Rodriguez
Rep. Elizabeth "Liz" Thomson

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Copies of handouts and other written testimony are in the meeting file.

Tuesday, November 5

Welcome and Introductions

Senator Shendo welcomed attendees and asked members of the subcommittee and LCS staff to introduce themselves.

Updates from State Auditor and Attorney General (AG) on Behavioral Health Matters

Hector H. Balderas, state auditor, provided a written response (see handout) to members regarding their July 15, 2013 letter inquiring about the financial affairs and transactions of the Human Services Department (HSD), its Behavioral Health Services Division (BHSD) and the Interagency Behavioral Health Purchasing Collaborative. The letter asked the state auditor to answer specific questions in connection with the Medicaid payment holds placed by the HSD on 15 behavioral health providers following an audit performed by the Public Consulting Group, Inc. (PCG).

Mr. Balderas briefly reviewed the state auditor's jurisdiction and involvement and said that as part of this process, his staff auditors are currently working closely with the independent auditor who is conducting the HSD's annual financial audit. Due to the HSD's significant expenditure of federal funds, Mr. Balderas said, his independent auditors are required by federal law to test and report whether the HSD has adequate procedures in place to identify fraud and safeguard federal funds. Consequently, his auditors are required to test whether the HSD has established and implemented procedures to safeguard against unnecessary utilization of care and services, and it is within this context that it was necessary for his auditors to review and analyze the PCG audit report.

In a review of his efforts to obtain the PCG audit, Mr. Balderas described the court-ordered subpoena to the HSD to produce all audit reports and to cooperate fully with his office. Since receipt of that report, his office has requested and received numerous additional documents and information from the HSD, Mr. Balderas said, and his auditors have been in frequent contact with the federal Centers for Medicare and Medicaid Services (CMS) for guidance on proper verification of credible allegations of fraud. Further, he said, his auditors have been in communication with PCG to discuss in more detail the process that PCG used to plan and conduct the audit, including PCG's analysis and extrapolation methodology as they relate to the HSD's verification process.

Mr. Balderas said that as part of this fiscal year's audit process, his staff thoroughly assessed and evaluated each question in the subcommittee's July 15 letter, but because the audit has not yet concluded, he was unable to provide detailed answers that day. Certain of the questions outlined in the subcommittee's letter appear to fall outside the state auditor's jurisdiction, he said, and may require separate engagement outside of the HSD's financial audit to

get meaningful answers. A comprehensive and detailed response to each question will be provided once the financial audit is complete. Barring any unforeseen circumstances, Mr. Balderas expects the HSD financial audit report to be submitted to his office no later than December 16, 2013. Once the audit report is publicly available, Mr. Balderas said, he would immediately transmit a copy to the Behavioral Health Subcommittee and provide an update to its July 15, 2013 queries.

Questions/Concerns

Subcommittee members had numerous questions for Mr. Balderas and for Chief Deputy AG Albert J. Lama, who was present to discuss the separate investigation of his office into allegations of fraud among the 15 behavioral health service provider agencies.

The HSD's settlement with two providers that repaid the state \$4.2 million for alleged improper billings. A member asked if these recently announced payments would apply to any fraud findings by the AG. Mr. Lama said that the HSD settlement with the two providers would not have any impact on the AG's investigation. Credible allegation of fraud was a determination made by the HSD; the AG's investigation will determine if there was actual civil or criminal fraud. Another member asked why all 15 of the suspended providers could not have been afforded the same opportunity. Mr. Lama said he could not speculate on why the HSD chose to reinstate these two providers. Asked if the two reinstated providers (Presbyterian Medical Services and Youth Development, Inc.) would still be under investigation, Mr. Lama said yes, the AG's process is independent from the HSD's process.

Time frame for results of the AG's investigation. Mr. Lama described the resources his office has dedicated to this investigation: 16 individuals on the team, including two investigators from the Federal Bureau of Investigation (FBI), who have been divided into three smaller teams that meet weekly. The 15 providers also have been divided into groups assigned to each team. Data collection has been extensive, Mr. Lama said, involving literally hundreds of thousands of documents. The investigative team also includes three certified data collectors (one from the FBI) who started work in July. The teams have received good cooperation from the HSD, he said. What the teams are looking for is very specific information. When the PCG audit identified "irregular billing practices", Mr. Lama said, that does not necessarily indicate that there is civil or criminal action; it might indicate a technical issue. He said he could not yet give a specific date for completion of the investigation.

A member asked Mr. Balderas for the name of the firm conducting the independent audit of the HSD. It is Clifton Morris, Mr. Balderas said, and this is that firm's second year of conducting the annual HSD audit.

Mr. Balderas said that there is an opportunity to make improvements in the detection of fraud throughout state government, and his office may come forth with some "best practices". There could be increased training about detecting fraud and possibly some regulatory or statutory changes to help bring about increased oversight.

Public Comment

Hannah Leigh Bull is a behavioral health provider who practices in Rio Arriba and Santa Fe counties and is a descendant of four generations of lawyers and judges. A simple concept that most Americans can grasp is "due process", Ms. Bull said, just as Mr. Lama and Mr. Balderas had been describing in their respective investigations. She said her colleagues who were cut off by the HSD were not afforded due process. Some of the audited providers could not even talk to clients they had worked with for many years, and they lost their businesses and their reputations that had taken many years to build. Ms. Bull said she is starting to let go of her Medicaid patients because she does not trust the state, Centennial Care or the managed care organizations (MCOs).

Trish Daino is a licensed independent social worker with nearly 40 years of service in the mental health field in four states. She has been a regional and county mental health coordinator, has worked with prisons and has been chair of a local health council for the past three years. Since the suspension of payments to two agencies in her community, there has been limited communication and care coordination, Ms. Daino said. There has been no community outreach by the Arizona agency that took over the provision of services and no contact with other private providers or the local health council. The county commissioners were unaware of the Arizona agency's presence in their community, and no information has been provided by state agencies. Private agencies are not taking new Medicaid clients because they fear the coming action.

Eleanor Van Inwegen worked for Valencia Counseling Services and stated that she is glad to see that this subcommittee is concerned about behavioral health. She said she has just one piece of advice: follow the money. "What happened to the \$17.8 million that HSD got for the transition?" she asked. Employees with the new Arizona provider say they have not seen any dollars, and they were told that some would get new computers — but not everyone, because there was not enough money. The case files are locked up with no means of access, even with client authorization. The new providers did not address any mental health problems in treatment plans, just behavioral health, and Ms. Van Inwegen is concerned about nurses who are having to prescribe medication without background history on the client. This can be a waste of time and money and is harmful to the client.

Ed Church also worked for Valencia Counseling Services and was hired by Valle del Sol, which took over Valencia Counseling Services. He received an email directing employees not to talk to the press, he said, and no efforts were made in the community to introduce the new provider. The clinic went from six therapists to one full-time-equivalent (FTE) therapist serving 383 clients, Mr. Church said. A lot of the more stable clients have been given three- and four-month prescriptions, appointments have been canceled with no follow-up and rumors abound that only Medicaid and self-pay clients will be served. It is a crisis, he said, and what has been done is criminal.

Andres Paglayan works in information technology in the behavioral health industry and said he has now become an activist. He thanked subcommittee members for their efforts, saying

it seems like they are the only ones in government who care about what is going on. Clearly, there have been a lot of problems with services, he said, and he asked if anyone knew if the new agencies had been promised computers.

Hashem Faidi, a civil engineer with the Department of Transportation, has two autistic sons who were receiving services through TeamBuilders, which has now become Agave Health. His sons' services were cut in August, he said; Agave said it is hard to find providers. There were 60 children in the program, which provided after-school activities for two hours a day and for four hours a day during holidays. It was an excellent program, he said, and it now has been cut off. Mr. Faidi said he was very surprised to hear about fraud allegations against TeamBuilders and others, and he urged that the program be restored. His sons are on the waiting list for the developmental disabilities waiver, and the school-based program was great for them and for the family.

Anna Otero-Hatanaka, executive director of the Association of Developmentally Disabled Community Providers, said that many providers have concerns about what is going on with behavioral health, especially the negative impact of some persons "falling through the cracks". She is especially concerned about the validity of the allegations and the lack of due process or dispute resolution for the accused provider agencies. There is concern among her organization's members that Arizona providers could be brought in to take over developmentally disabled services, just as they were for behavioral health.

Questions/Concerns

Several subcommittee members expressed frustration with what they described as a lack of accountability for the Arizona providers. The more the subcommittee hears, the more it becomes evident that there are many problems with the behavioral health transition, one member commented. There have been significant layoffs, according to testimony, with Arizona agencies saying they cannot afford the employees. Their contracts were issued under an emergency provision, circumventing the Procurement Code, another member pointed out, and he asked the state auditor if he had noticed anything in the HSD contracts with the Arizona providers about requiring proof of financial responsibility. Mr. Balderas said that his auditors are examining the HSD procurement and contract compliance as part of the ongoing audit. Another member noted what appears to be a double standard: Arizona companies were handed contracts, certification and credentialing for their professional staffs, but now they are laying off people, claiming they do not have enough funds for providing services, yet New Mexico companies were told they had to provide the current level of services without getting paid.

There also was some discussion among members regarding HSD General Counsel Larry Heyeck's role in the AG's investigation. Mr. Lama assured members that Mr. Heyeck has no role in the AG investigation and will not be privy to any of the AG's findings prior to public release. Another member commented that it seems like legislators are being tested by state agencies and asked if these agencies are accountable.

Mental Health and Community Reentry Issues Among Rural Women in State Prisons

Cathleen Willging, Ph.D., senior research scientist at the Behavioral Health Research Center in Albuquerque, reported to subcommittee members the results of a recent study of 98 women incarcerated in a New Mexico state prison (see handout). In New Mexico, 45 percent of women prisoners are from rural communities. The purpose of the study, Dr. Willging said, was to identify needs for successful reentry of inmates into their communities. Eighty-five percent of the female prisoners screened tested positive for substance dependence; 50 percent screened were positive for current mental disorders; and 46 percent tested positive for both. Exposure to trauma was universal (100 percent), and 83 percent reported sexual trauma.

Dr. Willging presented three case histories to the subcommittee to illustrate the difficulties for female felons, all of whom had high hopes for their own reentries. The women had little knowledge of behavioral health resources, she said, and they needed to enhance their parenting skills. The assumption that family will provide support after a woman's release is faulty, Dr. Willging said. Lack of adequate housing and financial support render most women vulnerable to reincarceration, so there is need to intervene after the first incarceration. Many female prisoners suffer multiple substance dependencies and major depression and anxiety disorders, and there is a high level of stress about supporting their children on low-wage jobs. Incarcerated women receive few evidence-based instructions for what to do following release, Dr. Willging said. New Mexico spends a lot to keep women in prison and to support children while their mothers are in prison; it is a reactive rather than a preventive approach that prevails, she said.

Critical Time Intervention (CTI) is a national program that has been adapted for persons leaving psychiatric institutions, prisons and homeless shelters, Dr. Willging said. It is an evidence-based program that uses specially trained managers who emphasize issues that are crucial to rural women. In conclusion, Dr. Willging asked, is it better to give a woman \$6,292 to help her transition back to her community or spend \$40,000 a year to put her back in prison?

Questions/Concerns

There has been a spike in the female inmate population in New Mexico, one member noted, and the member wondered if Dr. Willging knew why. Dr. Willging said the spike is due to increased incarceration of women for drug abuse problems, and it has happened nationwide. Supported housing and vocational training are issues that should be considered for female inmates, another member offered. Dr. Willging agreed, noting that evidence-based reentry programs have a specific focus on the work force. Jobs and training have to be a priority in order to prevent recidivism, she said. Another member commented that components of the CTI program are considered Medicaid services in some states, and perhaps the CTI program could be made part of New Mexico's Medicaid plan, if the HSD would be willing to include it. The member suggested that the CTI program be put on the table when the full Legislative Health and Human Services Committee meets to consider recommended legislation.

Another member who represents 19 chapters of the Navajo Nation said molestation and alcohol abuse are huge concerns for Navajos. Education is needed, she said, and it is difficult to

get tribal jurisdictions to do it. Gaming compacts are now under negotiation, and it would be good to access some of that revenue to pay for this kind of education.

Integration of Behavioral Health and Primary Care for the Seriously Mentally Ill

Cory Nelson, deputy director of the Arizona Department of Health Services (DHS), described Arizona's new approach to integrating behavioral health with physical health care (see handout) through a collaborative approach between the state Medicaid agency and the DHS. Instead of integrating behavioral health into physical health, Arizona is carving physical health services into behavioral health for this small subset of the population, Mr. Nelson said. The seriously mentally ill (SMI) population dies from chronic medical diseases at a much earlier age than the general population, he pointed out, and 60 percent of Medicaid's highest-cost beneficiaries with disabilities have co-occurring physical and behavioral health conditions. In 2013, the DHS received a CMS waiver that allows one entity to be entirely responsible for the SMI population. Arizona Health Care Cost Containment System is the single state agency that contracts with the DHS as the MCO for behavioral health. The DHS, in turn, contracts with four regional behavioral health authorities and with six Native American tribes that operate as tribal regional behavioral health authorities.

Planning for the new model, Mr. Nelson said, involved a two-year process of building a relationship between the state Medicaid agency and the behavioral health provider community. The DHS started with an executive steering committee that met biweekly so that top executives could learn to cooperate from the top down, he said. The DHS also went out into the community for input and made certain that the process was totally transparent and that all decisions were posted on the agency web site in real time. The committee spent several months drafting a request for proposals for the MCOs, he said. There were five bidders, and the winning bidder continued to use the existing behavioral health networks and focused on integrated clinics where behavioral health and primary care were available at the same site. It is a single-payer health care portal, and the winning agency had gone out into the community for help with writing its proposal.

Anticipated benefits of the new health care model for the SMI population, in addition to better cost containment, include overcoming disparities through integrated care, screening, prevention, early intervention, education and helping the SMI individuals lead more productive lives, Mr. Nelson said.

Questions/Concerns

Several members of the subcommittee had questions for Mr. Nelson about New Mexico's HSD and whether its managers had spoken with him about Arizona's behavioral health model. Mr. Nelson said that they had not. Another member asked Mr. Nelson if he was familiar with the Arizona providers that were brought into New Mexico by the HSD. Mr. Nelson said that he was aware that these entities did provide services in Arizona, but he was not personally familiar with their work. Another member urged subcommittee members to note that in Arizona, Native American tribes are state contractors in the behavioral health system.

Local Perspectives on Funding for Indigent Behavioral Health

Jolene Schneider, executive director of Four Winds Recovery Center in Farmington, told subcommittee members that San Juan County continues to have severe problems due to substance abuse, including methamphetamine use among juveniles. During the last year, the population in detoxification programs was 3,500, 90 percent of whom were Native American, she said. There were 224 individuals admitted into residential treatment, and over half of these individuals were Native American, Ms. Schneider said. Currently, Four Winds Recovery Center, which was founded in 1979, operates with 37 FTE staff on a budget of \$1.7 million. Seventy-five percent of referrals to Four Winds Recovery Center are court-ordered, Ms. Schneider said, and nearly all individuals are low- or no-income clients, and Medicaid does not cover these services. The San Juan Indigent Care Fund provides \$404,000 to the center annually, she said, and loss of these funds would result in the closure of the protective custody detoxification program, the loss of treatment beds and an increase of up to five months that individuals spend on the waiting list.

Lauren Reichelt, director of health and human services for Rio Arriba County, told members that Rio Arriba County is the first county in New Mexico to create its own health and human services department in response to the substance abuse epidemic there. The county looked at statistics of who was entering the hospital emergency room, who was in the county jail and who required the highest cost of care. The county found that the vast majority of these individuals were there because of substance abuse or mental illness. Rio Arriba County has adopted a care coordination model using outcome-based measures, i.e., babies born at greater than five pounds and without addictions, and their program now has become a national model. The county gross receipts tax, plus an additional mill levy, is very important to the program, Ms. Reichelt said, with the indigent fund providing \$564,000 annually. If the county has to ask taxpayers for another tax to replace this one, citizens might fear another intercept, she said. One of the aims of the federal Patient Protection and Affordable Care Act is to empower local solutions, Ms. Reichelt said, and Rio Arriba County has an excellent health council that is working to develop an affordable housing plan in response to the needs of the homeless. The local hospital had 318 admissions directly related to substance abuse, but any savings created for the hospital stay with the hospital.

Ms. Reichelt said she also wanted to address the loss of behavioral health services in the community, which has seen a reduction in services. Losing infrastructure will reduce the level of service in Rio Arriba County. Ms. Reichelt said she is currently co-located with the Espanola Public Health Office and El Centro in a central location with a state-of-the-art treatment center that promotes care coordination and maximizes grant application opportunities. There is great concern about large organizations coming in from out of state to provide care that is already being provided locally.

Robert Mitchell, administrator of the San Juan County Alternative Sentencing Division, described three different programs — probation services for magistrate courts, jail-based driving while intoxicated (DWI) treatment and jail-based 60-day methamphetamine treatment — and "a

lot of investment" by the community in these special populations. The DWI program population is 76 percent Native American, and the methamphetamine program has an entirely female population, driven by the high number of children in protective custody. Visitation is tied to family programming, Mr. Mitchell said, and last year there were 185 family members involved in more than 400 treatment episodes. This is why the indigent fund is so important, because Medicaid and private insurance stop after an individual is incarcerated. The indigent health care fund pays for 30 percent of these two programs, Mr. Mitchell said, and the programs would end without this funding.

Kristine Carlson, a licensed independent social worker, is program and clinical administrator of Totah Behavioral Health Authority. There are "huge issues" with alcohol and substance abuse among the population served by her organization, which utilizes traditional mental health services, Diné healing and traditional medicine men and women. In a collaboration among the city, tribal government and county government, the program is focused on getting people out of the hospital emergency room and/or jail and, through joint-intervention intensive rehabilitation, into housing and employment. Thirty-two percent of the funding comes from the county indigent fund, Ms. Carlson said, which provides funding for traditional services. Ms. Carlson said that the program has a high success rate in the first three months and provides a huge savings to the county. The local collaborative has worked very hard to provide a continuum of care, she said.

County Detention Health Care Costs

Grace Phillips, attorney with the New Mexico Association of Counties, presented information (see handouts) about detention costs, design bed capacity and the average daily population in New Mexico detention facilities, broken down by county. On any given day in New Mexico, there are more people in county jails than in the state corrections system, Ms. Phillips said. She also provided a copy of several New Mexico Sentencing Commission reports, one on length of stay and the other on the effect of a mental health diagnosis on the length of stay. The length of stay has increased over time, and the current median length of stay is 140 days for those held but never sentenced. Twenty percent of inmates are already on a mental health caseload in Bernalillo and Dona Ana counties, and a psychotic diagnosis will increase the length of stay in jail to an average of 290 days, she said. The more serious the mental disorder, the longer that individual will stay in jail. There is frustration that the county detention centers have a population that really should not be there in the first place, Ms. Phillips said.

Questions/Concerns

One subcommittee member commented on the disparities in revenues and offsets in Ms. Phillips' charts. Most of the disparity between Bernalillo County and any other county is due to revenue that comes from housing federal inmates, Ms. Phillips said. Luna County has a 400-bed facility, but the majority of those bed spaces are sold to the U.S. Marshals Service. Santa Fe County also sells bed spaces and houses state inmates and federal prisoners. Another member commented that the current system of jails has become big business. The member said that he had just read a report indicating that Native Americans spend more time in jail for the same

crime than others do, and he feels a lot of the revenues are from housing Native Americans who come from the federal system. Native Americans just sit there because no one is paying any attention, the member asserted. This chart just reflects dollar amounts, he said to Ms. Phillips, but it does not show the cost of taking someone's freedom. He asserted that if society spends more money on building jails than on its children, then there is a problem.

Update on the HSD's Fiscal Year 2015 Budget Request for Behavioral Health

Greg Geisler, principal analyst with the Legislative Finance Committee (LFC), said that the HSD's budget request for fiscal year (FY) 2015 is \$5.8 billion from all revenue sources, an increase of \$394 million, or 7.3 percent, from the FY 2014 budget (see handout). The FY 2015 total Medicaid budget for physical health is \$4.2 billion, Mr. Geisler said. FY 2015 will be the first year of Medicaid expansion paid for by the federal government, anticipated to exceed \$400 million for 60,000 newly eligible adults. The HSD is projecting savings of \$15.3 million of the \$42 million base general fund support of behavioral health services due to 15,000 clients being covered by Medicaid starting in 2014 with 100 percent federal revenue, Mr. Geisler said. However, the HSD is proposing to reallocate the majority of these savings, \$12.1 million, as an expansion request for other purposes, including enhancing non-Medicaid services, value-added services and audit and compliance. Key questions to the HSD in the LFC report included the following:

- data to support anticipated savings;
- the rationale for adding five employees to the audit and compliance unit and how this unit will mesh with MCOs and behavioral health contractor oversight;
- more detail of plans for \$3 million for technical services and training for provider agencies and \$4 million to enhance non-Medicaid services; and
- more information about the proposed \$3.5 million for value-added services, including \$2.5 million for transitional living services and \$1 million for the behavioral health phone crisis line. The LFC is seeking more detail about the phone line and the funding history, sources and planned service levels for transitional living.

In summary, Mr. Geisler said, the HSD is proposing a major restructuring of the BHSD budget and an expansion of its staff. The substance abuse strategy proposed by the HSD is weighted toward intensive outpatient services, but network issues are an obstacle, according to the report. State and local governments will continue to bear the cost burden of inpatient or residential programs for adults. The LFC report advised that the state should optimize opportunities for Medicaid support for both physical and behavioral health.

Questions/Concerns

Mr. Geisler was asked about the \$68 million pool for uncompensated care, which is less than the previous sole community provider funding. The HSD wants to intercept the one-eighth tax increment from the counties. Keith Gardner, chief of staff for the governor, who was in attendance, said he is looking for a consensus proposal. The final proposal definitely will come before the legislature in the upcoming session, Mr. Gardner said.

A member asked about the \$17.8 million that was transferred to the HSD from the general fund to pay the new Arizona behavioral health services providers. In August, the HSD applied for a budget adjustment request, so the funds have already been transferred, Mr. Geisler said, adding that the HSD has heard that it is approaching the maximum amounts that can be spent on these contracts, and it wants the new providers to start billing Medicaid. There does not appear to be any request for continued funding for the Arizona providers, Mr. Geisler noted. Another member asked if anyone knows what amount is "in the bucket" that OptumHealth is holding for services that have not been paid for. Mr. Geisler said that the HSD claims that the \$18 million from the general fund will be offset from what OptumHealth has been accumulating. Another member questioned the need to add five more auditors to the compliance staff of 37 at the HSD.

Approval of Minutes

A motion was made to approve the minutes from the September 30 meeting of the subcommittee. A member pointed out an error in the second paragraph of page 3, where the words "Centennial Care" should be replaced by "Native Americans" regarding fee-for-service. The motion was seconded and passed unanimously with the above change.

Marijuana as Harm Reduction

Jessica Gelay, policy coordinator for the Drug Policy Alliance, presented information to the subcommittee about the use of medical marijuana as harm reduction (see handout). Ms. Gelay said that there are now nearly 9,000 registered users of medical marijuana in New Mexico, and described the use of marijuana as an alternative for prescription psychotropic drugs, which are often accompanied by significant side effects. The Drug Policy Alliance calls for the nonjudgmental, noncoercive provision of services and resources to people who use medical marijuana to assist them in reducing attendant harm. Marijuana use can help with physical symptoms of chemical withdrawal by dampening receptor signals for craving, Ms. Gelay said. It can also reduce seizures, and the risk of overdose and dependence is less than with other drugs. Consider that marijuana has been misclassified, she said, and that it should be added to the pharmacopeia of use as a drug. Ms. Gelay said she brought several clients with her to today's presentation in order to put a human face on these issues.

The Reverend Gerald White, a retired Methodist minister, and his wife, Judy, described the long journey of their brain-injured adult son and how, after many years of taking various pharmaceuticals, they found that marijuana obviates the need for prescription drugs, which have significant side effects, and gives him relief from other symptoms, such as seizures. It was actually his psychiatrist who recommended that he try marijuana, Mrs. White said. The Whites are hoping the state will expand approval of medical marijuana as a treatment for traumatic brain injury, as well as for Parkinson's and Huntington's diseases.

Tim Origer is a Vietnam veteran and amputee with significant phantom pain. Mr. Origer said that after years of using unsatisfactory prescription drugs, he applied for medical marijuana so that he could have a drug to use only when he needed it. He now does advocacy work with

other veterans and said he would like to see the stigma removed from medical marijuana so there could be more access for other veterans who need it.

Questions/Concerns

A subcommittee member thanked the presenters for telling their stories and agreed that years of use of psychotropic drugs comes with significant risks of side effects. Dave Schmidt, who also works with Ms. Gelay at the Drug Policy Alliance, told subcommittee members that the Department of Health medical advisory board will be meeting the following day and will vote on whether to add traumatic brain injury and Parkinson's and Huntington's diseases to the list of approved uses for medical marijuana. The board's action will then go to the secretary of health, who will make the final decision. Another member asked about the current status of the law, and Mr. Schmidt described an impending shortage of producers. There are now 9,000 individuals approved for medical marijuana, he said, and the number of producers needs to be increased to meet demand without driving people into the black market. Issues with medical marijuana and the developmental disabilities waiver (the federal government still considers marijuana to be illegal) are ongoing, Mr. Schmidt said, and it might be worthwhile to look at how other states are handling this issue.

Public Comment

Patricia McKeen, a mental health counselor with New Awakenings in Albuquerque, told subcommittee members that she feels there are huge capacity issues in the transition into Centennial Care. The only counselors who will be reimbursed for services under Centennial Care are licensed professionals, she said she was told by Magellan, who manages these services for Presbyterian Medical Services. New Awakenings has been serving hundreds of clients and previously was reimbursed under OptumHealth. A subcommittee member said she would look into this issue.

Nat Dean has a brain injury from an automobile accident and has been on medication for years. Medical marijuana not only works for her, but provides a milder form of treatment. It has reduced her doctor visits, and, Ms. Dean said, she is no longer addicted to narcotics. The New Mexico program is tightly regulated and provides access to having the cannabis tested so she knows exactly what is in it, and she can buy a strain that is not psychoactive.

David Olson said he has used Medicaid and received medical and behavioral health services, but with no case management, the state was spending twice as much as needed. Modern psychotropic drugs can be very helpful, he said, but the majority of people who take them suffer more harm than good. Diagnoses are not consistent and can vary from provider to provider, Mr. Olson said.

Adjournment

There being no further business, the fourth meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee for the 2013 interim adjourned at 5:30 p.m.

DISABILITIES CONCERNS SUBCOMMITTEE MINUTES

**MINUTES
of the
FIRST MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

July 8, 2013

**Easter Seals El Mirador, Mark Johnson Building, 10 A Van Nu Po
Santa Fe**

The first meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Nancy Rodriguez, chair, at 9:41 a.m. on July 8, 2013 in the Mark Johnson building at Easter Seals El Mirador (ESEM) in Santa Fe. The chair requested legislators and staff to introduce themselves.

Present

Sen. Nancy Rodriguez, Chair
Rep. Doreen Y. Gallegos, Vice Chair
Sen. Craig W. Brandt
Sen. Linda M. Lopez

Absent

Rep. Nora Espinoza
Rep. James Roger Madalena

Advisory Members

Rep. Miguel P. Garcia
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS

Guests

Guests are included on the guest list in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, July 8

Welcome

Mark Johnson, chief executive officer of ESEM, welcomed members of the subcommittee to the facility and described the work and mission of his organization. ESEM was one of the first community-based organizations to provide behavioral health services and has

been doing so since 1970. It has sites across New Mexico, including Alcalde, Espanola, Raton and Taos. Most sites are involved in behavioral health services on an outpatient basis, he said, and these sites also provide community living and comprehensive services for the developmentally disabled (DD) population. Mr. Johnson said the services emphasize freedom of choice and provide an array of choices throughout the state. Many of the DD services include small, integrated assisted-living arrangements.

Update on *Jackson* Litigation

Gabrielle Sanchez-Sandoval, general counsel, Department of Health (DOH), was joined by Cathy Stevenson, director of the Developmental Disabilities Supports Division (DDSD), DOH, and Debbie Hambel, Department of Vocational Rehabilitation (DVR), DOH. Also joining the DOH employees was Kathyleen Kunkel, attorney with Walz & Associates.

The *Jackson* federal class action lawsuit was filed in 1987 against the DOH, the Human Services Department (HSD), the DVR and several state officials. The case was brought to protest conditions at several state institutions for people with developmental disabilities and to remedy violations of the federal Rehabilitation Act of 1973 that subjected people with severe disabilities to discrimination and unnecessary segregation. In 1990, Judge James A. Parker found constitutional violations in the provision of services and in supports to DD individuals. In 1997, all individuals were de-institutionalized. Over time, a number of experts have been hired by the state to help the DOH disengage on behavioral health and medical issues. But in a 2012 ruling on a noncompliance motion, Judge Parker agreed that the DOH had made many improvements but was not ready for disengagement.

In January, Dr. Sue Gant was appointed compliance administrator. As an agent of the court, she has authority to assess compliance, provide technical assistance, facilitate compliance, make binding recommendations, mediate disputes and hire consultants. Since January, counsel representing the DDR, HSD and DOH have been collaborating on what actions need to take place to ensure that the DOH can exit from court supervision by July 2014, per Judge Parker's directive.

Ms. Stevenson said that in October 2012, Judge Parker urged the state to do some additional work to finish the litigation, and the DOH received a special appropriation of more than \$2 million to work on disengagement. Attorney fees were paid, as were additional attorney fees for fiscal year 2013 and for consultants named by Dr. Gant. The DDSD has been working closely with those consultants on incident management, Ms. Stevenson said, with the goal of ensuring DD individuals' safety from abuse, neglect or exploitation. Working with professional investigators on staff, a report of 34 recommendations was produced, which is broad and extensive, and has improved how the DDSD collaborates with adult protective services, Ms. Stevenson said. There also has been a series of stakeholder meetings to find out what is important. She said that everyone wants clearly specified and delineated roles. Very important work has commenced since January, Ms. Stevenson said, and is ongoing, with weekly and monthly meetings in small groups.

A second area of focus for these work groups is health — keeping DD individuals healthy by getting proper assessments and ensuring that providers know the people they are serving well enough to be able to detect health concerns. One of the experts recommended by Dr. Gant is Dan Sheridan, Ph.D., R.N., from the University of Minnesota. Dr. Sheridan is a medical investigation specialist who can teach how to look at injuries to figure out what happened to the person.

A third focus for these groups is supportive employment. The court is interested in all *Jackson* class members being employed if they wish, said Ms. Stevenson, and three initiatives have been identified to accomplish this:

1. identification of interests and jobs;
2. identification of systematic barriers and obstacles; and
3. working with the New Mexico Employment Institute and the University of New Mexico in a direct service and teaching project to connect with DOH efforts.

Ms. Hambel told subcommittee members that the DVR is looking at how to collaborate with the DOH to ensure as many employment opportunities as possible. The division has worked in the past with many *Jackson* class members, Ms. Hambel said, and has learned that these individuals often need transitional employment because they are not always successful in their first posting. Ms. Hambel coordinates services through the DDR to get referrals in place and to get adequate service. "We consider ourselves to be an employment-first state", she said. "All who want to work should be able to get jobs."

Upon questioning from subcommittee members, the presenters addressed the following concerns and topics.

Meeting the 2014 court deadline. Ms. Kunkel said that the DOH is currently finalizing a plan to lay out specific activities and time lines to accomplish this. Dr. Gant and the *Jackson* parties will review these, and Dr. Gant will either accept the plan or make other binding recommendations, which will be accommodated. The *Jackson* parties were involved in the January/February meetings to develop goals in safety, health and employment, but the DOH has independently been crafting its response to those plans and will submit its response to Dr. Gant, she said.

Process by which Dr. Gant was chosen. Both plaintiffs and defendants searched for candidates, and these were interviewed by both sides, Ms. Kunkel said. It was narrowed down to two finalists; in the end, the state's candidate withdrew and Dr. Gant, who holds a Ph.D., was chosen because of her New Mexico experience and extensive work with DD individuals.

Consumer Perspectives on *Jackson* Compliance

Doris Husted, public policy director for The Arc of New Mexico, an organization devoted to improving the quality of life for all individuals with developmental disabilities, is also the parent of a woman who is DD, and she said she has a "vested interest" in the outcome. The Arc is an intervenor in the *Jackson* suit but not a signatory to the disengagement stipulation. Ms.

Husted described The Arc as a national nonprofit that works to give DD individuals choices about where to live, play, work and socialize closest to home and their communities. The Arc always works on behalf of its protected class members, now about 85 persons, and attends all quarterly meetings regarding the lawsuit. Ms. Husted explained that The Arc used to bear the name "Americans for Retarded Citizens" but that the "r" word is no longer used. The organization has advocated for legislation to update and clean up some of the language using the word "retarded" and continues efforts to educate the public.

A member of the subcommittee pointed out that not all who have special needs should be labeled mentally retarded or even DD.

Sally Faubion, director of guardianship for The Arc, serves DD individuals across the state as well as the 85 who are *Jackson* class members. Many parties see this as a top-down process, said Ms. Faubion, but The Arc sees it through the eyes of the class members, whose health is often declining as their ages advance. She emphasized the importance of an interdisciplinary team that cares for individuals on a daily basis. Guardians, case members, therapists and the nurses who serve as a link between the individuals and other professionals must be able to relate to all involved, so appropriate training is important. Coordination should be focused on improving all individuals, whether they are part of the protected class or not.

Concerning safety issues with regard to abuse investigations, the location of the investigating agency and time lines for investigations all relate directly to improving class member safety, Ms. Faubion said. Many incidents must be investigated as soon as possible after the event, and while providers should stop investigating themselves, they can help with access to evidence and participants. Response must be quicker than it currently is, and she urges more transparent investigations.

Regarding supported employment, the focus has changed from external to self-directed choice for class members, Ms. Faubion said. Pressure on teams to employ has left a bad taste for many clients, and the plan now is to follow the wishes of the individual. If an individual chooses, a plan will be made available, and it may or may not include work. Activity must be meaningful for the individual, and in no case should there be meaningless work. Ms. Faubion stated that "we believe in a single-service system with all individuals receiving the same services — class member or not". The Arc supports the plan process as part of providers' right to due process, she said, and criteria must be enhanced and provider screening improved. It is not fair to offer few, if any, options for new providers.

In response to questions about guardianships from subcommittee members, Ms. Faubion said that before the class action lawsuit, families were told that the only available services were offered at DOH facilities, and that families must give up guardianship to the state. In his ruling, Judge Parker found it was not appropriate for the state to continue guardianship for the plaintiffs. Some family members assumed guardianship, and the state made arrangements with the court for

The Arc to assume other guardianships. Today, The Arc has a significantly reduced number of protected persons — about 85.

Patsy Romero spoke about her aunt, Josefita "Fita" Romero, who received excellent care at Fort Stanton. After the lawsuit, Fita moved in with a surrogate family, Ms. Romero said, and she was forced to go to a lot of services, including the dentist, and to a day habilitation center at age 92 and to other services that were disruptive. She wanted to stay home and did not want massages or dental work. If her surrogate family did not ensure that she was involved in work, the family was in violation. Some of the individuals ESEM serves are in their homes and want to stay there, but as they are class members, they are not allowed to stay home. Part of the lawsuit has been good for DD individuals, but there are flaws.

Ms. Romero described difficult cases with dual diagnoses of DDMR/mental illness, often coming out of the pediatric system, where individuals are exhibiting psychiatric issues that are putting themselves and others at risk. They are very hard to place, she said. Some needed evaluation for medications when suicidal or homicidal, and hospitals will not admit them because they have a DD diagnosis. The gap in services for these individuals is huge, Ms. Romero said. "As providers, we have extensive regulations with which we must comply; they are important for health and safety. But we need to look at regulations for fairness and to make certain they are participant-centered."

Questions/Comments

In response to subcommittee members' questions about regulations, Ms. Stevenson clarified that the regulations specify that services be selected. The team must clearly explain why an alternative to services is more advantageous to the individual. Pressure is real, she said, but it is not a requirement to send someone to day services.

Ms. Husted explained that family living provides a monthly stipend; providers are not paid for hours. How do you put staff coverage in place for an individual staying at home for those 30 hours? This is a huge problem for elderly individuals who do not want to leave home, and it is a systems issue that must be addressed, Ms. Husted said. The family gets paid one particular bundled rate, and surrogate families do not get paid for care of the DD individual during the day. The idea behind supported employment and quality-of-life activities is good, she said, but there should be flexibility for individuals whose age or capacity makes these activities unreasonable. "The regulations sometimes contradict each other. We want to center more on the DD individual's choice."

Ms. Romero addressed a member's question about the overlap between mental illness and developmental disabilities and whether the *Jackson* suit addresses these dually diagnosed individuals. The legal action, she believes, was trying to prevent involuntary institutionalization, but with 6,000 on the waiting list now for a developmental disabilities waiver, young individuals who had been institutionalized as minors and have a mental illness component are not adequately being served in this environment. In response to a member's question about whether recent

changes could force clients from their homes, Ms. Romero briefly described how the new Supports Intensity Scale (SIS) system of assessing need places individuals in budgeting categories. Scoring in categories A and B entails no services at home. Families must either request a new assessment or appeal the categorization, a process she says is proving difficult.

Subcommittee members discussed the *Jackson* lawsuit from many angles. A lot of good came from it, one member said, as instances of abuse were dramatic, with physical, sexual and emotional abuse occurring. It is important to understand that the lawsuit was addressing the health, safety and employment opportunities for DD individuals. Another member offered the opinion that he is starting to see a coalition of legislators and advocates to finally bring this lawsuit to an end, hopefully by the 2014 deadline.

In response to a question about what happens to the personal care option (PCO) under Centennial Care (CC), there were several responses from different presenters. Ms. Husted said much is still not clear. Ms. Stevenson said the program will be split — the DOH will manage DD individuals if they are on Mi Via until it expires, or the PCO will be amended into a self-directed option under the developmental disabilities waiver, and will look much as it looks today.

Jim Jackson, Disability Rights New Mexico, offered that, as he understands it, in the CC proposal, a number of services will allow self-direction or agency direction. The theory is that each managed care organization (MCO) can decide how to facilitate self-direction; it might hire its own care coordinators or it could contract with existing agencies. The whole system is based on MCO discretion to figure out how to facilitate self-directed services. No one in attendance seemed to know if this would be decided before January.

According to a subcommittee member whose adult son is on the developmental disabilities waiver, there is a lot of difficulty with the SIS. Many family members will no longer be able to work if they lose services because they will have to stay home to care for a DD child or adult.

Public Comment

Katie Brown, employed with the San Juan Center for Independence in Farmington, spoke about the major changes taking place. The rollout of CC will allow a consumer-delegated function, but no longer allow consumer direction. The consumer-directed PCO would be eliminated. She presented a letter from one of the center's consumers, who described a situation where her doctor and a provider discussed her returning to a nursing home, and she decided to change companies. "They wanted to take my independence", she wrote. "I think they were surprised." Consumers can direct their own care, said Ms. Brown, but this model would require them to handle all their finances themselves, including a budget and ensuring that attendants are paid.

Mr. Jackson spoke of plans for the LHHS to spend a full day on the developmental disabilities waiver at its meeting in September, and he said that legislators had heard updates on

the *Jackson* lawsuit from everyone but the plaintiffs. He noted that the July 2014 compliance plan ordered by the judge is still not done, so it is behind schedule, and community providers have had multiple, ongoing problems. He urged legislators to look at the state progress report and the community monitor's report and to schedule some time for plaintiffs to be heard at that meeting.

Peter Cubra, Albuquerque attorney and founder of Advocacy, Inc., presented a report from the Human Services Research Institute (HSRI). The SIS is a mistake, he said. New Mexico results on the SIS scale are greatly skewed. Mr. Cubra said the tool shows that the state is not overspending; it is cutting spending based on a false premise. According to the HSRI report, of the 3,218 individuals who have been assessed, 583 have requested a reassessment. He asked why people from Washington, DC, are being paid \$3 million to do the assessments instead of hiring locals. Case managers are supposed to submit a budget two months in advance, and Molina Healthcare, Inc., has two months to provide a budget. With all the chaos, Molina was not processing budgets, Mr. Cubra said. Budgets were expiring, leaving people without budgets. Providers stopped providing services, and some of Mr. Cubra's clients are going without speech pathology services and are at risk of suffocation. "The system is in meltdown", he said, "and people are not getting services to which they are entitled".

Former Secretary of Aging and Long-Term Services Michael Spanier addressed the issue of whether PCO self-direction is going away and reported that, after some confusion, he was told that the HSD has decided that this option is definitely being eliminated. Mr. Spanier said he feels the option should be maintained for consumers and caregivers and that the subcommittee should meet with Julie Weinberg, director of the Medical Assistance Division (MAD), HSD, and others to try to come to some reasonable, peaceful resolution of this issue.

Ed Kaul, chief executive officer of ARCA of NM, which serves people on the developmental disabilities waiver, said waiver budget approval is an issue. "When the money is not coming in, we deplete our lines of credit." On May 1, there were more rate reductions for services, but there have been no reductions in regulations or the costs of overhead, he said. Mr. Kaul wants to encourage the subcommittee to consider rate increases for the developmental disabilities waiver. "We also need very aggressive, intensive mid-level supports", he said. "We need to pay direct care and mid-level management adequately."

Robert Kegel said he was one of those who originally lobbied for this program; his son has been on the waiver for 28 years. Now it has turned into a bureaucratic fiasco. The people who know how to fix this program are parents and providers, he said. Stakeholder input was minimal. "We are lost", he said, and the changes are "patently ridiculous". Mr. Kegel was highly critical of the SIS, a tool that is culturally biased, he said, is "proprietary" and costs \$850 a pop. The regulations are convoluted, he said, and his son's providers are quitting the developmental disabilities waiver.

Ellen Pinnes, who works with the Disability Coalition, has concerns about CC and changes in self-direction. There has been no formal announcement of the changes to the PCO, and secrecy and a lack of stakeholder input have prevailed. Work groups charged with this are composed entirely of state agency employees who tell providers nothing and ask for no meaningful input. Ms. Pinnes urged the subcommittee to push the HSD to have a more open process. It was decided by a subcommittee member to include this topic on one of the upcoming agendas and to include Ms. Weinberg.

Sustainability of the Developmental Disabilities Waiver and Continuation of Compliance

Anna Otero-Hatanaka, executive director, Association of Developmental Disabilities Community Providers, represents about 30 providers, both large and small. Ms. Otero-Hatanaka provided a presentation on the redesign of the developmental disabilities waiver program instituted on May 1, 2013 for new persons entering the service system and for persons currently receiving services whose plans of care and budgets need to be revised. The purpose of the redesign is to save money by reducing services to individuals currently in the system in order to fund services for persons on the central registry waiting list for services, she said. Providers had already endured cuts in rates for services of five percent across the board in January 2011, with annual resource allotments reduced eight percent and additional cuts ranging from six percent to more than 40 percent, she said. Core services are being threatened or eliminated, and some long-time providers have gone out of business. Providers have cut staff salaries, dropped health insurance and work overtime that cannot be compensated through Medicaid. Budgets have not been approved, and providers provide services for which they cannot bill. Adding the developmental disabilities waiver revisions to the mix has produced a "perfect storm", she said.

In a PowerPoint presentation titled "Waiver Revision, A Provider's Perspective" (see handout), Ms. Otero-Hatanaka described changes to standards (provider responsibilities), the way individuals are evaluated for services (SIS), Medicaid rates (based on a study by Burns & Associates) and the service packages (number of service hours available per person based on eight SIS levels). The problem the revision is attempting to address is that individual costs have increased over the years, with New Mexico having the sixth-highest cost per person. Driving this increase is the extensive use of residential services. With the dissolution of the state institutions, family living became a popular service and increased faster than anticipated, along with ancillary services.

Ms. Otero-Hatanaka's presentation details the effects of these reductions on providers. Direct services staff members are the hardest hit, with 75 percent to 85 percent of the cuts being personnel-related. Mid-level support has been reduced, and the quality of service suffers. The decrease in rates, increased standards and constant audits have become unsustainable for providers, she said. Rate recommendations made by Burns & Associates inaccurately reflected costs and were based on unaudited data, she said, and recommendations for further cuts in reimbursement rates, per the Burns survey (see handout), range from six percent to more than 40 percent. In conclusion, Ms. Otero-Hatanaka said that New Mexico is serving a significantly more disabled population than other states, with smaller residential services, more family living

and more therapies. Lower rates will dictate more congregate services and will disproportionately affect direct services staff, therefore reducing the number of viable providers and the number of available services.

Questions/Comments

One member of the subcommittee stated that it is clear that rate increases are needed. Another member requested Ms. Otero-Hatanaka to make the independent certified public accountant assessment critical of the Burns study, which she referred to in her presentation, available to the subcommittee, to which she agreed. These were really hot-button, red-flag issues last year, said another member, "but then the ACA-related measures took precedence". It must be ensured that some of these issues stay on the front burner, through community forums, special invites to individual legislators, etc., he said. A member of the audience whose adult son is on the developmental disabilities waiver rose to speak about monetary waste in the system. He says he has never received a copy of a bill for services for his son. "Any Medicaid provider could charge anything to my kid's account, and I'd never know." Senator Gerald Ortiz y Pino has sponsored a memorial to require the MAD to publish statements.

Regulation of Intermediate Care Facilities (ICFs)

Linda Sechovec, executive director of the New Mexico Health Care Association, joined Mr. Johnson in a presentation about the ICF delivery system within the state's 42 sites, operated by five nonprofit organizations and one by the state. The size of these facilities ranges from four persons to 16 persons, with 274 individuals currently being served at sites in Santa Fe, Espanola, Alcalde, Los Lunas, Albuquerque, Carlsbad and Carrizozo. ICFs provide a person-centered, home-like environment for individuals with disabilities, Ms. Sechovec said. "We work with 24-hour, seven-days-a-week providers. The system is at a real crisis point right now", she said, motioning to the book of regulations, which is about five inches thick. "It is very costly to provide these services."

Senator Rodriguez then recognized Nat Dean as a valued community advocate, and the meeting adjourned at 2:49 p.m. for a tour of an ICF home.

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

**October 1, 2013
Adelante Development Center
3900 Osuna Road NE
Albuquerque**

The second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order on October 1, 2013 by Senator Nancy Rodriguez, chair, at 9:35 a.m. at Adelante Development Center in Albuquerque.

Present

Sen. Nancy Rodriguez, Chair
Rep. Doreen Y. Gallegos, Vice Chair
Sen. Craig W. Brandt
Sen. Linda M. Lopez

Absent

Rep. Nora Espinoza
Rep. James Roger Madalena

Advisory Members

Rep. Miguel P. Garcia
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Guest Legislator

Sen. Gerald Ortiz y Pino

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Tuesday, October 1

Welcome

Senator Rodriguez welcomed everyone and asked legislators and staff to introduce themselves.

Mike Kivitz, president and chief executive officer of Adelante Development Center, Inc., said his nonprofit organization provides individualized support services and employment for more than 900 New Mexicans with mental, physical and developmental disabilities. The center was able to purchase the building for \$48.00 per square foot, and U.S. Senator Pete Domenici and U.S. Representative Heather Wilson were able to help for a federal appropriation for remodeling. Adelante has other ventures, such as a document destruction and imaging company, and runs a web site called BackInUse.com, which makes available to the disabled repaired and reconditioned durable medical equipment free of charge. Mr. Kivitz said Adelante's current total budget is \$23 million, which is down due to sequestration and recent changes in Medicaid waivers. Since the advent of managed care, Adelante no longer provides any behavioral health services.

Los Lunas Community Program for the Developmentally Disabled

Jon Hellebust, administrator of the Los Lunas Community Program, accompanied by Lynn Gallagher, deputy director of the Department of Health (DOH), described the community-based program that operates at the old Los Lunas training center, which was closed in the mid-1990s. All residences in the program are leased facilities, and consumers leave the residences for a minimum of six hours a day to receive services. Mr. Hellebust said that the program has oversight of the old training center, where there are various types of therapy offered, swimming pools, a foster grandparents program, a fish hatchery, a bookmobile and a local police substation. In another section of the old training center, there is an intermediate care facility run by the Corrections Department for men who are developmentally disabled sexual or violent offenders. Los Lunas is a statewide crisis center for short- or long-term placement, he said.

Currently, there are 65 individuals being served at Los Lunas year-round, Mr. Hellebust said, and this number is expected to rise to 70 in the next year. These are primarily high-need medical and behavioral health clients. Residential consumers need 24-hour-a-day staffing in houses that serve one to four persons, Mr. Hellebust said. Services are provided for these and 65 to 70 other consumers who may need only day services or supported employment. Half of the population at Los Lunas are *Jackson* class members, he said, and their programs are reviewed by *Jackson* auditors on a regular basis. The program's annual operating budget is \$16 million (nearly half from Medicaid through the developmental disabilities (DD) waiver), Mr. Hellebust said, and it is currently able to recoup about 90 percent of its billable budget. The program is seeking to become nationally certified by the Commission on Accreditation of Rehabilitation Facilities, which will enhance its reputation and attract more qualified staff and additional providers.

The dental clinic at Los Lunas is home to the only board-certified special care dentist currently operating in New Mexico, Mr. Hellebust said. The clinic serves 900 to 1,100 patients annually and is operated on a fee-for-service basis through Medicaid, with an additional appropriation of \$150,000 from the legislature. There is a total clinic staff of five, including two hygienists and two dental assistants. There are 30 community dentists who serve the disabled through Medicaid, he said, but the low rate of reimbursement has caused some to leave the program. Currently, there are two vacancies at the clinic, where the work is very challenging, and sometimes dangerous, in the provision of services to highly compromised clients. Mr. Hellebust said the clinic is hoping to be able to offer higher pay grades for more successful recruiting. Right now, there is a year's wait to see Dr. Ray Lyons.

DD Issues

Cathy Stevenson, director of the Developmental Disabilities Supports Division (DDSD), DOH, provided a handout for subcommittee members in which she answered questions brought up at the LHHS meeting in September in Socorro. In addition, she gave another presentation that described the time lines, benefits and services of the newly designed DD waiver and the Supports Intensity Scale (SIS) tool used to assess consumers into groups of services based on need. After going over the numbers (4,000 enrolled in the DD waiver and 6,300 on the waiting list), Ms. Stevenson said there are many points throughout the individual assessment for the redesigned waiver at which consumers can access their right to a hearing. The DOH will pay for a professional interpreter, if one is needed, and there are team members who can help speak for consumers who are unable to speak for themselves. The system is responsive, Ms. Stevenson said, both to the individual and to the need for policy changes and adjustments based on public and provider comment. Listed on the last page of her presentation are DOH goals for the future, including moving 325 additional people off the waiting list and into waiver services for fiscal year (FY) 2013, and moving 400 additional people in FY 2014. Ms. Stevenson promised subcommittee members that she will provide an in-depth report on the problem of reversion to the general fund of funds that were intended by the legislature to take individuals off the waiting list and onto the waiver. The subject of these annual reversions has been contentious at previous meetings, and members have stated that they are looking for a clear explanation of the problem and ideas on how to fix it.

Questions/Concerns

A subcommittee member told Ms. Stevenson that he found the use of the word "rich" inappropriate in describing an array of services on page 6 of one of the handouts. "These are services that people need", the member stated. Ms. Stevenson assured him that the word "rich" could be struck.

In response to a question about qualifications of those on the waiting list for the DD waiver, Jennifer Thorne, who works with intake and eligibility for the DDSD, described the four status levels: 1) *start*: in the process of submitting paperwork, does not yet qualify for the program; 2) *pending*: children under age eight with a related condition rather than developmental disability, who do not yet have evidence of dysfunction in three or more life

areas; the department invites applicants to send evidence of functional limitations when the child reaches the age of eight (usually available through special education testing by that age), and the application will be revisited at that time while preserving the original application date; 3) *complete*: eligible, but must demonstrate financial eligibility criteria upon allocation; and 4) *on hold*: when the applicant is not yet ready but wants to keep a place in line. There are approximately 1,200 new applications each fiscal year, Ms. Thorne said, and of those, only 300 have sufficient documentation to be confirmed and placed in complete status. There are "related conditions", such as cerebral palsy and autism before the age of 22, that can be considered. A clinical team determines eligibility, she said. There is a second review, and this can be appealed through a fair hearing.

A member wanted to know who works with these individuals to determine services. There is an interdisciplinary team that comes up with a plan, looks at the service package and selects services needed for that year, Ms. Stevenson said. Case managers are independent companies under contract with the state; they are not state employees. The member also asked if there is any incentive for a case manager to approve or disapprove of services. Ms. Stevenson said that case managers do not have any incentive one way or the other, and the consumer can always ask for a different case manager. The member asked how Medicaid hearing officers are chosen. Hearing officers are in the Human Services Department (HSD), Ms. Stevenson said, and come from a multitude of backgrounds and are completely independent. They are not part of the Medicaid division.

Some consumers are not spending money because there are not enough providers, observed another member. Cutting the budget means there are no providers, and this is a vicious circle, he said. Ms. Stevenson agreed that therapists are scarce, especially in the outlying areas. The DDS tries to track instances when people want therapy and cannot get it, she said. The DDS offers an incentive rate for therapists and a good rate for therapy extenders.

Several subcommittee members continued to question Ms. Stevenson about why there is such a discrepancy between increased legislative funding to get people off the waiting list and into the waiver and the lack of desired results. Another member inquired about the capacity of infrastructure and resources if the DDS were able to keep all of the money instead of reverting it. Ms. Stevenson agreed that, with current allocations, the staff is maxed out. A dramatic increase of people being brought into the system would strain the DDS's resources and the health care work force. Perhaps more funds should be allocated for administration, the member said. Ms. Stevenson said that the DDS is trying to be a better manager of that money. The DDS has been assuming an annual attrition of 30 consumers, she said, when in fact, this year, 84 people left the program. "We were not managing our attrition rate appropriately", she said.

Senator Rodriguez told Ms. Stevenson that the subcommittee wants her to be on the agenda again to present the reversion information in depth, and Ms. Stevenson agreed, saying she wants to be able to give more meaningful answers to these questions. She gave members her

personal guarantee and pledged that more people on the waiting list will be brought into the DD waiver program.

Senate Memorial (SM) 20 Update

Doris Husted, director of public policy for The Arc of New Mexico, is co-chair of the task force formed in response to SM 20, passed during the 2013 legislative session, which asks for DD waiver wait times of no more than three years. Ms. Husted described the work of the task force of about 30 individuals, who met for a full day every other week for eight weeks. The group included people on the wait list, families, providers, DOH employees, agencies, The ARC, Mi Via Advisory Committee members and others. It was very broad-based, she said. They looked at infrastructure, pre-allocation issues and the number of state employees needed to process new consumers. One thousand two hundred new consumers would need to be allocated to the DD waiver for each of the three years, and the task force concluded that this would not be possible. It would double the size of the current waiver, and the state and provider infrastructure could not be grown this quickly. The three-year plan would require \$35 million from the general fund and an additional \$84 to \$85 million in federal matching funds to accomplish this, the group estimated.

According to Ms. Thorne, who also served on the SM 20 Task Force, interim recommendations included the following: 1) look at how state general-funded DD services might be improved by stretching them out over a longer period; 2) look at the Mia Via Self-Directed Waiver program (Mi Via) to make it more appealing, as it does provide more flexibility for consumers in choosing providers; and 3) expand the state infrastructure to put more people into DD waiver services and to monitor them. To address the reversion of funds intended to move consumers off the waiting list and onto the waiver, the group suggested the possibility of a pilot project using state general funds in an amount smaller than the state Medicaid match to provide more flexibility and less paperwork without the stringent Medicaid requirements. The dollars that now revert could go to annual contracts outside of Medicaid, the task force suggested. The involvement of the Legislative Finance Committee (LFC) and the Department of Finance and Administration (DFA) would be essential in helping to outline a way to do this.

One task force suggestion was to revisit allocations across the state, starting with consumers who have the oldest date of application. Currently, 15 percent are given priority to anyone with a caregiver who is 65 years of age or older, and it was decided to leave this distribution alone for now. Another suggestion was to conduct an update of contact information. During the recession and hiring freeze, the department sent out mailers only to the top 150 on the list. This year, a mailing to the entire list will be resumed, and the task force emphasized that follow-up phone calls are critical to this process. Growing the state infrastructure may take as much as \$85 million in additional funding over a three-year period, Ms. Thorne said.

A member referred to the base budgets listed on page 8 of Ms. Stevenson's presentation and asked if there had been any changes over the past year in the dollar amounts. The member asked where the changes from the SIS come in and whether the presenters can show the dollar

amounts before and after the SIS. Ms. Stevenson responded that the figures listed in the chart on page 8 are the SIS base budgets. She said she could get the old numbers to compare. Three years ago, everyone's budget was reduced by eight percent, she said, but there have not been any changes since then. The DDS is aware that it needs to build provider capacity, Ms. Stevenson said. The member advised the task force to be sure to include increases in provider rates in its financial projections.

The SM 20 Task Force is preparing a final report, which that should be delivered in one month.

Role of Molina Healthcare

Julie Weinberg, director of the Medical Assistance Division of the HSD, provided several charts (see handouts), one on DD waiver expenditures over the past five years and another on a breakdown of payments for DD waiver services from January through July 2013. She then introduced Patti Kehoe, president of Molina Healthcare of New Mexico (Molina), the third-party assessor (TPA) for Medicaid in New Mexico. Molina determines medical necessity and does utilization review for the DD waiver, the Mi Via, the HIV waiver and several other programs, Ms. Kehoe said. Its arrangement with the state is through competitive bidding.

The TPA hires nurses, social workers, clerks and data entry specialists from DD waiver providers, Ms. Kehoe explained, and it makes a determination and uploads into the Omnicaid payment system. It is held by the state to a turnaround time of 10 days. Budgets also must be turned around in 10 days, Ms. Kehoe said. The TPA monitors accounts on a daily basis, and it monitors *Jackson* class consumers, specifically. If the numbers served on the DD waiver were to increase, Molina would have to hire more staff to handle its contract with the state, she said.

Questions/Concerns

Delay in payment to providers. A member expressed concern about hearing numerous complaints that it is taking too long for Molina to approve budgets, so providers are not getting paid. Ms. Kehoe admitted that in June and July, Molina had issues, and the turnaround time was 24 days. To address this, the time frame of the budget was extended. The backlog has been reduced and the turnaround time is 12 days, she said. Some documentation was not correct, so the process is being streamlined. Any request for information will slow down the review process. In response to a question about rates, Ms. Kehoe explained that Molina does not set rates; rather, it does a review of medical necessity. Its staff enters information and authorizes services over a period of time. So when a claim comes in from a provider, and it has been authorized by Molina, Omnicaid can process and pay that claim. The department changed the review process, Ms. Weinberg said, in defense of Molina's slow-down in the review process. Another member asked why Molina is needed after the plan has been entered in the system. Ms. Weinberg responded that even after the plan is in the system, Molina makes sure the service is medically necessary and looks for over- and under-utilization. If there is a change in services, a C-waiver must be filed in order to pay the provider.

What is Omnicaid? Ms. Kehoe explained that this is a brand name for the Medicaid Management Information System, which is software for a main frame computer that is required by federal law. This is run by Xerox. Molina is also the fiscal agent in processing all encounters from managed care organizations.

How is a service plan determined? A team made up of service providers, such as nurses and direct support staff, comes up with a plan for the consumer that is within the rules of Medicaid and within the provisions of the waiver. There are seven therapists on staff as reviewers, and a physical therapist reviews any budget that includes physical therapy. A new prior authorization process involves review of the request by a therapist within the relevant discipline. A subcommittee member asked if therapists are paid to go to team meetings. Ms. Stevenson said that a therapy plan code should allow some time that would cover this. The member disagreed. A therapist cannot give away this many hours and still make a living, the member observed.

How is Molina paid? Molina is paid on a case-rate, one-payment-per-year-per-recipient basis, no matter how many times it touches the case, Ms. Weinberg said. The rate is \$500 per case, even if the plan changes. If the team and case managers say that the service plan needs to be changed, documentation is completed and sent to Molina, then it is uploaded into Omnicaid. The revision goes to Molina with a 10-day turnaround. If the revision is approved, services should not be interrupted, Ms. Weinberg said. One member noted that on page 8 of Ms. Stevenson's presentation, family living cost for Group C is \$60,000 a year, but the member knows that families do not get this. They get \$2,150 per month. The member is troubled by the fact that those providing the services get paid less than those who administer the services. For FY 2014, Molina's total contract with the state is \$7 million for all services, not just the DD waiver. Oversight of Molina is from corrective action plans that are built into its contract with the HSD, Ms. Weinberg said, and these can lead to financial sanctions.

Early Intervention Services from Birth to Age Three

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers (ADDCP), made a presentation to the subcommittee (see handout) asking for \$6.9 million to implement the recommendations of the DOH 2003 independent study of reimbursement rates for the early intervention programs providing services for the Family Infant Toddler (FIT) program.

The FIT program provides a statewide comprehensive system of free early intervention services for children from birth to age three who have developmental delays, disabilities and serious illnesses. It serves 13,000 children, Ms. Otero Hatanaka said. Intervention is more effective and less costly when it is provided early in life, and a cost-benefit analysis shows that for every \$1.00 invested in quality early childhood programs, a savings of \$7.00 to \$17.00 in benefits by the time the child becomes an adult is realized. The program's focus is on therapeutic strategies for the parents of these children.

FIT early intervention services are provided through a network of 33 community provider agencies that serve families in all counties and in Native American communities in New Mexico, Ms. Otero Hatanaka said. The program has continued to provide services at the same rates that were deemed insufficient in the 2003 study and, in some cases, at rates that have been lowered, she said. The FIT program is an entitlement program; it is not based on financial need; and there is no waiting list. The FIT program has been in a deficit situation, and the DOH has asked for supplemental deficiency funding and for more funding in the future. A subcommittee member asked about the source of funding, and Ms. Otero Hatanaka said there is part C of the federal Individuals with Disabilities Act Funding, state general funds and private funds from insurance companies. A rate increase for providers would have to come from the general fund to cover the non-Medicaid and Medicaid state portions.

Minutes Approved

A motion was made, seconded and passed unanimously to approve the minutes of the July 8, 2013 meeting.

Public Comment

Robert Kegel, parent of a DD waiver adult child, presented subcommittee members with a 25-page review of the "Recent History and Perspective of the New Mexico DD Waiver" (see handout), in which he vigorously disputes the process by which the waiver was changed, the figures that the HSD and the DOH continue to provide to the public, the reliability of the Burns & Associates rate study and the use of the SIS to categorize consumers and assign service packages. Mr. Kegel says cuts to the DD waiver do not take inflation into account and that projections assume that providers will be paid the same amount throughout the years. He asked that the HSD reveal the amount of money that was paid to Human Services Research Institute and Burns & Associates and that the HSD publish on its web site the algorithm that is being used in the SIS. Ms. Stevenson said she will address Mr. Kegel's points in writing.

Mr. Kivitz said that the five percent and eight percent cuts since 2010 have caused a great deal of pain for providers and for his organization and has resulted in a \$1.2 million reduction in Adelante's budget. Mr. Kivitz does not believe that rates that resulted from the Burns & Associates study are "revenue neutral". Core services have been cut, supported employment has been cut and, as a result, Adelante will have to cut mid-level managers, insurance coverage and direct service staff and reduce retirement plans. For the first time, Mr. Kivitz said, Adelante does not have the infrastructure to help persons on the DD waiver waiting list. Problems with Molina are short term, he said. His organization is looking at other non-waiver options to keep the agency alive.

Ms. Otero Hatanaka agreed with Mr. Kivitz that the new rates are not budget neutral. She presented subcommittee members with a position statement (see handout) from her organization regarding the *Jackson* litigation. Increasingly, many providers have come to feel that the *Jackson* lawsuit represents their last significant leverage on the DD service system. *Jackson* class members are not part of the redesigned DD waiver and are held harmless from any reduction in

services due to their SIS scores, the position states. Operating dual systems of services is a practice many feel is discriminatory. ADDCP members do not want the lawsuit to end until there is assurance that both *Jackson* class and non-*Jackson* DD waiver participants will receive the same services under the same standards, at rates adequate to meet all individuals' needs and requirements.

Ernestine Morales has a daughter with microcephaly who is now 45 years old, and Ms. Morales struggled with care for many years until she found out about the DD waiver, which was a blessing, she said. On the waiver, her daughter began to improve. Then, in 2010, changes began to happen, with five percent cuts across the board. Her daughter was part of the pilot program for the SIS, but it took over a year to get the results. Her daughter got a D, but family members thought it should have been an E, but they were afraid to retest. On March 26, 2012, caregivers met to discuss the changes to the DD waiver program, and that was the start of the New Mexico Providers Association. Ms. Morales urged subcommittee members to listen to caregivers, because home living costs the state half of what it costs for consumers to live in group homes.

Ted Romero, who has one son at Los Lunas and another on the DD waiver, said he has had difficulty with incident reports not being provided to him as a parent. He and his wife have had problems with translators, and during their son's SIS assessment, the interpreter left. Mr. Romero has brought this to Ms. Stevenson's attention, and she said services will continue under the previous budget until this is sorted out.

Evangeline Zamora is chief executive officer of Life Quest, Inc., the only provider in Grant, Luna, Catron and Hidalgo counties. Life Quest has provided services for 40 years but it has had to eliminate some services in supported living because the cost of providing the services exceeded the payments. Life Quest was able to provide these services fully until the recession and the rate reductions. Now, it cannot put together its budgets because the SIS assessments have been trickling in, she said. Life Quest has a lot of community support, but it has had to make big changes. Early intervention services are difficult for rural areas, Ms. Zamora said, and it is hard to find therapists.

Laurie Ross-Brennan, who is a speech and language pathologist and auditory integration specialist, said that several hundred of the SIS assessments were not done accurately, and the state has had to pay twice. The SIS is using Canadians who are not trained professionals to decide who gets clinical services. Her agency had a budget that was held up for months, and it has lost eight full-time speech pathologists who went to work for the schools. The HSD has cut services, Ms. Ross-Brennan said.

Cyndy Mantagna, an occupational therapist who works in Las Cruces and in Sierra County and sees children in their homes as part of the FIT program, said she is begging for a rate increase for FIT providers. There has been no increase for more than a decade, she said, and

therapists are going to work in public schools, where they get vacations, retirement and automatic raises.

Sylvia Washington of Tresco Tots in Las Cruces has a letter of support for the rate increase for FIT providers. She met with Michael Yune regarding preschool for all and told him of concern about three-year-olds who do not qualify for services at schools. Mr. Yune said he was hopeful that preschool for all could provide a place for them, she said.

Kathleen Cates is chief executive officer of Life Roots, which has been providing early intervention services in New Mexico since 1958. Ms. Cates said she appreciates how inquisitive and smart the subcommittee members have been in learning about how all of these programs work. The \$4 million shortfall in FIT early intervention was because funds were used to shore up another program, Ms. Cates said. This year, contracts have been reduced. Creative approaches are needed to develop other sources of revenue, now that supported employment pays only \$200 a month. Adelante is one of the largest agencies in New Mexico, Ms. Cates noted, and only the largest agencies can tread water long enough to wait things out. One hour of service requires three hours for travel, paperwork and billing.

Jim Ogle, president, New Mexico National Alliance on Mental Illness (NAMI), said he wanted to change the subject to treatment guardians out of the New Mexico Disabilities Planning Council. NAMI's Sue Wentzel has been part of the treatment guardian program for a long time, he said, and NAMI has had a contract with the planning council since 1995. NAMI won its last request for proposals (RFP) in 2011. This year, NAMI was asked to rebid. NAMI was the only bidder, but it did not get the contract. Another RFP went out, and two other organizations got the contract, which was supposed to start July 1. The point Mr. Ogle wanted to make is that there were no treatment guardians in the state for about two months. One bidder got northern New Mexico, the other southern New Mexico. After one month, the northern New Mexico bidder pulled out. NAMI was asked to take over the Las Vegas contract, and the original documents for this were received from the council on September 16. Nothing has been signed or is in place, so this means there have been no treatment guardians for Las Vegas for quite some time. NAMI will not take action on the new contract until it recovers payment for the last two months of last year's contract; it is still owed \$31,000. NAMI is an all-volunteer organization, Mr. Ogle said, and it is working off reserves because it has not been paid.

Ruby Ann Esquibel, LFC analyst, said that she has been reporting on treatment guardians not getting paid. The contracts must be bid because they are over \$50,000. The program is limping along and in pieces, she said, and RFPs were never completed, so contracts were not taken care of. There also has been a staffing problem at the agency, with loss of staff, and a loaner financial analyst is being used, Ms. Esquibel said. The head of the agency is on administrative leave. The LFC has been speaking to the DFA, and there will be a hearing later this month before the LFC to find out more about the situation.

The meeting was adjourned at 5:15 p.m.

**MINUTES
of the
THIRD MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**November 4, 2013
Room 322, State Capitol
Santa Fe**

The third meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Nancy Rodriguez, chair, on November 4, 2013 at 8:55 a.m. in Room 322 of the State Capitol.

Present

Sen. Nancy Rodriguez, Chair
Rep. Doreen Y. Gallegos, Vice Chair
Sen. Craig W. Brandt
Rep. Nora Espinoza
Rep. James Roger Madalena

Absent

Sen. Linda M. Lopez

Advisory Members

Rep. Miguel P. Garcia
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Guest Legislators

Sen. Jacob R. Candelaria
Sen. Gerald Ortiz y Pino

Staff

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Branden Ibarra, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file.

Monday, November 4

Welcome and Introductions

Senator Rodriguez welcomed the assembled group and asked members and staff to introduce themselves.

Summary of Fiscal Year (FY) 2015 Requests from the Department of Health (DOH)

Ruby Ann Esquibel, principal analyst for the Legislative Finance Committee (LFC), presented information to subcommittee members regarding the DOH FY 2015 requests (see handout), explaining that it is a general fund summary and does not include other state or federal funding. All departments are required to submit budget requests by September 1, Ms. Esquibel said, and the DOH is requesting to revise its budget because, with Medicaid expansion beginning in January, fewer general fund dollars will be needed. A detailed discussion of the Developmental Disabilities Supports Division (DDSD) budget ensued. Ms. Esquibel provided information on changes for FY 2015, which represent a 7.1 percent increase over the previous year. Subcommittee members discussed further the following topics.

Family Infant Toddler (FIT) Program. There has been an eight percent increase in the number of children being served in the FIT program, and because funds from the federal American Recovery and Reinvestment Act of 2009 have tapered off, more general funds will be needed to offset that loss, Ms. Esquibel said. A \$5.1 million increase for the FIT Program has been budgeted. When queried by a subcommittee member, Ms. Esquibel said the DOH had not requested any rate increases in FY 2015 for FIT Program Providers.

Supports Intensity Scale (SIS) assessments. Because Medicaid no longer will be providing matching dollars for the assessments, the testing will be funded in 2015 by general fund dollars. The additional \$1.2 million for SIS in the DOH budget actually represents a switch from one agency's budget to another, Ms. Esquibel explained. Cathy Stevenson, director, DDSD, added that the DOH has always paid the cost of SIS but the Human Services Department (HSD) held the contract. This year, the DOH will hold the contract, she said, so there really is no increase in the funding. The DOH will continue to use the SIS as required under New Mexico's developmental disabilities (DD) waiver with the Centers for Medicare and Medicaid Services (CMS), Ms. Stevenson said.

Jackson lawsuit expenses. An additional \$4 million is being budgeted by the DOH in FY 2015 for compliance with the long-standing *Jackson* lawsuit, from which the department is striving to disengage, Ms. Esquibel said. The additional funding is needed to cover increased costs in attorney fees, contractual services and personnel. While many DOH staff members work on different aspects of *Jackson* compliance, the department is proposing to add full-time

personnel to coordinate the effort, Ms. Stevenson said. If disengagement is successful in July, the full \$4 million may not need to be expended.

Supplemental Nutrition Assistance Program (SNAP) cuts. A member of the subcommittee asked Ms. Esquibel if the state had any plans to supplement SNAP funding due to cuts in the program at the federal level. There is no additional state funding budgeted for SNAP, Ms. Esquibel said. A discussion followed among several members about the consequences of the cuts — a \$36.00-a-month reduction of SNAP benefits for a family for four — and what one member described as an apparent lack of concern about the many children who go to school hungry.

Centennial Care for DD Waiver Recipients and Those on the Waiting List

Julie Weinberg, director of the Medical Assistance Division, HSD, provided a PowerPoint presentation (see handout) for the subcommittee. Centennial Care begins operation, along with Medicaid expansion, on January 1 and incorporates four managed care organizations (MCOs): Blue Cross Blue Shield, Molina Healthcare of New Mexico, Presbyterian Health Plan and United Healthcare Community Plan of New Mexico.

Centennial Care is designed to integrate physical health, long-term care services and supports and behavioral health services into a comprehensive care delivery system, Ms. Weinberg said. MCOs are required to conduct a health risk assessment for each member, which helps identify candidates for care coordination; level 1 provides some monitoring, level 2 provides significant coordination and level 3 provides the most intensive level of care coordination. Members in level 2 and level 3 will receive a comprehensive needs assessment to determine needs for physical and behavioral health, long-term care and disease management; following such assessments, a comprehensive care plan will be developed. During the assessments, a care coordinator may recognize the need for a nursing facility level of care (NFLOC) assessment, and people who meet a NFLOC standard are eligible for the community benefit (CB). The CB, Ms. Weinberg said, is a package of long-term services and supports (LTSS) that helps people remain in their community; included services are for personal care, adult day health, respite and environmental modifications. The cost per individual of CB services cannot exceed the cost of nursing home care.

Currently, Ms. Weinberg said, only persons who have a coordination of long-term services (CoLTS) "c" waiver get the full LTSS benefit package; there are approximately 900 individuals still on the CoLTS waiting list. Under Centennial Care, anyone who is Medicaid-eligible and meets NFLOC requirements will have access to the CB, opening up more CB slots in Centennial Care for people who are not otherwise Medicaid-eligible. Members may choose to receive CB services through an agency or they may self-direct their care, Ms. Weinberg said. Persons on the DD waiver will receive care coordination through their Centennial Care MCOs, which will be responsible for health care services. Persons on the DD waiver will continue to receive their services through the fee-for-service system, and the Centennial Care MCOs will not be responsible for DD waiver services. Individuals on the medically fragile (MF) waiver will

continue to receive their waiver services through June 2015; on July 1, 2015, the MF waiver will transfer to Centennial Care.

Questions/Concerns

Subcommittee members had questions for the presenters in the following categories.

Centennial Care and disabled populations. Persons on the waiting list for the CoLTS waiver (approximately 900) and who are Medicaid-eligible and meet the NFLOC requirements are immediately eligible for the CB, as are those in intermediate-care facilities, Ms. Weinberg reiterated. The HSD will then take a much closer look at who is on the CoLTS waiting list, since many spaces for those who do not qualify for Medicaid now will be opened up. CB services are nearly identical to "c" waiver services. Annual assessment of an individual or renewal of a care plan will be done through Centennial Care, Ms. Weinberg said, and these assessments are staggered so that there are no interruptions of service.

Although the MF waiver will be folded into Centennial Care in July 2015, the University of New Mexico (UNM) will continue to manage this group of fragile individuals, Ms. Weinberg said, referring members to page 26 of her handout for a clear description of what will happen to different disabled populations under Centennial Care. Asked by a member how Centennial Care will improve the quality of care, Ms. Weinberg said that through care coordination, there will be more people checking in on individuals, collecting information and establishing baselines, and it is expected that many "cracks" will be closed to achieve better outcomes. In the arena of behavioral health, Ms. Weinberg said, all previous services still will be available to individuals, in addition to several new ones, to provide community-based care.

Several subcommittee members expressed regret that many of New Mexico's behavioral health providers have been put out of business and thus are unable to be part of these changes.

Costs of Jackson compliance. A member noted that the DDS budget seeks to add 16 full-time-equivalent (FTE) employees for *Jackson* compliance and asked for further clarification. Ms. Stevenson described her staff as currently maximized. Five of the 16 will be additional investigators who are being put in place now, she said, but not just for *Jackson* compliance. There will be an additional FTE at each regional office, and several additional registered nurses, including one for individuals placed in nursing homes to determine whether they have been properly placed or would be better off in the community. The key attribute the court is looking for (before disengagement) is sustainability, Ms. Stevenson said. Another member asked about the funding allocated to the court-mandated compliance administrator Dr. Sue Gant. These funds will be used to employ her staff and for hiring expert consultants, Ms. Stevenson said.

Reversion of general funds intended to reduce the DD waiver waiting list. Ms. Stevenson provided subcommittee members with a written discussion (see handout) of factors affecting the FY 2013 projected reversion of \$4.3 million, as she said she promised at the October meeting of the subcommittee. Factors contributing to the reversion included a delay of entry into service of

new individuals, due to delayed approval by CMS of the state's new DD waiver amendment; allocation issues (more individuals left the DD waiver in FY 2013 than in previous years) that now will be able to be detected by the DOH's new ASPEN computer system; and the fact that more individuals selected the Mi Via waiver (Medicaid self-directed waiver), a less expensive option than the traditional DD waiver that saved more funding than had been anticipated.

Ms. Stevenson said that 465 individuals who have been on the waiting list will be moved into DD waiver services in FY 2014, 15 of those on an expedited basis. Asked how reversions can be avoided in the future, Ms. Stevenson said that the DOH needs to do a better job of bringing people into the program more quickly, and she pointed out that more FTEs (requested in the FY 2015 budget) will greatly enhance these efforts. Another member commented on the increasing popularity of the Mi Via waiver and encouraged the DOH to take steps to promote the program to the public — a win-win situation, since it also saves money for the state.

Senate Memorial 20 Final Report

Doris Husted, policy director for The ARC of New Mexico and co-chair of the Senate Memorial (SM) 20 task force, created as a subcommittee of the DOH Advisory Council on Quality, reported the group's findings to the subcommittee (see handout). The SM 20 task force was charged with determining what would be required to reduce the time frame between application and placement on a DD waiver to not more than three years by FY 2018. The task force was asked to examine what would be needed to accomplish this goal, including effective use of current programs and resources, and to determine critical components for success. The final report, presented today, is very important to families who are waiting for services and for agencies in terms of planning, Ms. Husted said. The composition of the task force was diverse, she said, and included individuals with developmental disabilities and their families, representatives from multiple state agencies, subject-matter experts from UNM, service providers, case managers and individuals from advocacy organizations (see Appendix B of the report for a complete list of participants). Senator Bill B. O'Neill and Representative Stephanie Garcia Richard also served on the task force.

The DDS Intake and Eligibility Bureau receives approximately 1,000 registrations for the DD waiver and other services each fiscal year, and of these, approximately 300 meet the qualifications and are approved, according to the executive summary of the task force report. In order to improve the waiting list time frame, the task force made the following recommendations:

- expand the DD home- and community-based Medicaid waiver. The rate of attrition and a reduction of the budgets of individuals currently on the DD waiver cannot begin to meet the needs of people waiting;
- increase the appeal of the Mi Via home- and community-based Medicaid waiver;
- improve intake, information, referral and community navigation; and
- expand and redesign the state general fund program into a flexible supports model.

Significant challenges must be overcome for the task force recommendations to be carried out, the executive summary concludes. Among the most difficult are the need for additional appropriations and infrastructure/work force gaps — there simply are not enough providers in the community, Ms. Husted concluded.

Ms. Stevenson praised task force members for their hard work and dedication, and for arriving at consensus through many diverse perspectives. She also presented subcommittee members with a memorandum detailing the DOH perspective (see handout) on task force recommendations.

Regarding expansion of the DD waiver, Ms. Stevenson said the three-year time frame for eliminating the waiting list — which would assume the addition of 3,900 to the DD waiver annually — is not a feasible approach, given the lack of system capacity to provide necessary services in a manner that assures quality and safety. Ms. Stevenson said that a more measured approach of adding 300 to 500 individuals to the system each fiscal year would reduce wait time and allow for successful expansion of the service system. Working with the legislature, Ms. Stevenson said that a more aggressive approach to waiver allocations already is in process, with 328 being moved off the waiting list into services in FY 2013 and 465 projected to be moved off the list and into services in FY 2014. The DOH agrees with the task force recommendation to increase the appeal of the Mi Via self-directed waiver through improved marketing and adding a peer-to-peer support program; also, the DOH agrees with the recommendation for improved intake, information and referral and community navigation systems. Regarding redesign of the state general fund program into a flexible supports model, Ms. Stevenson said the DOH has previous experience with successful alternatives to Medicaid waiver services, and the department would welcome the opportunity to develop a pilot program related to this recommendation.

Ms. Husted noted that other members of the SM 20 task force were in the audience, and she asked them to stand and be recognized for their efforts.

In response to questioning by a subcommittee member about the possibility of an increase in provider rates, Ms. Stevenson said that rates certainly are part of the discussion about increasing provider capacity, and the recommendation on rates is for further study.

Approval of Minutes

Upon a motion made and seconded, the minutes of the October 4, 2013 meeting were approved, with the caveat that Ms. Mathis would confirm with Ms. Stevenson a question about "financial need" being a requirement for DD waiver eligibility as discussed earlier in this meeting.

SM 102 Progress Report

Nancy Koenigsberg, legal director of Disability Rights New Mexico (DRNM), presented subcommittee members with a progress report and tentative recommendations (see handout) from the SM 102 task force, which has met six times since July 2013. Members include

representatives from the Office of Guardianship of the Developmental Disabilities Planning Council, DOH, HSD, National Alliance on Mental Illness New Mexico, Public Defender Department, Administrative Office of the District Attorneys, Administrative Office of the Courts, Office of the Attorney General, Albuquerque Police Department and Disability Rights New Mexico and a corporate guardian and an individual living with mental illness.

As described in the task force handout, a treatment guardian is a person temporarily appointed to make mental health treatment decisions for an individual who the court finds is not capable of providing informed consent. In 2012, there were 665 petitions filed for treatment guardians statewide. New Mexico has the highest rate in the country of adult mental illness admissions to hospital emergency rooms and the highest number of incarcerated individuals who are mentally ill. Ms. Koenigsberg said that jail has become the largest mental institution in the state. Over the past several years, it has become apparent that the system for treatment guardians (created in provisions of the New Mexico Mental Health and Developmental Disabilities Code) needs additional resources to develop a more uniform process statewide, enabling consumers to access appropriate treatment when needed, and decreasing incarceration and crisis/emergency room interactions. District attorneys throughout the state have become concerned, Ms. Koenigsberg said, because at times they have had to prosecute persons clearly in need of a treatment guardian, and district attorneys do not have mental health expertise and are uncomfortable in this role.

Recommendations being considered by the SM 102 task force include the following:

- increase numbers of qualified treatment guardians throughout the state and provide more public information about how to use the process;
- develop uniform forms and rules to improve efficiencies and consistency across the state. This issue is currently being addressed by the New Mexico Supreme Court Ad Hoc Rules Committee for Mental Health Proceedings;
- develop standardized training for treatment guardians and education for judges, lawyers, clinicians and family members and others to ensure a consistent process throughout the state;
- promote more widespread use of psychiatric advance directives through increased outreach to consumers, families, clinicians and other key stakeholders;
- recommend legislation for the upcoming session to authorize the Office of the Attorney General to represent the state at petition hearings for treatment guardians through the use of special commissioned attorneys contracted to the Office of Guardianship;
- increase the \$200 stipend to treatment guardians for each individual represented and undertake a study to determine appropriate compensation in the future;
- develop links between treatment guardians, discharge planners and MCO care coordinators for better outcomes for consumers returning to the community; and
- improve data collection and reporting.

Ms. Koenigsberg said the task force also explored a number of ways in which the success of implementing these recommendations could be measured.

Not everyone who needs a treatment guardian is on Medicaid, Ms. Koenigsberg said, but most individuals who do need a treatment guardian are single adults and may qualify for the Medicaid expansion, so the possibility of care coordination may be better now than ever before.

Questions/Concerns

John Block III, executive director of the Developmental Disabilities Planning Council (DDPC) and a SM 102 task force member, was asked by a subcommittee member about previous reports to their group that treatment guardians were not getting paid. Mr. Block said he looked into this assertion and found that it was true; there are many prior-year payments that have not been made — \$250,000 — but the council cannot use its current year's budget for a prior year's payments. Mr. Block said he reported this problem to the Department of Finance and Administration and to the LFC and he has asked for waivers. Hopefully, by the end of the business day today, he said, the DDPC will have the authority to make those payments and will issue checks by the end of the week.

Another member asked when the task force report will be finalized. Ms. Koenigsberg said the task force intends for it to be complete in time for the upcoming legislative session. For two of the recommendations — 1) taking the district attorney out and putting the attorney general in; and 2) the request for additional funding to pay for specially commissioned attorneys general in the community — the task force is seeking this subcommittee's endorsement, she said. In response to a member's question about choosing a treatment guardian, Gabrielle Sanchez-Sandoval, general counsel at the DOH, said that a family member is looked at first, but often this population does not have that person available.

Grace Phillips, attorney and task force representative from the New Mexico Association of Counties, said the Bernalillo County Metropolitan Detention Center has the most robust program for the use of treatment guardians, but many administrators in the state do not know how to go about accessing the treatment guardian program and could use more education about the process.

State Use Act Report

Pamela June, executive director of Horizons of New Mexico, described the work of her nonprofit organization on behalf of the New Mexico Council for Purchasing from Persons with Disabilities. The State Use Act, enacted in New Mexico in 1978, expands employment opportunities for people with disabilities, Ms. June said. Currently, Horizons holds contracts valued at over \$2 million for businesses employing more than 900 persons. The State Use Act increases the amount of taxes paid to government while decreasing the amount required to be paid out in benefits, she said. There are now 23 other states that have a state use act.

Ms. June conducted a PowerPoint presentation (see handout) for the subcommittee highlighting five businesses currently under contract. Representatives of those businesses joined her for the presentation, including Henri Grau of Henri Grau Design and Photography; John A. Bishop, Jr., and Ellen Driber-Hassall of Aging Matters, LLC; Ruben Navarro of Galactic Network Integrators; Robert Rayner, architect with R2 Architectural Design & Consulting, LLC; and Cody Unser of the Cody Unser First Step Foundation.

In response to a question about requirements for an employer, Ms. June confirmed that the owner must have a significant disability, and 70 percent of direct labor must be performed by disabled individuals who all must be paid at least minimum wage. At least 51 percent of the business must be owned by the disabled person, Ms. June said. The businesses are fully integrated, with the disabled working alongside individuals who have no disabilities. "Disabled" is defined by Social Security, a physician or the Veterans Administration, and there are many pages of qualifiers as to what is considered "disabled". Ms. June said she would be happy to provide copies of the required paperwork to the subcommittee.

Public Comment

Tim Carver, chief financial officer of San Juan Center for Independence in Farmington (SJCI), noted that vocational rehabilitation funding in New Mexico has been cut by 17 percent, and he urged that Centennial Care be directed to "get the consumer back in with the personal care option". The SJCI is one of five independent living centers in New Mexico; the centers are non-residential, consumer-controlled and disability-focused programs that assist individuals to live independently in their communities.

Jim Jackson, executive director of DRNM, said he wanted to address three separate issues discussed in today's meeting: 1) regarding the SM 20 task force and the waiting list for the DD waiver, Mr. Jackson said he found it troubling that the DOH has led this task force and yet has requested zero dollars for the waiting list in its new budget. He would like to look at more creative ways to keep dollars meant to get individuals onto the waiver from reverting back to the general fund; 2) in response to the use of the SIS, some individuals are experiencing a reduction of therapy services, Mr. Jackson said, and he has concerns about their due process; and 3) regarding the State Use Act, Mr. Jackson said that he was surprised there was not more data in the report presented today and that he has some concerns about the program and the fact that businesses are required by law to contract with these disabled providers. He said he is not sure this is the best way to do integrated employment. Mr. Jackson told members that two years ago, the Governor's Commission on Disability convened a task force to address issues with the State Use Act, and he could provide a copy of its recommendations to the subcommittee.

James Stevens described an accident that occurred in New Mexico three years ago in which he was a passenger in a vehicle that was hit by a truck driven by a worker for Comcast who lived in Colorado but was uninsured. Mr. Stevens said he tried to get the sheriff to write up the driver for lack of insurance, but to no avail. "How can Comcast hire someone from out-of-state who does not have insurance? Where is the justice?", he asked. Mr. Stevens is seeking

\$3,000 to cover his medical bills, but cannot get help from anyone at the state level; he says he has been to the Public Regulation Commission, the Office of Governor and the Insurance Division and no one will help him.

Anna Otero-Hatanaka, executive director of the Association for Developmental Disabilities Community Providers (ADDCCP), spoke about the importance of the FIT Program, which has a \$4 million deficit this year, the same as last year, she said. The FIT Program is losing staff because there has been no rate increase for providers for 12 years. Ms. Otero-Hatanaka also spoke about guardianship for the developmentally disabled, which is given for life. In fact, DD individuals may not need a guardianship for their entire lives, she said; the point of many therapy services is to help them become independent. Ms. Otero-Hatanaka said she feels the State Use Act is a very important program to provide employment opportunities for the disabled, and especially for returning veterans of the wars in Iraq and Afghanistan. She was asked by a member about recent changes to the FIT Program, which now ends on the child's third birthday. If the child qualifies, some can get continued help through the public schools, but there are many in the at-risk category who do not qualify, the member said. It was noted by other members that \$5.1 million has been budgeted for the program in FY 2015.

Robert Kegel, who has a developmentally disabled adult son, is highly critical of the state's use of SIS assessments and has done considerable research on the topic. Mr. Kegel presented a detailed critique of changes to DD waiver services based on the SIS, asserting that Down syndrome individuals are being unfairly targeted by the SIS for reductions in services. Mr. Kegel presented members with a copy of public comments and responses to the rate-setting project prepared by Burns & Associates, Inc., of Phoenix (see handout). There is a disparity between rural and urban in the rate study, he said, with rates favoring large urban providers. Savings are being effected by reducing employment and knocking down the family living budgets, Mr. Kegel said. Out-of-state assessors are being used to conduct SIS evaluations, and this year, \$4.6 million is being budgeted for this, but no one knows what is in this contract, he asserted.

In response to questions from subcommittee members, Mr. Kegel said he had spoken to the CMS about his concerns. The CMS has referred him to the Office of Civil Rights, and he is now preparing a report for that office. Ms. Stevenson, who stayed at the meeting through the public comment process, told members that she would like to submit a formal written document in response to Mr. Kegel's presentation. She also wants to present written information to the subcommittee on the number of SIS reassessments that have been conducted to date. A member noted that some consumers have been discouraged from appealing their SIS scores, because the second score will prevail regardless. Ms. Stevenson said that the SIS score can be appealed through a fair hearing and that she stands behind the SIS as an effective tool. Another subcommittee member, who has a disabled adult son, disagreed, stating that she had felt bullied during her son's SIS evaluation and that it was not a strong enough tool to decide someone's future. Mr. Jackson commented that DRNM, just in this past week, has sent out a fair hearing form to recipients of SIS assessments.

Mr. Kegel assured subcommittee members that he has no agenda except to improve the lives of New Mexico's developmentally disabled.

Adjournment

There being no further business, the meeting adjourned at 5:00 p.m.

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ENDORSED LEGISLATION

last updated: 01/03/2014

Legislation for the 2014 Regular Legislative Session, Endorsed by the Legislative Health and Human Services Committee

202#	Title	Content	Sponsor
1	194519.1 DD waiting list	5-yr plan to decrease DD central registry wait	Soules
2	194634.4 Jaden's Way	requesting policy to serve children with high needs	Torraco
3	194655.2 health care procurement	guidelines for health care procurement contracts	Keller
4	194686.4 brain injury services	amend Insurance Code to require brain injury coverage	Keller
5	194697.1 Medicaid disability	oversight of Medicaid disability svc	Keller
6	194749.1 inmate services	inmate BH services to reduce recidivism	Madalena
7	194751.2 PBM regulation	establishing guidelines for pharmacy benefits mgrs	Espinoza
8	194845.1 health councils	\$900k for community needs assess. by health councils	Tripp
9	194846.1 work force	health care work force task force	Candelaria
10	194878.4 heart disease screening	heart disease screening for newborn	Espinoza
11	194985.3 dental therapy	creating dental therapy-hygiene practice	Roch
12	194989.1 school meals	HJM: donate excess school meals	Gallegos, David
13	194992.1 dental therapy	creating dental therapy-hygiene practice	Shendo
14	194994.2 NA Medicaid opt-in	Native Americans not in MCO Medicaid unless opting	Madalena
15	195015.2 brain injury defined	brain injury fund to serve all types brain injury	Trujillo
16	195099.1 pharm. board	board of pharmacy — change composition	Sapien
17	195175.1 SUIDS	SM: sudden unexpected infant death task force	Ortiz y Pino
18	195196.2 AA infant mortality	African American infant mortality & maternal health care pilot	Ortiz y Pino
19	195215.3 early child health	reconvene J Paul Taylor TF on early child mental health	Ortiz y Pino
20	195216.2 ACE screening	infant mental health provider credentialing; approp.	Ortiz y Pino
21	195217.2 maternal/child committees	maternal & child infant health committees @ health councils	Ortiz y Pino
22	195269.1 health cost commission	const. amend indep. health cost & quality transp. commn	Keller
23	195328.2 HIX voter reg	require exchange to provide voter registration	Candelaria
24	195330.1 DD general fund	\$2.65 million for DD general fund provider reimb.	Hall
25	195349.2 commy. health spec.	HM: task force to study new health role	Garcia
26	195377.7 emergency meds in schools	allow lay administration of emergency medications	McSorley
27	195378.2 at-risk services	amend Home Visiting Accountability Act to prioritize at-risk children	Ortiz y Pino
28	195379.2 infant mental health	no credentialing of infant providers; appropriation	Ortiz y Pino
29	195404.1 credible allegation of fraud	procedural requirements for Medicaid fraud allegation	Papen
30	195409.2 emergency meds requirements	compliance on emergency meds in schools	Smith, James