LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

2014 INTERIM FINAL REPORT

New Mexico Legislative Council Service
Santa Fe, New Mexico
January 2015

2014 INTERIM REPORT
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
INCLUDING
THE DISABILITIES CONCERNS SUBCOMMITTEE AND
THE BEHAVIORAL HEALTH SUBCOMMITTEE

CONTENTS

EXECUTIVE SUMMARY

LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
2014 SUMMARY

Appointments — Meetings

The New Mexico Legislative Council reappointed Representative James Roger Madalena as chair and Senator Gerald Ortiz y Pino as vice chair of the Legislative Health and Human Services Committee (LHHS) for the 2014 interim. Representative Doreen Y. Gallegos was appointed chair, and Senator Nancy Rodriguez was appointed vice chair, of the Disabilities Concerns Subcommittee.

The New Mexico Legislative Council elected to re-create for the 2014 interim the Behavioral Health Subcommittee, appointing Representative Elizabeth "Liz" Thomson as chair and Senator Benny Shendo, Jr., as vice chair.

The LHHS held meetings in Albuquerque, Elephant Butte, Las Cruces, the Pueblo of Santa Clara, the Pueblo of Taos, Santa Fe and Silver City this interim.

Committee Review

Children and Families

The well-being of children and families was under review by the LHHS throughout this interim. The committee heard testimony from the Children, Youth and Families Department (CYFD) and local and national experts on children's health care and children's services related to state intervention in abuse and neglect cases, including evidence-based intervention, foster care rules, child trauma treatment, obesity and psychotropic medications. At two meetings, in Las Cruces and in Santa Fe, the LHHS heard recommendations from state government and community stakeholders related to changing the statutory and programmatic structure for the state's substitute care review system. The LHHS held hearings about CYFD rulemaking related to child care center reimbursement and accreditation. It heard recommendations from the J. Paul Taylor Early Childhood Task Force on children's well-being statewide, from a group of grandparents raising grandchildren and from experts on child obesity. The LHHS also heard recommendations from experts and stakeholders relating to workplace accommodations for pregnancy and parental leave.

Medical Assistance

The LHHS held several hearings related to the state's Medicaid program and the first months of the implementation of a new Medicaid waiver program called Centennial Care. These included testimony relating to care coordination, Native American services and enrollment, long-term care, nursing facility reimbursement, a pediatric dental services pilot proposal and enrollment of individuals who have been incarcerated. The LHHS heard testimony from the Human Services Department (HSD), its contractors and public assistance stakeholders, experts and advocates. Matters relating to the HSD's referral of behavioral health provider agencies for investigation and possible prosecution for credible allegations of fraud were an ongoing discussion before the LHHS this interim.

The committee also heard an update relating to federally and state-sponsored coverage under the Basic Health Program authorized under the federal Patient Protection and Affordable Care Act.

Human Services

The LHHS heard testimony from the HSD, experts and stakeholders on proposed changes to the state's Supplemental Nutrition Assistance Program, also known as "SNAP" and formerly known as "Food Stamps". The proposed changes would add greater participation requirements for work and training programming through SNAP.

A hearing on the Temporary Assistance for Needy Families (TANF) Program included testimony from advocates and the HSD about TANF enrollment and work and training program changes.

The Human Trafficking Task Force provided testimony pursuant to 2014's House Memorial 16, which called for a study of the services needed for victims of human trafficking — recently classified as a felony in New Mexico — especially for minors who are being exploited.

Corrections and Justice Joint Meeting

The LHHS held a joint meeting with the Courts, Corrections and Justice Committee in Albuquerque in August. The Corrections Department, the HSD, experts and stakeholders appeared before the LHHS to discuss health care and human services provided to incarcerated New Mexicans. They provided testimony related to health care access, quality and cost-effectiveness and human services aimed at preventing and addressing prison rape under the federal Prison Rape Elimination Act of 2003. As noted above, the LHHS continued its ongoing discussion relating to getting inmates access to Medicaid services through enrollment suspension or enrollment upon release.

Health Care Infrastructure

The HSD, the New Mexico Hospital Association and the New Mexico Association of Counties provided testimony relating to the first months of implementation of the "safety net care pool", a new funding system that replaces the former federal Medicaid sole community provider funding. The safety net care pool allows the state to use county assessments to match federal dollars for funding indigent care statewide.

The Health Care Work Force Working Group provided testimony and recommendations for addressing the state's health care work force shortage, including some best practices in the field for recruiting and retaining health care professionals.

The committee also heard testimony about facilities and infrastructure in Sierra County, as well as testimony about a Las Cruces clinic's health care integration model.

Health care experts and staff testified about the policy implications of health facilities' work to promote advance care planning to ensure that patients are accorded the care they want even if they are later incapacitated.

The Department of Health provided testimony relating to the state's ability to respond to a public health crisis, such as the Ebola outbreak occurring in West Africa.

The LHHS held further hearings on the feasibility of creating a liver transplant facility in the state.

Representatives from the state's chiropractic physician community provided testimony both in favor of and against scope of practice changes proposed for their profession.

The committee also heard testimony about the use of nurse advice lines among New Mexico health insurance carriers and medical assistance programs, with recommendations for ensuring the viability of a local nurse advice line.

Health Care Coverage

The New Mexico Health Insurance Exchange provided updates on exchange enrollment, policy changes, administration and funding at most of the LHHS's meetings this interim. This included testimony by board members and by the new chief executive officer, Amy Dowd, as well as the former acting chief executive officer, Mike Nunez.

The committee also heard from the superintendent of insurance and his staff as well as experts and stakeholders on matters relating to health coverage enrollment and affordability and provider network adequacy.

The committee held a hearing with respect to managed health care credentialing of health care providers, including a legislative proposal to mandate faster credentialing procedures.

The Interagency Benefits Advisory Committee, made up of the Risk Management Division of the General Services Department, Albuquerque Public Schools, the Retiree Health Care Authority and the Public School Insurance Authority, provided an update to the committee on the committee's mission to consolidate health care purchasing wherever feasible and cost-effective.

Behavioral Health

The LHHS heard testimony from tribal officials, the HSD, advocates and stakeholders on the provision of behavioral health services to Native Americans in the state. It held a hearing on incarceration diversion for individuals living with mental illness and substance use disorders. The committee also heard from experts about assisted outpatient treatment programming and the prescribing of psychotropic medications to foster children.

The Behavioral Health Subcommittee met in Albuquerque, Española, Gallup and Silver City this interim. Throughout the interim, it worked to gauge the impact of the transition of most of the state's behavioral health services to new Arizona providers by seeking information from stakeholders from communities throughout the state and from the HSD. A working group convened by the subcommittee identified seven strategic and long-term initiatives to expand and improve consumer access to behavioral health services that included: supportive housing; the establishment of a behavioral health information clearinghouse; expansion of school-based health clinics; the University of New Mexico's Project ECHO's behavioral health training for rural clinics; FOCUS/Milagro work with addicted mothers and infants; increased psychiatric nurse slots at New Mexico State University; and supplemental funding for an adolescent transitional living and recovery center. Appropriations for these proposals were endorsed by the LHHS.

Disabilities Concerns Subcommittee

Focus on the Developmental Disabilities Waiver Program and the use of the Supports Intensity Scale to evaluate the needs of waiver recipients continued in 2014. The subcommittee met in Las Cruces and Santa Fe and appeared at the Southwest Conference on Disabilities in Albuquerque this interim. It heard testimony from numerous service providers from throughout the state raising issues related to the impact that historically low reimbursement rates have had on their ability to retain and attract staff and to continue services. Service providers also reported that, despite the 2014 passage of appropriations to fund small rate increases as of July 1, 2014, technology system problems continued to delay rate increases.

WORK PLAN AND MEETING SCHEDULE

Revised: June 25, 2014

2014 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. 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
Rep. Vickie Perea
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Edward C. Sandoval
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

Work Plan

The Legislative Health and Human Services Committee (LHHS) was established pursuant to Section 2-13-1 NMSA 1978. It is charged with undertaking a continuing study of the programs, agencies, policies, issues and needs relating to health and human services in the state. The topics that the LHHS will cover during the 2014 interim are as follows.

Human Services Department

Medicaid/Centennial Care — The new Centennial Care program approved by the federal Centers for Medicare and Medicaid Services has begun implementation as of January 1, 2014. The LHHS will hear testimony from the Human Services Department (HSD), local and national experts, consumers and advocates for consumers on the transition from the previous Medicaid system that had separate programs for children and families, disabled individuals and behavioral health coverage to a system that integrates physical health, behavioral health and long-term care coverage — with the exception of developmental disability supports and services.

The LHHS will examine the effects that the expansion in Medicaid eligibility, alongside the Centennial Care changes, changes in hospital reimbursement and ongoing Medicaid fraud allegations and investigations, are having on Medicaid recipients, providers and the state at large.

The LHHS will also hear testimony related to the program of all-inclusive care for the elderly or "PACE", which is currently offered only to those Medicaid long-term service

recipients living in Albuquerque. The LHHS will examine the possibilities for extending PACE's availability to Medicaid long-term service recipients statewide.

The LHHS will track developments and hear status updates on Medicaid fraud allegations and hear testimony from the HSD, the New Mexico attorney general and other agencies, local providers, consumers, advocates and experts as well as information from other states that are facing similar situations.

Income Support Division — The LHHS will hear testimony from the HSD and its Income Support Division (ISD), applicants and recipients for public benefits administered by the ISD and advocates and experts relating to matters under the ISD's administration. These include findings by federal oversight agencies and allegations by applicants, recipients and advocates about problems experienced in application processing, eligibility determinations, training and employment programs and erroneous disenrollments from programs.

The LHHS will also hear testimony relating to recent changes in eligibility and participation guidelines for the Temporary Assistance for Needy Families (TANF) cash and medical assistance program, which are reportedly leading to a significant reduction in TANF rolls and are affecting the performance of TANF contractors.

Children and Families

The LHHS will make child and family welfare a major focus this interim. At its May 23, 2014 organizational meeting, the committee heard testimony from the Legislative Finance Committee on its investigations into an evidence-based program to reduce child maltreatment and its program review of the Children, Youth and Families Department (CYFD). This review will hear testimony related to the effect that adverse childhood events have on future outcomes for individuals, families and the state.

The LHHS will also review the CYFD's and other agencies' and institutions' work to improve protective services and increase retention, staff training and the foster care system and supports. This review will include receiving a report pursuant to Senate Joint Memorial 3 from the 2014 regular session, which is expected to include detailed information on protective services and foster care. The LHHS will also review supports necessary to have fully functioning citizen review boards.

The LHHS will hear testimony on the risk factors, status, supports and services for homeless children in the state.

The LHHS will examine the prevalence and causes of hunger among New Mexico children and families in light of recent Supplemental Nutrition Assistance Program cuts and other factors that have contributed to New Mexico children being rated as facing the greatest hunger in the United States, according to a recent study.

The committee will hear testimony on the issue of obesity, obesity interventions and malnutrition.

The LHHS will also hear reporting pursuant to House Memorial 16 from the 2014 regular session on services for sexually exploited minors; a study on African American maternal and infant health; the continued work of the J. Paul Taylor Early Childhood Task Force; and grandparents as care givers.

Health Coverage

Two major health coverage provisions of federal law have been implemented in recent months: the New Mexico Health Insurance Exchange (NMHIX) began its initial operations in October 2013, and the state's Medicaid program has expanded its eligibility to all previously ineligible adults with incomes below 138% of the federal modified adjusted gross income. The LHHS will examine the effects of increased Medicaid enrollment and enrollment in qualified health plans on the NMHIX. The LHHS will hear reports pursuant to requests for health care coverage data from the NMHIX, Medicaid and the Office of Superintendent of Insurance. The LHHS will hear generally about the operations of the NMHIX in its first year and the transition to a wholly state-operated exchange from a partially federally operated exchange as of October 2014. Related issues that the LHHS will review include the effect of coverage expansions on the Indian Health Service and tribal health programs and the future of the federal and state high-risk health insurance pools as well as related premium taxation.

The LHHS will hear testimony from experts, state agencies and advocates on a Basic Health Program option available pursuant to federal law to cover individuals greater than the Medicaid eligibility maximum.

The LHHS will also hear testimony on the status of health insurance premiums and other health insurance market information from experts, including the Office of Superintendent of Insurance.

The LHHS will hear the Legislative Finance Committee's recent report on the Interagency Benefits Advisory Committee and the state's health care purchasing through its constituent agencies.

Joint Meeting with the Courts, Corrections and Justice Committee (CCJ)

Due to the overlapping concerns of the LHHS and the CCJ relating to several matters, the LHHS will hold a joint meeting with the CCJ to hear testimony on behavioral health treatment; the availability of behavioral health treatment for both mental illness and substance dependence; Medicaid for individuals released from custody; and corrections health care, including the Corrections Department's contracts for medical laboratory services.

Health Care Work Force

The LHHS will hear the report of the working group convened pursuant to Senate Joint Memorial 6 from the 2014 regular session requesting that an interdisciplinary working group on the state's health care work force needs and existing infrastructure be convened by the University of New Mexico Health Sciences Center. The LHHS will also hear the reports of working groups created pursuant to legislative memorials relating to other health professional communities. This will include testimony about three states that have enacted legislation to create the profession of "dental therapist". The committee will also hear testimony on the effect that managed care organization provider credentialing practices have on the state's work force; on Department of Health staff compensation policies; and on a proposal to create the profession of community health specialist using personnel with health professional licensure from other jurisdictions.

Public Health/Health Infrastructure

The LHHS will hear testimony on the status of hospitals statewide in the wake of changes in Medicaid and other federal and state reimbursement, including changes in hospital funding approved by the legislature during the 2014 regular session.

The LHHS will hear from the Department of Health, which administers the state's medical cannabis program, and from medical cannabis producers, potential producers, users and advocates on production quotas, provider selection criteria and the availability of medical cannabis.

The committee will hear testimony on advance health care planning, including the practice of some health care providers to assist patients in making their wishes known through advance directives. The committee will also continue its examination into end-of-life choices, including aid in dying and the Oregon death-with-dignity model.

Pursuant to 2013's House Memorial 48, there has been a research study performed by experts on the feasibility of creating a liver transplant facility in the state. The LHHS will hear the recently issued final report on this issue.

The committee will hear testimony on brain injury. House Memorial 9, which passed during the 2014 regular session, requests the Brain Injury Advisory Council to study the effects of concussions on athletes and veterans statewide. The LHHS will hear the council's report pursuant to this study. The committee will also hear presentations on traumatic brain injury and sports-related brain injury, including traumatic brain injury inflicted during military service or through substance use. Among the programs that the committee will review are the University of New Mexico's "Brain Safe Project" and similar programs nationwide that make pre-injury and post-injury assessments of sports-related injuries.

The committee will hear testimony on programs to decrease the effects and incidence of sexual assault in the state, including sexual assault that occurs in correctional facilities.

Health, aging and disability experts from a variety of camps have identified a lack of transportation for individuals seeking access to medical services as a major challenge to individuals' health and independence. For some individuals, such as new dialysis patients, adequate and reliable transportation can mean the difference between surviving and not surviving their first difficult months on dialysis. Individuals in Native American communities and rural New Mexico who have been enrolled in health coverage due to increased access to coverage may not be able to access health care due to a lack of transportation. The LHHS will examine possible solutions to these unmet transportation needs.

Behavioral Health

The LHHS' Behavioral Health Subcommittee was created by the New Mexico Legislative Council at its May 5, 2014 meeting and charged with conducting a study of behavioral health programs and services in the state during the 2014 interim. The Behavioral Health Subcommittee will focus on the current state of the state's behavioral health system; substance use and abuse; adolescent and school-based behavioral health; violence as a public health issue; the role of law enforcement and corrections in addressing behavioral health needs of inmates and detainees; strategies to reduce hospitalization and incarceration of persons who suffer from mental illness; funding challenges; and local programs.

The LHHS will hear testimony from experts, state agency officials and staff and stakeholders on safety concerns for individuals with mental illnesses living in the community in housing situations often called "boarding homes", where conditions might be substandard and where these mentally ill individuals might be subject to unsafe conditions, exploitation or abuse.

The subcommittee will also focus on developing a long-term and realistic strategic plan to reach needed behavioral health service capacity in five years.

Disabilities

The Disabilities Concerns Subcommittee of the LHHS was created in 2010 pursuant to Section 2-13-3.1 NMSA 1978 and is charged with a continuing study of the programs, agencies, policies, issues and needs relating to individuals with disabilities. The Disabilities Concerns Subcommittee will continue its review of the implementation of and services provided to eligible persons under the state's developmental disability waiver and under Centennial Care, the state's new Medicaid waiver program. The subcommittee will also hear testimony relating to autism spectrum disorder.

The Disabilities Concerns Subcommittee will hold one of its meetings during the 2014 Southwest Conference on Disability in Albuquerque.

Legislative Health and Human Services Committee
2014 Approved Meeting Schedule

Date	Location
July 17-18	Pueblo of Taos
August 5	Albuquerque &
August 6-7	Albuquerque — Joint Meeting with CCJ
September 10	Las Cruces &
September 11-12	Truth or Consequences
October 20	Pueblo of Santa Clara &
October 21-22	Santa Fe
November 24-25	Santa Fe
December 3-5	Santa Fe

Behavioral Health Subcommittee

Date	Location
July 24	Espanola
September 17	Silver City
October 8	Albuquerque
November 5	Gallup

Disabilities Concerns Subcommittee

Date	Location
August 15	Santa Fe
September 9	Las Cruces
October 9	Albuquerque — Southwest Disabilities Conference

LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE AGENDAS

Revised: May 19, 2014

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

May 23, 2014
State Capitol, Room 307
Santa Fe

Friday, May 23

9:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair
—Senator Gerald Ortiz y Pino, Vice Chair

9:40 a.m. (1) **Evidence-Based Interventions in Child Maltreatment; Foster Care**
—Yolanda Berumen-Deines, Secretary, Children, Youth and Families Department (CYFD)
—Jared Rounsville, Director, Protective Services Division, CYFD
—Charles Sallee, Deputy Director for Program Evaluation, Legislative Finance Committee (LFC)
—Jon Courtney, Program Evaluator, LFC

11:30 a.m. (2) **Public Comment**

12:00 noon **Lunch**

1:00 p.m. (3) **2014 Legislative Highlights**
—Michael Hely, Staff Attorney, LCS

2:00 p.m. (4) **Review and Adoption of Legislative Health and Human Services Committee Interim 2014 Work Plan and Meeting Schedule**
—Michael Hely, Staff Attorney, LCS

4:00 p.m. **Adjourn**

Revised: July 15, 2014

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

July 17-18, 2014
Pueblo of Taos, Community Center
220 Rotten Tree Road
Taos, New Mexico 87571

Thursday, July 17

9:30 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee (LHHS)
—Senator Gerald Ortiz y Pino, Vice Chair, LHHS

9:40 a.m. (1) **Welcome from the Governor of the Pueblo of Taos and the Director of Health and Community Services**
—The Honorable Clyde M. Romero, Governor, Pueblo of Taos
—Ezra Bayles, Director, Health and Community Services Department, Pueblo of Taos

10:00 a.m. (2) **Review of Legislation for the First Regular Session of the Fifty-Second Legislature**
—Michael Hely, Staff Attorney, Legislative Council Service

12:00 noon **Lunch**

1:00 p.m. (3) **Public Comment**

1:30 p.m. (4) **Concerns Regarding the Department of Health's (DOH's) Proposed Medical Cannabis Rules**
—Joel White, Vice President, New Mexico Medical Cannabis Patients' Alliance
—Emily Kaltenbach, State Director, Drug Policy Alliance
—Len Goodman, Chairman and Executive Director, NewMexiCann Natural Medicine

2:30 p.m. (5) **DOH: Proposed Rules Relating to the Medical Use of Cannabis**
—Brad McGrath, Chief Deputy Secretary, DOH

4:30 p.m. **Recess**

Friday, July 18

9:00 a.m. **Welcome and Introductions**

9:10 a.m. (6) **Advocates on the Human Services Department's (HSD's) Income Support Division and Public Benefits Case Management**
—Gail Evans, Esq., Legal Director, New Mexico Center on Law and Poverty (NMCLP)

9:40 a.m. (7) **Public Benefits Case Management Through the HSD's Income Support Division**
—Brent Earnest, Deputy Secretary, HSD

11:00 a.m. (8) **Public Comment**

12:00 noon **Lunch**

1:00 p.m. (9) **Concerns About Benefits Cuts, Enrollment and Work Force Education and Training Components of the Temporary Assistance for Needy Families (TANF) Program**
—Ruth Hoffman, Director, Lutheran Advocacy Ministry
—Susan Loubet, Executive Director, New Mexico Women's Agenda
—Sovereign Hager, Staff Attorney, NMCLP

1:30 p.m. (10) **Update on TANF Eligibility, Enrollment and Work Force Education and Training; Update on the Transition to Centennial Care Medicaid Waiver Program**
—Brent Earnest, Deputy Secretary, HSD

3:00 p.m. (11) **New Mexico Health Insurance Exchange**
—Jason Sandel, Member, Board of Directors, New Mexico Health Insurance Exchange

4:00 p.m. **Adjourn**

Revised: July 30, 2014

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

August 5, 2014
University of New Mexico
Albuquerque

Tuesday, August 5 — University of New Mexico Hospital: Pavilion Conference Room at the Barbara and Bill Richardson Pavilion, First Floor, Room #1500, 2211 Lomas Blvd. NE, Albuquerque

9:00 a.m. **Welcome and Introductions, Approval of July 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) **Welcome from the University of New Mexico (UNM)**
—Paul Roth, M.D., Chancellor, UNM Health Sciences Center (HSC)

9:30 a.m. (2) **Advocates and Child Care Providers on Proposed Child Care Reimbursement Rates**
—Joy Losey, President, New Mexico Child Care and Education Association
—Carmela Salinas, President, Early Educators United
—Ellen Gore, School Director, Guadalupe Montessori
—Raquel Roybal, OLÉ Working Parents Association

10:00 a.m. (3) **Child Care Providers and the Proposed Rules for Child Care Reimbursement**
—Yolanda Berumen-Deines, Secretary, Children, Youth and Families Department (CYFD)
—Steve Hendrix, Director, Early Childhood Services Division, CYFD

11:30 a.m. (4) **Public Comment**

12:00 noon **Lunch**

1:00 p.m. (5) **UNM Pain Management Center**
—Senator Michael Padilla
—Joanna G. Katzman, M.D., M.S.P.H., Director, UNM Pain Center; Associate Professor, UNM School of Medicine and College of Nursing

1:30 p.m. (6) **UNM Center of Excellence in Child Maltreatment and Abuse**
—Leslie Strickler, M.D., Associate Professor of Pediatrics, Medical Director, Child Abuse Response Team, UNM HSC

2:30 p.m. (7) **Brain Safe Program**
—Kent A. Kiehl, Ph.D., Executive Science Officer and Director of Mobile Brain Imaging; Professor of Psychology, Neuroscience and Law, UNM

3:30 p.m. (8) **New Mexico Health Insurance Exchange**
—J.R. Damron, M.D., Chair, Board of Directors, New Mexico Health Insurance Exchange
—Roxane Spruce Bly, Director of Health Care Education and Outreach, Native American Professional Parent Resources, Inc.

4:30 p.m. **Recess**

(please see August 6-7, 2014 joint LHHS and CCJ agenda, which is separately posted.)

Revised: August 4, 2014

TENTATIVE AGENDA
for the
JOINT MEETING
of the
COURTS, CORRECTIONS AND JUSTICE COMMITTEE
and the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

August 6-7, 2014
University of New Mexico School of Law, Lobby
1117 Stanford Dr. NE, Albuquerque

Wednesday, August 6

9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee (LHHS)
—Representative Gail Chasey, Co-Chair, Courts, Corrections and Justice Committee (CCJ)
—Senator Richard C. Martinez, Co-Chair, CCJ

9:30 a.m. (1) **Assisted Outpatient Treatment Panel**
—Brian Stettin, Policy Director, Treatment Advocacy Center
—Nancy Koenigsberg, Legal Director, Disability Rights New Mexico

10:30 a.m. (2) **Court-Supervised Outpatient Treatment**
—Oscar Kazen, Associate Judge, Bexar County Probate Court

11:30 a.m. (3) **Behavioral Health Panel**
—Nils A. Rosenbaum, M.D.
—Mauricio Tohen, M.D., Dr PH., M.B.A., Chair and Professor, Department of Psychiatry, University of New Mexico

12:30 p.m. (4) **Working Lunch: Review of Assisted Outpatient Treatment Legislation**
—Shawn Mathis, Staff Attorney, Legislative Council Service

1:30 p.m. (5) **Supportive Housing Panel**
—Dennis Plummer, Chief Executive Officer, Heading Home
—Jodie Jepson, Deputy Director, Heading Home
—Paula Harper, Executive Director, Supportive Housing Coalition of New Mexico
—John Ames, Director of Community Housing, Supportive Housing Coalition of New Mexico
—K.C. Quirk, Executive Director, Crossroads for Women
—Elizabeth Simpson, Bernalillo County

3:30 p.m. (6) **Substance Abuse Treatment and Rehabilitation Panel**
—Miriam Komaromy, M.D., Associate Director, Project ECHO, Associate Professor of Internal Medicine, University of New Mexico Health Sciences Center
—John J. Romero, Presiding Judge, Children's Court, Division VII, Juvenile Justice Center
—Jolene Schneider, Executive Director, Four Winds Recovery Center
—Jennifer Miller, Administrator, San Juan County Alternative Sentencing Division

4:30 p.m. (7) **Public Comment**

5:30 p.m. **Recess**

Thursday, August 7

9:00 a.m. **Welcome and Introductions**
—Senator Richard C. Martinez, Co-Chair, CCJ
—Representative Gail Chasey, Co-Chair, CCJ
—Representative James Roger Madalena, Chair, LHHS

9:15 a.m. (8) **Health Care for Inmates**
—Paul Wright, Director, Human Rights Defense Center
—Gabriel Eber, J.D., M.P.H., Staff Counsel, American Civil Liberties Union (ACLU)
—Joe W. Booker, Jr., Deputy Secretary of Operations, New Mexico Corrections Department (NMCD)

11:00 a.m. (9) **Remarks to the Joint Meeting**
—Maggie Hart Stebbins, Bernalillo County Commissioner, District 3

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

12:30 p.m. (10) **Criminal Justice and Behavioral Health: The Sequential Intercept Model**
—Dave Webster, M.A., L.I.S.W., L.C.S.W., Co-Clinical Director, St. Martin's Hospitality Center

1:30 p.m. (11) **Prison Rape Elimination Act — The Status of New Mexico's Compliance**
—Joe W. Booker, Jr., Deputy Secretary of Operations, NMCD
—Robert Mitchell, Deputy Director for Facilities, Juvenile Justice Services, Children, Youth and Families Department
—Art Murphy, Detention Specialist, New Mexico Association of Counties (NMAC)

—Manuel Romero, Detention Specialist, NMAC
—Steven Robert Allen, Director of Public Policy, ACLU of New Mexico
—Donna Richmond, Executive Director, La Piñon Sexual Assault Recovery Services of Southern New Mexico
—May Sagbakken, Rape Crisis Center of Central New Mexico

2:30 p.m. (12) **Medicaid and Inmates**
—Matthew Elwell, Director, Luna County Detention Center; Chair, Detention Administrators Affiliate, NMAC
—Harris Silver, M.D., Behavioral Health Services Advocate
—Joe W. Booker, Jr., Deputy Secretary of Operations, NMCD
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department

4:00 p.m. (13) **Public Comment**

4:30 p.m. **Adjourn**

Revised: September 8, 2014

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

September 10-12, 2014
Las Cruces
Elephant Butte

Wednesday, September 10 — Barbara Hubbard Room, New Mexico State University (NMSU), Las Cruces

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) **Burrell College of Osteopathic Medicine at NMSU**
—Garrey E. Carruthers, Ph.D., President, NMSU
—George Mychaskiw, D.O., Dean, Burrell College of Osteopathic Medicine

10:30 a.m. (2) **Child Trauma and Well-Being Core Group**
—Susan Robison, Director, State Relations, Public Policy, Casey Family Programs
—Nina Williams-Mbengue, Program Director, National Conference of State Legislatures
—Annamarie Luna, Program Deputy Director, Protective Services Division, Children, Youth and Families Department (CYFD)
—Daphne Rood-Hopkins, Director, Office of Community Outreach and Behavioral Health, CYFD
—Veronica Öhrn-Lännerholm, M.A., Clinical Services Manager, Behavioral Health Services Division, Human Services Department (HSD)
—Beth A. Collard, Child Welfare and Juvenile Justice Attorney, Administrative Office of the Courts

12:00 noon **Depart Barbara Hubbard Room (Legislators and Staff Only: NMSU Vehicles)**

12:10 p.m. **Arrive Rentfrow Hall: Human Performance Dance and Recreation: High Impact on Health and Human Development**

12:45 p.m. **Lunch**

1:15 p.m. **Depart**

1:25 p.m. **Arrive Barbara Hubbard Room**

1:30 p.m. (3) **Southwest Region National Child Protection Training Center (SRNCPTC)**
—Shelly A. Bucher, L.M.S.W., Director, SRNCPTC, NMSU
—Esther Devall, Certified Family Life Educator, Family and Consumer Sciences Department, College of Agricultural, Consumer and Environmental Sciences, NMSU

2:30 p.m. (4) **Citizen's Review Board Update**
—Shelly A. Bucher, L.M.S.W, Director, SRNCPTC, NMSU

3:00 p.m. (5) **Best Practices for Addressing Childhood Obesity**
—Carol W. Turner, Ph.D., R.D., L.D., Department of Family and Consumer Sciences, NMSU
—Patty Keane, M.S., R.D., Principal Investigator, Lecturer II, Associate Scientist II, Prevention Research Center, Department of Pediatrics, University of New Mexico
—Healthy Kids, Healthy Communities Update
—Patty Morris, Ph.D., Director, Obesity, Nutrition and Physical Activity Program, Department of Health (DOH)
—Dawn Sanchez, M.B.A., Manager, Health Promotion Team, Southwest Region, DOH

4:00 p.m. (6) **La Clinica de Familia (LCDF)**
—Suzan Martinez de Gonzales, Chief Executive Officer (CEO), LCDF
—Daniel E. Armistead, M.D., Chief Medical Officer, LCDF
—Eileen McKeen, Chief Financial Officer, LCDF

4:30 p.m. (7) **Public Comment**

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

Thursday, September 11 — Elephant Butte Lake Event Center, Elephant Butte

9:00 a.m. **Welcome and Introductions**
—James Roger Madalena, Chair, LHHS

9:10 a.m. (8) **Sole Community Provider Hospitals Funding**
—Brent Earnest, Deputy Secretary, HSD
—Steve Kopelman, Executive Director, New Mexico Association of Counties
—Jeff Dye, President and CEO, New Mexico Hospital Association

11:00 a.m. (9) **Public Comment**

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

12:30 p.m. (10) **Proposed Rule Changes to the Supplemental Nutrition Assistance Program (SNAP)/"Food Stamps" Work Requirements**
—Brent Earnest, Deputy Secretary, HSD
—Kathy Komoll, Director, New Mexico Association of Food Banks
—Ruth Hoffman, Director, Lutheran Advocacy Ministry
—Sovereign Hager, Staff Attorney, New Mexico Center on Law and Poverty
—Ed Bolen, J.D., Senior Policy Analyst, Center on Budget and Policy Priorities

2:00 p.m. (11) **New Mexico Health Insurance Marketplace Status Update**
—John Franchini, Superintendent of Insurance, Office of Superintendent of Insurance

3:30 p.m. (12) **Aging in Sierra County**
—Majorie "Majie" Powey, M.S., R.N., R.D., Sierra Joint Office on Aging

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

Friday, September 12 — Elephant Butte Lake Event Center, Elephant Butte

9:00 a.m. **Welcome and Introductions**
—James Roger Madalena, Chair, LHHS

9:10 a.m. (13) **New Mexico Health Insurance Exchange Update (NMHIX)**
—Jason Sandel, Vice Chair, Board of Directors, NMHIX
—Amy Dowd, CEO, NMHIX

10:00 a.m. (14) **Health Coverage Provider Network Adequacy**
—Paige Duhamel, Staff Attorney, Southwest Women's Law Center
—Claire McAndrew, M.P.H., Private Insurance Program Director, Families USA

11:30 a.m. (15) **Public Comment**

12:00 noon **Adjourn**

Revised: October 17, 2014

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

October 20, 2014
Santa Claran Hotel
Espanola

October 21-22, 2014
State Capitol, Room 307
Santa Fe

Monday, October 20 — Santa Claran Hotel, Seventh Floor, 460 N. Riverside Dr., Espanola

9:00 a.m. **Welcome and Introductions**
—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) **Welcome; Health and Human Services in the Pueblo of Santa Clara**
—J. Michael Chavarria, Governor, Pueblo of Santa Clara

10:00 a.m. (2) **Pueblo of Jemez Experiences with Medicaid Centennial Care**
—Maria K. Clark, Director, Health and Human Services Department, Pueblo of Jemez

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

12:30 p.m. (3) **Psychiatric Medication Oversight for Children in Foster Care**
—Krystal Goolsby, President, Leaders Uniting Voices Youth Advocates of New Mexico
—Thomas Mackie, Ph.D., M.P.H., Tufts Medical Center
—Jared Rounsville, Director, Protective Services Division (PSD), Children, Youth and Families Department (CYFD)

2:00 p.m. (4) **Senate Joint Memorial 14 (2014) Report: Grandparents Raising Grandchildren**
—Jared Rounsville, Director, PSD, CYFD

2:30 p.m. (5) **Grandparents Raising Grandchildren**
—Senator Richard C. Martinez
—Elizabeth McGrath, Esq., Executive Director, Pegasus Legal Services for Children
—Rex Davidson, Executive Director, Las Cumbres Community Services
—Erwin Rivera, Community Resource/Family Specialist, Engaging Latino Communities for Education (ENLACE)

3:30 p.m. (6) **Mental and Behavioral Health Programs and Services Available to Native Americans**
—Wayne Lindstrom, Ph.D., Director, Behavioral Health Services Division, Human Services Department (HSD)
—Dr. Arturo Gonzales, Ph.D., Executive Director, Sangre de Cristo Community Health Partnership; Implementation Director, Clinical and Partner Site Implementation and Sustainability, New Mexico Screening, Brief Intervention and Referral to Treatment (SBIRT) Program
—Leslie Dye, Chief Executive Officer, Santa Fe Indian Health Service Unit
—Keahi Kimo Souza, Behavioral Health Director, Jemez Health and Human Services Department

4:30 p.m. (7) **Public Comment**

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

Tuesday, October 21 — State Capitol, Room 307, 490 Old Santa Fe Trail, Santa Fe

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

9:10 a.m. (8) **Medicaid Centennial Care Long-Term Care: Home- and Community-Based Services; Community Benefit; Self-Directed Services; Independent Consumer Supports System; Care Coordination; Alternative Benefit Package**
—Julie Weinberg, Director, Medical Assistance Division, HSD
—Chuck Milligan, J.D., Senior Vice President for Enterprise Government Programs, Presbyterian Health Plan, Inc.
—TBD, Molina Healthcare
—Elly Rael, Vice President, Health Services Delivery, UnitedHealthcare Community Plan, New Mexico
—TBD, Blue Cross Blue Shield of New Mexico
—Jim Jackson, Executive Director, Disability Rights New Mexico
—Claire Dickson, Staff Attorney, Senior Citizens' Law Office

—Sandra Skaar, Owner and Director, Self-Directed Choices
—Ellen Pinnes, J.D., Disability Coalition
—Guy Surdi, Disability Specialist, Governor's Commission on Disability

11:30 a.m. (9) **Long-Term Services Consumer Panel**
—Consumer Panel

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

2:00 p.m. (10) **Program of All-Inclusive Care for the Elderly (PACE)**
—Beverley Dahan, Vice President of Government and Legislative Affairs, New Mexico PACE
—Irene San Roman, M.D., C.M.D., Medical Director, InnovAge Greater New Mexico PACE — Albuquerque Center

3:00 p.m. (11) **Nursing Home Reimbursement Rates**
—Linda Sechovec, Executive Director, New Mexico Health Care Association

4:00 p.m. (12) **Long-Term Services Provider Panel**
—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers

4:30 p.m. (13) **Public Comment**

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

Wednesday, October 22 — State Capitol, Room 307, 490 Old Santa Fe Trail, Santa Fe

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

9:10 a.m. (14) **Update: Medicaid Credible Allegations of Fraud**
—Knicole Emanuel, Attorney, Williams Mullen, Raleigh, North Carolina
—Jim Kerlin, Chief Executive Officer, The Counseling Center, Inc.
—Senator Mary Kay Papen
—Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)

11:00 a.m. (15) **Public Comment**

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

1:00 p.m. (16) **Medicaid Pediatric Dental Pilot Proposal**
—Michael Wallace, Manager, Government and Corporate Relations, Delta Dental of New Mexico, Inc.
—Rick Lantz, Manager, Government Relations, Delta Dental of Michigan, Ohio, and Indiana

2:00 p.m. (17) **Basic Health Program Update**
—Michael Hely, Staff Attorney, LCS

2:30 p.m. (18) **New Mexico Health Insurance Exchange (NMHIX) Update**
—Amy Dowd, Chief Executive Officer, NMHIX
—Roxane Spruce-Bly, Interim Chief Executive Officer, Native American Professional Parent Resources, Inc.

3:30 p.m. (19) **New Mexico's Readiness to Confront a Public Health Crisis**
—Gabrielle Sánchez-Sandoval, General Counsel, Department of Health (DOH)
—Michael Landen, M.D., M.P.H., State Epidemiologist, DOH
—Gregory Myers, Secretary, Homeland Security and Emergency Management Department (HSEMD)
—Anita Statman, Deputy Secretary, HSEMD

4:30 p.m. **Adjourn**

Revised: November 21, 2014

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

November 24-25, 2014
Room 307, State Capitol
Santa Fe

Monday, November 24

9:00 a.m. **Welcome and Introductions; Approval of September Minutes**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee (LHHS)

9:10 a.m. (1) **SJM 3 (2014): Children, Youth and Families Department (CYFD) Reporting**
—Jared Rounsville, Director, Protective Services Division, CYFD

10:00 a.m. (2) **J. Paul Taylor Task Force Report**
—Claudia Medina, Director, Community Health Initiatives, Office for Community Health, University of New Mexico (UNM) Health Sciences Center

11:00 a.m. (3) **SJM 6 (2014) Health Care Work Force Working Group Report; HM 12 (2014) Community Health Specialists**
—Richard S. Larson, M.D., Ph.D., Executive Vice Chancellor and Vice Chancellor for Research, UNM Health Sciences Center

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

1:30 p.m. (4) **Engaging Market Forces, Competition and Quality to Attract, Retain and Compensate Health Care Providers**
—Martin Hickey, M.D., Chief Executive Officer, New Mexico Health Connections

2:30 p.m. (5) **Sexuality and Gender Equity (SAGE) Health Project**
—Senator Jacob R. Candelaria
—James Padilla, Epidemiologist, Chronic Disease Prevention and Control Bureau, Department of Health (DOH)
—Shelley Mann-Lev, Director, SAGE Health Project
—Robert Sturm, Training Coordinator, SAGE Health Project; Executive Director, New Mexico Community AIDS Partnership

3:30 p.m. (6) **Chiropractic Physicians' Scopes of Practice**
—Adrian Velasquez, D.C.
—Brad Fackrell, D.C.

4:30 p.m. (7) **Public Comment**

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

Tuesday, November 25

9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS

9:10 a.m. (8) **Falls Task Force Report**
—Toby Rosenblatt, Bureau Chief, Injury and Health Epidemiology Bureau, DOH
—Janet Popp, Adult Falls Prevention Coalition, DOH

10:00 a.m. (9) **Liver Transplant Facility**
—Wayne Dunlap, Executive Director, New Mexico Donor Services
—Julio Sokolich, M.D.
—Laura J. Aguiar, Transplant Services Consultant (via telephone)
—Han Grewal, M.D., F.A.C.S., F.R.C.S., M.B.A., Transplant Surgeon (via telephone)

11:00 a.m. (10) **Supportive Services for Liver Transplant Patients**
—Brad McGrath, Deputy Secretary, DOH

12:00 noon **Lunch**

1:00 p.m. (11) **Legalization of Marijuana**
—Representative Bill McCamley

2:00 p.m. (12) **Health in All Policies**
—Marsha McMurray-Avila, Coordinator, Bernalillo County Community Health Council
—Jacque Garcia, Bernalillo County Place Matters
—Kristina St. Cyr, Doña Ana County Place Matters
—Jordon Johnson, McKinley Community Place Matters

3:00 p.m. (13) **Behavioral Health Boarding Homes Task Force Report**
—Jim Jackson, Executive Director, Disability Rights New Mexico (DRNM)
—Miguel Chavez, Senior Advocate, DRNM

4:30 p.m. (14) **Public Comment**

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

Revised: December 2, 2014

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

December 3-5, 2014
State Capitol, Room 307
Santa Fe

Wednesday, December 3

9:00 a.m. **Welcome and Introductions; Approval of Minutes**
—Representative James Roger Madalena, Chair, Legislative Health and Human Services Committee (LHHS)

9:10 a.m. (1) **Report on the Interagency Benefits Advisory Committee**
—Maria Griego, Program Evaluator, Legislative Finance Committee
—Anthony J. Forte, Director, Risk Management Division, General Services Department
—Vera Dallas, Director, Employee Benefits, Albuquerque Public Schools
—Mark Tyndall, Director, Retiree Health Care Authority
—Christy Edwards, Deputy Director, Public School Insurance Authority

10:30 a.m. (2) **Managed Health Care Credentialing of Health Care Providers**
—Senator Cliff R. Pirtle
—Laura Hill, Independent Practice Association of Southern New Mexico
—Cody Dodson, Office Manager, Rio Pecos Medical Associates, Ltd.

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

12:30 p.m. (3) **Advance Care Planning — New Mexico**
—Senator Daniel A. Ivey-Soto
—Nancy Guinn, M.D.
—Michael Hely, Staff Attorney, Legislative Council Service (LCS)
—Stormy Ralstin, Esq., Executive Director, Legal Resources for the Elderly, New Mexico State Bar Foundation
—Ellen Leitzer, Esq., Executive Director, Senior Citizens' Law Office

2:00 p.m. (4) **Human Trafficking Task Force Report**
—Susan Loubet, Executive Director, New Mexico Women's Agenda

3:00 p.m. (5) **Recommendations of the Behavioral Health Subcommittee (BHS) of the LHHS**
—Representative Elizabeth "Liz" Thomson, Chair, BHS

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

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

Thursday, December 4

9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS

9:10 a.m. (7) **Poverty in New Mexico**
—Adelamar N. Alcantara, Ph.D., Director, Geospatial and Population Studies, University of New Mexico

10:30 a.m. (8) **Health Security Act**
—Senator Howie C. Morales
—Mary Feldblum, Executive Director, The Health Security for New Mexicans Campaign

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

1:00 p.m. (9) **NurseAdvice NM**
—Connie Fiorenzio, Program Director, NurseAdvice NM

2:00 p.m. (10) **Expansion of First Choice Community Healthcare Services**
—Bob DeFelice, Chief Executive Officer (CEO), First Choice Community Healthcare, Inc.

3:00 p.m. (11) **Pregnant Worker Accommodation and Parental Leave**
—Pamelya Herndon, Esq., Executive Director, Southwest Women's Law Center (SWWLC)
—Susan Scott, M.D., J.D., Member, Board of Directors, SWWLC

4:00 p.m. (12) **Public Comment**

4:30 p.m. **Recess**

Friday, December 5

9:00 a.m. **Welcome and Introductions**
—Representative James Roger Madalena, Chair, LHHS

9:10 a.m. (13) **Health Insurance Exchange Update; Integrated Medicaid and Qualified Health Plan Enrollment**
—Amy Dowd, CEO, New Mexico Health Insurance Exchange
—Sean Pearson, Acting Deputy Secretary and Chief Information Officer, Human Services Department

10:30 a.m. (14) **Substitute Care Review**
—The Honorable Petra Jimenez Maes, Justice, New Mexico Supreme Court
—Dede McCrary, Member, State Advisory Committee
—Linda Kennedy, Former Member, New Mexico Child Abuse and Neglect Citizen Review Board
—Jack Carpenter, Chair, State Advisory Committee
—Shelly Bucher, L.M.S.W., Director, Southwest Region, National Child Protection Center
—Jared Rounsville, Director, Protective Services Division, Children, Youth and Families Department

12:00 noon **Lunch**

1:30 p.m. (15) **Public Comment**

2:00 p.m. (16) **Review of 2015 Legislation for Committee Endorsement**
—Michael Hely, Staff Attorney, LCS
—Shawn Mathis, Staff Attorney, LCS

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

BEHAVIORAL HEALTH SUBCOMMITTEE AGENDAS

Revised: July 15, 2014

TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

July 24, 2014
Room AD101/102, Northern New Mexico College (NNMC)
Joseph Montoya Building
Española

Thursday, July 24

9:00 a.m. **Call to Order and Introductions**
—Representative Elizabeth "Liz" Thomson, Chair

9:10 a.m. **Welcome**
—Alice A. Lucero, Mayor, City of Española
—Dr. Nancy "Rusty" Barcelo, NNMC

9:30 a.m. (1) **Report from State Auditor**
—Hector Balderas, State Auditor

10:30 a.m. (2) **Consequences of Substance Abuse in New Mexico and Rio Arriba County**
—Dr. Michael Landen, State Epidemiologist, Department of Health

11:30 a.m. (3) **University of New Mexico (UNM) Pain Management Clinic**
—Brian Starr, M.D., Medical Director, UNM Pain Center; Associate Professor of Anesthesiology, UNM School of Medicine
—Daniel Duhigg, D.O., M.B.A., Director, Addiction/Mental Health Services, UNM Pain Center; Associate Professor of Psychiatry, UNM School of Medicine

12:30 p.m. **Working Lunch (Provided for Subcommittee Members)/Review of Work Plan**

1:00 p.m. (4) **Panel Discussion: Rio Arriba County School-Based Behavioral Health Issues**
—Christina Baca, Special Education Director, Española Public School District
—Rick Vigil, Social Worker, Española Public School District
—Dr. Alice Meador, School Psychologist, Española Public School District
—Dr. Lloyd Vigil, School Psychologist, Española Public School District

2:00 p.m. (5) **Rio Arriba County's Pathways and Treatment Model and the State of Behavioral Health in Rio Arriba County**
—Lauren M. Reichelt, Director, Rio Arriba County Department of Health and Human Services

3:00 p.m. (6) **Behavioral Health and Substance Abuse Impact on Public Safety and Law Enforcement in Northern New Mexico**
—Representative of Española Police Department (TBD)
—Major Ken Johnson, Santa Fe County Sheriff's Office
—Lt. Gabe Gonzales, Santa Fe County Sheriff's Office

4:00 p.m. (7) **Public Comment Period**

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

Revised: September 15, 2014

TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE

September 17, 2014
J. Cloyd Miller Library, 10th Street
Western New Mexico University
Silver City

Wednesday, September 17

9:00 a.m. **Call to Order and Introductions**
—Representative Elizabeth "Liz" Thomson, Chair

9:10 a.m. **Welcome**
—Dr. Joseph Shepard, President, Western New Mexico University (WNMU)

9:30 a.m. (1) **Behavior Management Services Panel**
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department (HSD)
—Wayne Lindstrom, Director, Behavioral Health Services Division, HSD
—TBD, Public Education Department
—Daphne Rood-Hopkins, Director, Behavioral Health Services Division, Children, Youth and Families Department (CYFD)
—Jennifer Padgett, Deputy Secretary, CYFD
—Michael Hely, Staff Attorney, Legislative Council Service
—The Honorable Marci E. Beyer, Third Judicial District Judge

10:30 a.m. (2) **Return on Investment for School-Based Health Clinics with Primary Focus on Behavioral Health**
—Suzanne Gagnon, CFNP, Robert Wood Johnson Foundation (RWJF) Nursing and Health Policy Fellow, RWJF Nursing and Health Policy Collaborative
—Adrian Carver, President-Elect of the Board of Directors, New Mexico Alliance of School-Based Health Care

11:30 a.m. (3) **Adult Substance Abuse Continuum**
—Ron Hall, County Commissioner, Grant County
—Mike Carrillo, Administrator, Grant County Detention Center
—Jim Helgert, M.A., L.A.D.A.C., L.P.C.C., Director, Chemical Dependency Counselor Program, Visiting Professor, WNMU
—Susie Trujillo, Project Development, Gila Regional Medical Center
—Mary Jo Silcox, Regional Chief Executive Officer, La Frontera New Mexico

12:30 p.m. **Lunch (Provided)**

1:30 p.m. (4) **Update on Sequoyah Adolescent Treatment Center**
—Brad McGrath, Chief Deputy Secretary, Department of Health (DOH)
—Carmela Sandoval, Sequoyah Administrator
—Jeremy Averella, Chief Facilities Officer, Fort Bayard Medical Center
—Dr. Stephen Dorman, Chief Medical Officer, DOH
—Shauna Hartley, Administrator, Turquoise Lodge Hospital

3:30 p.m. (5) **Subcommittee Business**

4:00 p.m. (6) **Public Comment**

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

Revised: October 7, 2014

TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

October 8, 2014
Ballroom A, Student Union, University of New Mexico (UNM)
Albuquerque

Wednesday, October 8

9:00 a.m. **Call to Order and Introductions**
—Representative Elizabeth "Liz" Thomson, Chair

9:10 a.m. **Welcome**
—Dr. Richard Larson, Executive Vice Chancellor and Vice Chancellor for Research, UNM Health Sciences Center

9:30 a.m. (1) **Mental Health Parity**
—D. Brian Hufford, Zuckerman Spaeder LLP
—Lisa Reid, Life and Health Director, Office of Superintendent of Insurance (OSI)
—Ernesto Baca, Legislative Coordinator, OSI
—Kika Peña, Bureau Chief, Rate and Production Filing Bureau, OSI
—Janice Torrez, Vice President of External Affairs and Chief of Staff, Blue Cross Blue Shield of New Mexico
—Anita Leal, Executive Director, CHRISTUS Health Plan
—Dr. Marcello Maviglia, Medical Director, Molina Healthcare
—Matt McFadden, Director of Behavioral Health Management, New Mexico Health Connections
—Carmen Meyer, R.N., Case Manager, New Mexico Health Connections
—Liz Locatur, Executive Director, Behavioral Health, Presbyterian Health Plan, Inc.
—Harris Silver, M.D., Health Care and Drug Policy Analyst, Co-Coordinator, Bernalillo County Opioid Abuse Accountability Initiative

12:00 noon (2) **Public Comment Period #1 (Working Lunch, Provided)**

1:00 p.m. (3) **Presbyterian Medical Services (PMS) Report on Behavioral Health Services and Capacity**
—Doug Smith, Executive Vice President, PMS
—Bill Belzer, Director of Behavioral Health, PMS

2:00 p.m. (4) **Results First Cost Benefit Analysis of Behavioral Health Services**
—Dr. Jon Courtney, Program Evaluation Manager, Legislative Finance Committee (LFC)
—Pamela Galbraith, Program Evaluator, LFC
—Ashleigh E. Holand, Manager, State Policy, Pew-MacArthur Results First Initiative

3:00 p.m. (5) **Project ECHO Proposal to Expand Capacity to Provide Behavioral Health Services in Primary Care**
—Miriam Komaromy, M.D., Associate Director, Project ECHO, Associate Professor of Internal Medicine, UNM Health Sciences Center

4:00 p.m. (6) **Heading Home Proposal**
—Dennis Plummer, Chief Executive Officer, Albuquerque Heading Home
—Jodie Jepson, Deputy Director, Albuquerque Heading Home

5:00 p.m. (7) **Public Comment Period #2**

6:00 p.m. **Adjourn**

Revised: November 6, 2014

TENTATIVE AGENDA
for the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 7, 2014
Room 322, State Capitol
Santa Fe

Friday, November 7

8:00 a.m. **Call to Order and Introductions**
—Representative Elizabeth "Liz" Thomson, Chair

8:15 a.m. (1) **FOCUS/Milagro Proposal**
—Larry Leeman, M.D., M.P.H., Medical Director, Milagro Program, Professor of Family and Community Medicine, Obstetrics and Gynecology, Co-Medical Director, University Hospital Mother Baby Unit, University of New Mexico Health Sciences Center (UNMHSC)
—Andrew Hsi, M.D., M.P.H., Professor of Pediatrics, Principal Investigator, FOCUS Program, UNMHSC
—Marcia Moriarta, PsyD, IMH-E(4), Licensed Clinical Psychologist, Associate Professor of Pediatrics, Executive Director, Center for Development and Disability, UNMHSC

9:15 a.m. (2) **New Mexico Crisis and Access Line (NMCAL) Update and Behavioral Health Clearinghouse and Helpline Proposal**
—J. Martin Rodriguez, Program Manager, NMCAL, ProtoCall Services
—Phil Evans, President and Chief Executive Officer, NMCAL, ProtoCall Services
—Caroline Bonham, M.D., Associate Director, UNMHSC Brain and Behavioral Health Institute

10:15 a.m. (3) **Project ECHO Proposal to Expand Capacity to Provide Behavioral Health Services in Primary Care**
—Miriam Komaromy, M.D., Associate Director, Project ECHO; Associate Professor of Internal Medicine, UNMHSC

11:15 a.m. (4) **Proposal to Protect and Expand Behavioral and Primary Health Services in School-Based Health Clinics**
—Adrian Carver, President-Elect, New Mexico Alliance for School-Based Health Care Board

—Suzanne Gagnan, CFNP, Robert Wood Johnson Foundation (RWJF) Nursing and Health Policy Fellow, RWJF Nursing and Health Policy Collaborative

12:15 p.m. **Working Lunch (Provided)**

(5) **Heading Home Proposal**
—Dennis Plummer, Chief Executive Officer, Albuquerque Heading Home
—Jodie Jepson, Deputy Director, Albuquerque Heading Home

1:15 p.m. (6) **Proposal for Additional Psychiatric Nurse Slots**
—Pamela Schultz, Ph.D., R.N., Associate Dean and Director, School of Nursing, New Mexico State University

2:15 p.m. (7) **Behavioral Health and Primary Care Coordination of Care: New Mexico Health Connections Perspective**
—Matt McFadden, Director of Behavioral Health Management, New Mexico Health Connections

3:15 p.m. (8) **Transitional Living Proposal**
—Jennifer Weiss-Burke, Executive Director, Healing Addiction in Our Community

4:15 p.m. (9) **Youth Risk and Resiliency Survey**
—Dan Green, M.P.H., Survey Epidemiologist, Injury and Behavioral Epidemiology Bureau, Department of Health

5:15 p.m. (10) **Public Comment**

6:00 p.m. **Adjourn**

DISABILITIES CONCERNS SUBCOMMITTEE AGENDAS

Revised: August 14, 2014

TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE

August 15, 2014
Room 307, State Capitol
Santa Fe

Friday, August 15

9:30 a.m. **Call to Order and Introductions**
—Senator Nancy Rodriguez, Vice Chair

9:45 a.m. (1) **Employment of Persons with Disabilities**
—Jim Jackson, Executive Director, Disability Rights New Mexico

10:45 a.m. (2) **Update on Centennial Care for Developmental Disabilities Waiver Recipients and Persons on Wait List and Update from the Income Support Division of the Human Services Department (HSD)**
—Brent Earnest, Deputy Secretary, HSD
—Jennifer Thorne-Lehman, Deputy Director, Developmental Disabilities Supports Division, Department of Health

11:45 a.m. (3) **Provider Panel: Update on Department of Health Rate Increases**
—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers
—Donna Hooten, Executive Director, LEADERS Industries
—Mike Kivitz, President and Chief Executive Officer, Adelante Development Center, Inc.
—Jim Copeland, Executive Director, Alta Mira Specialized Family Services, Inc.
—Edward J. Kaul, Chief Executive Officer, ARCA
—Jane Larson, Chief Executive Officer, Native American Professional Parent Resources

Working Lunch

1:45 p.m. (4) **Autism Update Panel**
—Patricia Osbourn, Deputy Director, University of New Mexico Center for Development and Disability (UNM CDD); Director, Autism and Other Developmental Disabilities Program, UNM CDD
—Gay Finlayson, Education and Outreach Manager, UNM CDD

3:00 p.m. (5) **Public Comment**

4:00 p.m. **Adjourn**

TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE

September 9, 2014
Barbara Hubbard Room
Pan American Center
New Mexico State University
Las Cruces

Tuesday, September 9

9:00 a.m.		**Call to Order and Introductions** —Representative Doreen Y. Gallegos, Chair
9:10 a.m.		**Welcome** —Garrey E. Carruthers, President, New Mexico State University (NMSU)
9:30 a.m.	(1)	**Southern New Mexico Provider Panel Update** —Pam Lillibridge, Tresco, Inc. —Evangeline H. Zamora, Chief Executive Officer (CEO), Life Quest, Inc. —Peggy Denson-O'Neill, CEO, Zia Therapy Center, Inc.
10:30 a.m.	(2)	**Navigating Autism Services in Southern New Mexico** —Abel Covarrubias, M.A., CCC-SLP, CEO, Aprendamos Intervention Team, PA; Board Chair and Co-Founder, Hearts for Autism Fund —Marisa Cano, Hearts for Autism Board Member and Parent Liaison
11:30 a.m.	(3)	**Tour of Speech and Hearing Center and Luncheon Presentation on NMSU Cleft Palate and Rural Outreach Programs (subcommittee members only)**
1:00 p.m.	(4)	**Department of Health (DOH) Update: Developmental Disabilities Waiver Waiting List; Supports Intensity Scale; Provider Rate Increases; Vacancy Rates** —Cathy Stevenson, DOH
3:00 p.m.	(5)	**Public Comment and Response by the DOH**
4:00 p.m.		**Adjourn** **Ice Cream Social Sponsored by Associated Students of NMSU**

Revised: October 7, 2014

TENTATIVE AGENDA
for the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

October 9, 2014
Hotel Albuquerque, Franciscan Room
Albuquerque

Thursday, October 9

10:00 a.m. **Call to Order and Introductions**
—Representative Doreen Y. Gallegos, Chair

10:15 a.m. (1) **Repealing the Federal Marriage Penalty for Persons with Disabilities**
—Marilyn Martinez, Self-Advocate

10:30 a.m. (2) **Provider Rate Increases (Continued)**
—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers (ADDCP)
—Mark Johnson, Chief Executive Officer, Easter Seals El Mirador; Officer, ADDCP

11:30 a.m. (3) **House Memorial 9 (2014) Status Report**
—Elizabeth Peterson, Director, Brain Injury Advisory Council
—Robert Thoma, Ph.D., Associate Professor and Clinical Neuropsychologist, Department of Psychiatry, University of New Mexico (UNM), and Center for Neuropsychological Services, UNM

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

1:30 p.m. (4) **House Memorial 87 (2014) Report**
—Susan Gray, Chair, Governor's Commission on Disability

2:30 p.m. (5) **Update on *Waldrop v. New Mexico Human Services Department***
—Jason Gordon, Lead Counsel, Disability Rights New Mexico

3:30 p.m. (6) **Proposed Amendment to State Use Act**
—Senator William E. Sharer

4:00 p.m. (7) **Public Comment**

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

LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE MINUTES

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

May 23, 2014
Room 307, State Capitol
Santa Fe

The first meeting of the 2014 interim of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Friday, May 23, 2014, 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. Benny Shendo, Jr.

Absent
Sen. Gay G. Kernan
Rep. Terry H. McMillan
Sen. Mark Moores

Advisory Members
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Nathan "Nate" Cote
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Rep. Vickie Perea
Sen. Nancy Rodriguez
Sen. Sander Rue
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta
Sen. Jacob R. Candelaria
Rep. Sandra D. Jeff
Sen. Linda M. Lopez
Rep. Paul A. Pacheco
Sen. William P. Soules

Staff
Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Rebecca L. Griego, Records Officer, LCS
John Mitchell, Law School Intern, LCS
Michelle Jaschke, Researcher, 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.

Friday, May 23

Call to Order

Representative Madalena called the meeting to order at 9:45 a.m.

Welcome and Introductions

The chair welcomed members, staff and guests, noting that it was the start of the interim season and pledging to give full and diligent consideration to the many serious constituent concerns coming before the committee this year. Committee members and staff introduced themselves at the request of the chair.

Evidence-Based Interventions in Child Maltreatment; Foster Care

Charles Sallee, deputy director for program evaluation, Legislative Finance Committee (LFC), presented results from an LFC study of evidence-based programs designed to reduce child maltreatment. Mr. Sallee provided a handout to accompany his presentation. The study examines the cost of child maltreatment in New Mexico, assesses current child welfare system performance in the state and details what programs have been shown to effectively improve outcomes for children and families. Dr. Jon Courtney, program evaluator, LFC, joined Mr. Sallee to provide information on the Pew-MacArthur Results First Initiative.

Mr. Sallee provided an overview of the study, which shows that the state receives 33,000 reports of child abuse and neglect each year and conducts 18,000 investigations. About 6,500 cases of abuse or neglect are substantiated, and about 2,600 children have to be removed from their homes each year. Roughly 300 children need an adoptive family, and some 15 children die as a result of abuse or neglect each year. Mr. Sallee noted that strict state and federal regulations set up incentives for how money is spent for child protective services, with the bulk of available money spent for foster care and adoption services, the "back end" of the system. Preventive, or "front end", services receive very minimal funding by comparison.

Child abuse prevention services in the state are funded at less than $1 million, while $7.4 million is spent on in-home services reaching approximately 2,000 children. In contrast, the cost of foster care services exceeds $36 million annually, and the cost of adoption for children who have to be removed from their homes is over $30 million each year, roughly $107,000 per child per adoption. Similarly, federal funding under the federal Title IV-B program provides under $2 million to help keep children safely out of foster care, while the Title IV-E program provides $27 million in matching funds to maintain children in foster care.

Mr. Sallee noted that a database spanning 2004-2012 provides the Children, Youth and Families Department (CYFD) with good information on what services are needed, as well as a means to examine the pyramid of system performance, which Mr. Sallee described for the committee, that runs from the 33,000 referrals received down to the numbers receiving foster care, adoption and in-home services. The pyramid reveals that questions remain about the disposition of some of the reported cases.

One of the main factors impacting child well-being in the state is poverty, Mr. Sallee reported. New Mexico also has a high rate of children who have had adverse childhood experiences that impact their social and emotional functioning as well as their future earning capacity. For a variety of reasons, the youngest children suffer the most maltreatment, and their early adverse experiences strongly predict the need for further state services. Mr. Sallee pointed out that intervention at the earliest stages can be very beneficial in preventing recurrent abuse, reducing system costs and improving long-term outcomes for children and families.

In assessing the state's performance, Mr. Sallee reported that over the past four years, child victimization rates in the state have risen, as have cases of neglect, while the number of sexual abuse cases has dropped slightly. The amount of time required to deal with cases of abuse and neglect has lengthened, with some offices performing better than others. The state ranks highest in the nation for the number of children with a drug-abusing caregiver involved in the child welfare system.

Given the many factors that impact child well-being in the state, including high rates of teen pregnancy, poverty and substance abuse, Mr. Sallee suggested that a focus for the committee should be to find ways to promote collaboration between the CYFD and other mission-critical state agencies. New Mexico should seek to employ remedies that have been shown to be effective based on the best research available nationwide.

Mr. Sallee covered a number of other topics related to system performance, including the high number of "frequent flyers", children who are repeatedly referred to the system over long periods of time, and those who suffer recurrent abuse. Over one-half of the children referred to the CYFD were re-referred, in some instances more than 20 times. He also noted that these children suffer many forms of toxic stress as a result of being in and out of foster care and that removing children from their homes is a traumatic event in itself. Many children will run away to return to dysfunctional families simply because those families are a known factor in a turbulent life. New Mexico compares poorly in national standards in preventing abuse recurrence.

With few resources currently focused on prevention, Mr. Sallee reported that New Mexico should look at other programs to reduce the number of referrals and child maltreatment, including a waiver that can be solicited from the federal government to rebalance federal funding to better address the front end needs of the system. Keeping children safely in their homes

reduces the high costs of foster care and adoption, decreases court intervention and helps families.

Mr. Sallee introduced Christine Boerner, a new budget analyst for the LFC, and asked Dr. Courtney to provide additional information regarding the evidence-based options that have been studied or are in place to improve outcomes for New Mexico children and families.

Representative Madalena noted that Representative James E. Smith had arrived at the hearing with students from a charter school in the East Mountains to observe the legislative process, and he and the committee welcomed Representative Smith and students.

Dr. Courtney reported on a national database of evidence of program effectiveness. The database enables a cost-benefit analysis of current New Mexico programs as well as other programs that could potentially be used in New Mexico to reduce cases of child abuse and neglect. The Nurse Family Partnership for low-income families currently operating in New Mexico has proven to be highly effective but lacks sufficient resources to serve the many families in need. The program promotes child development and seeks to improve parenting skills, targeting women pregnant with a first child. Overall, the program has documented a 26 percent reduction in recurrence of abuse and a 20 percent reduction in maltreatment.

Alternatives to traditional investigations and interventions, including the "Triple P", the Positive Parenting Program, which is designed to help keep children safely in their homes, have been proven to be highly cost-effective and to provide important help for families. Only one level of the five-level Triple P is currently operating in New Mexico. Studies of these programs show that families who accept alternative services see significantly lower rates of maltreatment and recurrence of abuse. Dr. Courtney encouraged the committee to use the data included in the study to assess the best practices for early intervention and prevention.

Mr. Sallee summarized the benefits of the evidence-based programs and the cost savings that alignment of resources with high-risk areas and homes can provide. He emphasized that first-born children are at risk and that many of the families involved have had contact with other agencies before they get to child protective services. He further described a need to leverage federal Medicaid dollars to help ramp up investment in preventive services and to look at all available resources and innovative ways to reallocate existing resources.

Recognizing that there is no "silver bullet" to remedy child maltreatment and recurrence of maltreatment, Mr. Sallee thanked the thousands of people who are working hard across the state to help children and families. Mr. Sallee described a fine line between too much and too little intervention by the state, as well as the difficult balancing act of resource allocation, cost-benefit analysis and program monitoring.

Representative Madalena also thanked those working in this field and promised the committee's support for efforts to improve services and provide help to children. He expressed

his desire to find ways to improve collaboration among state agencies. The chair introduced Yolanda Berumen-Deines, secretary, CYFD.

Secretary Berumen-Deines presented a response to the LFC report and noted that she would field questions after her presentation. The secretary thanked guests and committee members for their attention and concern. She stated that the CYFD has taken on a more collaborative approach and that it has felt a lot of pressure to demonstrate good outcomes for children and families. In addressing the issue of intervention, the secretary stated that intervention, not prevention, is the department's mandate. She further noted that because the department cannot prove a positive result from preventive services, funding sources skew services toward intervention. The secretary explained that early education efforts work to prevent maltreatment due to parent education, but there are children who do not come to early intervention programs or are already in the system.

Secretary Berumen-Deines described a new program to get social workers into at-risk homes. Currently, the CYFD cannot intervene with families unless children are removed from their homes. She commented that she feels removal is an assault on the children. Removing children from their homes is a legal and an emotional ordeal. Frequently, foster care parents are viewed by the children as evil because the children feel they have taken them from their families. In many cases, according to the secretary, removal creates additional problems. The secretary asked for the committee's help in delivering services to at-risk families, stating that the department currently does not have that ability.

Secretary Berumen-Deines lamented the fact that many families discontinue treatment options that may be available because the in-home treatments are demanding. This results in more recurrence and maltreatment. Many families have severe problems that are still insufficient to require child removal, and the department avoids removal because of the many associated problems and costs. With regard to rebalancing federal funding, the secretary indicated that the need for funding is great in the Title IV-E program (foster care services) because state resources do not exist once children are placed and the state needs federal help to cover costs.

Jared Rounsville, director, Protective Services Division (PSD), CYFD, addressed the committee to follow up on questions regarding protective services and thanked the secretary, Mr. Sallee and Dr. Courtney for all of the data they had presented. Mr. Rounsville observed that New Mexico is a poor state with a significant number of people struggling with substance abuse. In addition, the delivery of services is complicated by the rural nature of many areas of the state and the lasting effects of the economic downturn. These and other economic factors have impacted what happens to children and families as well as staffing for protective services. Mr. Rounsville pointed out that unless there is an appropriate service array across the state, improvements in outcomes for children and families will be difficult to achieve. He advocated a focus on capacity-building in rural New Mexico to assist children and families. At present, the PSD is struggling to meet needs at the investigation level and lacks resources for follow-up services.

Mr. Rounsville questioned how rural New Mexico can be assisted with home visiting and other services.

Representative Madalena agreed that many poor and rural areas of the state lack services and thanked the panel for seeking solutions to these difficult problems.

Mr. Sallee reminded the committee that the majority of all child welfare cases fall in the more heavily populated Rio Grande corridor. He suggested that the state look to the Department of Health (DOH) for nurses to do home visitation in rural areas and also noted that the state has two teaching universities with high profiles in rural areas that could be of help in building capacity in those areas. Instead of inventing new programs, Mr. Sallee proposed a focus on establishing and expanding model early intervention programs with proven cost-benefit effectiveness.

The chair thanked the panel and noted that he and other members of the committee had questions.

Dr. Courtney responded to questions about the Triple P, explaining that it is currently operating only in some counties and that many options for expansion are under consideration.

One member of the committee asserted that the value of early intervention has been well established following years of debate and study and that the pressing issue now is how to target resources and take responsibility for implementing successful early intervention programs. He welcomed the Pew-MacArthur Results First Initiative as an important tool for monitoring and assessing the effectiveness of child welfare programs. The member expressed a concern about insufficient funding for early intervention efforts, questioning whether the federal government had "caught up" in recognizing the importance of early intervention. Thanking the secretary for the information she provided, the committee member asked if a new cabinet-level agency should be established to focus on prevention and early intervention, if that is not the mandate of the CYFD. The member also expressed concerns about how families will be identified to participate in early intervention programs.

Mr. Sallee explained that in the case of the SafeCare program, the CYFD is responding to an initial report of abuse or neglect. A system of differential response may place a family in a category where the family can receive intervention services to prevent removal and recurrence. This differential response also keeps families from going from low risk to high risk and is a sort of triage system engaging the family in a partnership with providers. Mr. Sallee asserted that it is known that teen parents and poverty-stricken homes are at risk. These families may not be under child protective services but could be receiving services from other agencies where they could be identified as at risk. Where resources are placed should therefore be on a continuum related to when intervention is needed and can best be made available. Generally speaking, Mr. Sallee reported, families are brought to the attention of intervention programs after a first report of abuse or neglect.

Secretary Berumen-Deines commented that she liked the idea reiterated by one committee member of adding something to the system to promote intervention, but she suggested that perhaps another division of the CYFD, ahead of early education efforts, is the answer.

Another LHHS member thanked visitors and child welfare workers for the unimaginable amount of work they perform on behalf of the state's children and families. This member asked how the screening process for foster care still allows children to be placed with substance abusers.

A discussion ensued among the panel and committee members about screening processes. Secretary Berumen-Deines stated that some cases are screened out because the CYFD may not have enough information to even locate the family that has been reported, or there may be a non-custodial parent or other person involved, making follow-up difficult.

The committee member clarified that her question was related to the screening process for caregivers, asking how it is that children are placed with substance abusers. The member explained that she had read about placements with inappropriate caregivers.

Mr. Rounsville and Secretary Berumen-Deines reported to the committee that foster families are screened very rigorously and that the process is very invasive, including reference and background checks that pass through a panel of people. The reality, the secretary stated, is that circumstances change in foster care homes as well and that addiction issues can arise.

The committee member expressed extreme frustration with the fact that some children are still in a bad situation after 20 referrals to the CYFD.

Secretary Berumen-Deines responded that complaints may range from lack of food to a variety of other issues and that workers try to help families address whatever issues have arisen. The threshold for determining when to remove a child is very high, the secretary reported, and unless there is a law that mandates services to at-risk families, these families will likely continue to be unstable.

In response to a committee question regarding who is responsible for follow-up services, Mr. Rounsville indicated that once an investigation is completed, the CYFD does not have a legal right to monitor the family's affairs. He noted that the CYFD has an independent group of case reviewers who travel around the state to help caseworkers implement strategies to improve monitoring and services.

Committee members expressed concern about the number of referrals that appear to receive no initial response and/or no follow-up services. Secretary Berumen-Deines strongly recommended that the legislature pass a law that allows the CYFD to stay in families' lives to provide preventive services, and she acknowledged that she shares the committee's concerns in that area.

Mr. Sallee agreed that there is no record of what happened to those families that did not receive services. He also stated that many families reject services and that court-ordered services or a legislative mandate for services could be the answer in those instances. Mr. Rounsville noted that when risks are lower for families, they may be referred to services, but there is nothing to require that they follow through.

Discussion ensued about a pilot program for early intervention in Bernalillo County, but no information was available about why the program was discontinued.

One committee member noted that the CYFD already has its own evidence-based program successes. The member described the case of foster parents in the New Mexico system who took on some of the most difficult foster care cases, including children with fetal alcohol syndrome and other substance abuse-related issues. He suggested implementing a "boot camp" using experienced foster care parents to mentor other foster care parents and described a need to institutionalize the use of existing foster parents as training resources.

The committee was asked to welcome Deborah Armstrong, an unopposed 2014 candidate for District 17 of the New Mexico House of Representatives. One of the members noted Ms. Armstrong's strong qualifications to serve as a member of the LHHS. The member also thanked the panel and CYFD staff for their service and related her belief that the "sleeping giant" for child abuse and neglect in the state is substance abuse. More specifically, the member laid out the serious need for drug treatment facilities and services in the state. She advocated for new Medicaid provisions to pay close attention to the need for substance abuse treatment, as well as for expansion of the highly successful drug court programs in the state. She also suggested that new legislation should mandate drug testing as a follow-up to reports of child abuse and neglect and that perhaps getting a waiver for the use of federal funds in New Mexico could provide new treatment options.

Mr. Sallee acknowledged that about 29 percent of children taken into the system had a substance-abusing parent. Effective substance abuse programs are mission critical for all of these agencies, according to Mr. Sallee, particularly for reunifying families. However, he noted, substance abuse treatment programs do not lend themselves to a time line for early and successful family reunification.

Secretary Berumen-Deines stated that the CYFD has considered applying for the federal waiver but that the application is labor intensive and that staff are struggling to complete current initiatives and do not have time at present to put together the application.

In response to the committee's questions, panel members noted that the federal waiver only allows New Mexico to move existing money around; it is not a new fund. Moving money to the front end would be predicated on the hope that the federal government will help keep resources for foster care and adoption in place; however, the state is still responsible for

providing those services. Committee members noted that it would be the legislature's prerogative to provide additional general fund money to assist in these areas.

Questions arose as to why the presented screening numbers do not add up. Dr. Courtney responded that one difference in reporting is between individual children and families. Other reporting discrepancies were revealed to be due to re-victimization and differences between substantiated and unsubstantiated reports. One member asked if the high numbers of unsubstantiated reports and recurrent abuse indicate that caregivers get a free pass for child abuse and neglect unless the child is removed from the home.

Secretary Berumen-Deines agreed that this was, in essence, the case, as the CYFD cannot mandate that families receive services. Mr. Sallee responded to additional questions, indicating that the referral numbers can be broken down to provide more information. Discussion ensued about the high cost of adoption services. Children are entitled to an adoption subsidy, which adds up over time, and the cost of adoption negotiations is high, especially when children with special needs are involved. In addition, by statute, the process requires a lot of time.

When asked what factors influence recruiting staff for the CYFD, Secretary Berumen-Deines commented that retention is more of an issue than recruitment. Social work as a practice is not as difficult as facing the shocking circumstances of child trauma and difficult family circumstances on a daily basis. CYFD staffers are constantly responding to crisis situations and in fact require a crisis diffusion process at day's end. The secretary reported that the CYFD is also working on up-front assessment to let people know what they will be facing, as well as implementing an assessment once staff have been on the job for four months. Staff development is handled in-house. A major factor in retention is headhunting by managed care organizations, which can offer big salary incentives to the best and the brightest. The committee discussed loan repayment, stipend and tuition assistance programs as incentives to retain child welfare workers.

One member asserted that the CYFD is indeed charged with prevention and not just with intervention and removal. He spoke of a clear legislative intent to house prevention services in the CYFD. The secretary responded that current prevention efforts are housed in early childhood education. The member responded that it is within the secretary's purview to expand prevention to other areas.

Secretary Berumen-Deines stated that she hopes that the CYFD can expand prevention to other children, but commented that the federal mandate for prevention falls in the area of early childhood education. The committee member responded that the main thing to take away from this discussion is the need for capacity-building. He pointed out that a mandate for follow-up services would be empty if resources do not exist for behavioral health and other services. The CYFD participates in the Interagency Behavioral Health Purchasing Collaborative, and he noted that all of these children will be eligible for Medicaid. He asked if the CYFD has money placed with the collaborative for services not covered by Medicaid.

Secretary Berumen-Deines responded that non-Medicaid services dollars are spread thin, but she would like to bring those services back to the CYFD. She indicated that staff are working to build capacity in various communities and that the system-of-care network should be comprehensive.

The member thanked the secretary for trying to get behavioral health funding back to the CYFD to enable different means of using the money to secure the right services. He also noted that if abuse and neglect are substantiated, the possibility exists to have legal custody reside with the CYFD and physical custody with the parents, leveraging increased prevention possibilities. Mr. Rounsville responded that the CYFD wants to be able to intervene before taking legal custody.

Additional questions arose regarding the qualifications of staffers who analyze the need for removal of children. Mr. Rounsville explained that removal is a law enforcement decision. PSD staff must at a minimum have two years of experience in social work or a related field to make a recommendation. Law enforcement decisions are based on a uniform safety assessment, including the protective capacity or lack of protective capacity of parents.

Committee members further discussed when the CYFD is involved in custody decisions. It was noted that the CYFD is not involved in the instance of divorce custody. One member urged the committee to look at the qualifications of those making custody and removal decisions.

Mr. Sallee stated that he would look into the costs involved in ramping up the Triple P program across the state, including hiring more staff, at the request of a committee member.

The chair solicited questions from audience members.

Julianna Koob, New Mexico Coalition of Sexual Assault Programs, introduced herself and asked if the CYFD or the LHHS would look into the information on page nine of the report presented by Mr. Sallee, showing substantiated allegations of sexual assault at a near static rate across the past four years. Ms Koob pointed out that in contrast to the reported information, her organization has experienced an increase in the number of sexual assault cases. She further requested that the LHHS look at what is happening with funding for rape kits and rape crisis centers and that the LHHS review a prison rape reduction study.

Public Comment

Dick Mason, New Mexico Alliance of Health Councils, thanked the committee for funding used to hold community meetings around the state to assess health needs. The alliance would like to address the LHHS during the interim on the health councils' findings, including the need for funding for a range of prevention programs. Mr. Mason spoke specifically about county needs for pregnancy prevention funding and the need to consider the impact on the population's health of a full range of policies, not just those normally associated with health.

David Schmidt addressed the committee as both a representative of the Drug Policy Alliance (DPA) and as a private citizen. Mr. Schmidt stated that he is a registered lobbyist with the DPA and provided a handout to the committee. The DPA is concerned that the DOH has recently issued and released a lengthy proposed rule change regarding the medical cannabis program. The change is of great concern to patients, as it appears to further limit the supply of medical cannabis in the state. Further, the proposed rule change includes proposals to conduct background checks for medical cannabis patients and would enact patient fees to receive medication.

Mr. Schmidt pointed out that no other prescription medication requires a background check. In addition, the proposed rule change imposes numerous new producer restrictions. The DPA feels strongly that if producers cannot come up with an adequate supply, access will be further restricted and will steer patients to dangerous black market options. According to the DPA, no public or state advisory committee was involved in development of the proposed rule change. The DPA is requesting that the committee request postponement of the upcoming rulemaking deadline until adequate input can be gathered. Mr. Schmidt suggested that the LHHS hear rules before the rules go to the DOH. He asserted that without legislative involvement, this program would not be in place and that the new regulations are being developed by the DOH in-house without proper oversight or public comment.

A second issue the DPA hopes to bring before the committee during the interim is overdose prevention. Narcan, a drug carried by emergency personnel, has been proven to help prevent overdoses. A request has come before the legislature for the past two years to supplement funding for the DOH to make Narcan more widely available. Mr. Schmidt commented that the State of Massachusetts, with only half the number of overdose deaths as New Mexico, has declared a public health emergency regarding its rate of overdose deaths and that New Mexico needs to do more in the area of prevention.

Committee members asked what is driving the proposed medical cannabis rule change and why regulations are being promulgated without public input. Audience and committee members speculated about the interests being represented in the rulemaking process. Mr. Schmidt stated that he could not speak to the issue of whether or not the administration's intent was to eliminate the program, only to the fact that this will create hardships for patients.

One committee member stated that the DOH is already in violation of federal statute by not meeting patient needs for medical marijuana supply. The new regulations are so far reaching, he stated, that they create a new set of problems. Product testing is an important part of the process, but the new standards are so stringent as to preclude testing being conducted in New Mexico. The new regulations would also curtail the current "grow your own" provisions that help meet patient needs. It was noted that the state is moving in the wrong direction with the proposed rule change if it is statutorily mandated to provide an adequate supply for patients.

The issue of background checks particularly troubled committee members, as this would likely involve the state police. Clarification was provided that the background checks would now involve consumers and not just producers. It was generally agreed that there was some adverse reaction in the state to the recent changes in Colorado marijuana laws and that it would be advantageous to have more public comment and a more open hearing process to help everyone understand the issues.

The chair asked that the discussion be steered back to the audience to allow for public comment.

One committee member added that she is familiar with a medical marijuana producer in her district who had walked her through the entire process of growing and dispensing so that she could make an informed assessment of the proposed rule change. This member stated that the proposed rule change essentially rewrites what is currently in statute to create huge obstacles to an already well-regulated process. Not only are the changes extensive, she noted, but they have been made without public input and have huge implications for Alzheimer's patients and other difficult-to-serve populations. She added that the program includes other formulations of cannabis that benefit these consumers. At a minimum, the DOH should have sought input from program consumers and producers, the member stated, stressing that there are many controlled substances that are physician-prescribed but do not require a background check.

The LHHS agreed to return to the issue of writing a letter to the DOH regarding the rule change following public comment.

Mr. Schmidt stated that, as a private citizen, he would like to propose that the LHHS become a year-round committee, similar to the LFC and the Legislative Education Study Committee, with a full-time permanent staff. He noted that Representative Sandoval had previously proposed this approach.

Nat Dean, advocate for the disabled, addressed the committee regarding the proposed medical cannabis rule change. She stated that the changes that the DOH has proposed are enormous for producers and patients, and follow a seven-year effort on the part of many interested parties to establish the existing program. The new regulations were developed without input from stakeholders and would essentially shut down the program in New Mexico, according to Ms. Dean. Further, the existing New Mexico program has often been used as a model for other states because of its efficacy. In Ms. Dean's estimation, the proposed rule change would severely impact the ability to provide compassionate care. Ms. Dean asked the LHHS for an appropriate examination of realistic changes to the program. The current shortage of medical cannabis in the state requires an immediate response time on the part of patients to successfully order and make an appointment to secure a needed supply. This has the effect of forcing criminal activity, she explained, and limits the supply of product adequately tested for medical uses. She urged the LHHS to ask the DOH to delay making a ruling until input can be heard.

A member of the audience showed the committee a copy of the proposed rule change with pages and pages of changes highlighted in red ink. The chair proposed that members get copies from the internet.

Sabrina Montoya, New Mexico Highlands University, read a statement on human trafficking, referring to it as modern-day slavery. She reported that individuals of all ages and gender are trafficked for sexual exploitation and asked that the LHHS include human trafficking in its interim discussions and legislative planning.

The LHHS members cautioned audience members to ensure that their definition of human trafficking covers people who are not protected by current laws. Ms. Montoya and her associate asked for further guidance from the committee in this regard, and members responded that it is important to find new ways to protect people who are being criminalized.

It was noted that this issue would be included in the LHHS's work plan. Committee members recalled that some legislation had been passed recently with regard to human trafficking, and Ms. Montoya explained that recent legislation included the posting of numbers for victims to call for help, as well as changes to the Criminal Code. The advocates would like to see new legislation to increase fines and seize assets to be used to help victims and to maximize how the system serves young children to limit victimization. Committee members suggested coordinating with the Courts, Corrections and Justice Committee (CCJ). The chair informed the committee that it would be holding a joint meeting with the CCJ during the interim, although Mr. Hely noted that human trafficking is not on the agenda for the joint meeting.

Susan Loubet of the New Mexico Women's Agenda outlined three areas of study she proposed to bring before the LHHS during the interim: the service needs of sexually exploited children; the negative impact of changes in reporting requirements for the Temporary Assistance for Needy Families (TANF) program; and the need to consider funding for sexual assault programs in order to respond to federal mandates.

Pamela Blackwell, project director for rural health access, Health Action New Mexico, asked to present information to the LHHS during the interim on dental services in the state. She provided a brief update on programs in Alaska, Maine and Minnesota, which use dental therapists to help meet dental needs in rural areas. She expressed her hope to provide good economic and practice-related information from the other states' programs to the committee during the interim. Ms. Blackwell thanked the committee for its previous support and discussed clarifying some provisions of the proposed legislation regarding dental therapists with committee members.

Ms. Blackwell also addressed the LHHS on behalf of the Telehealth Alliance. She proposed having professionals and experts present information to the committee during the interim on the overarching issue of telehealth, as well as providing a real-time demonstration of

how telehealth works. She also hopes to discuss the impact of telehealth on behavioral health issues.

Bill Jordan, New Mexico Voices for Children, presented the new Kids Count publication information, reporting that New Mexico had dropped to "dead last" in child well-being in the nation. He lamented that neither the legislature nor the governor has come forward with any legislation to address New Mexico's standing as worst in the nation in measures of child well-being. Mr. Jordan pointed out that thousands fewer families are now receiving child care and Medicaid services and that only a few million dollars are needed to address the wait for child care.

Mr. Jordan asserted that the state is not adequately addressing higher education needs and reportedly had the fifth-deepest cuts in the nation to K-12 spending. He also noted that the state is spending 14 percent less on youth suicide prevention services for families. Although the recession has been tough, he commented, the state still found money for tax cuts. Mr. Jordan placed New Mexico last in the West in job growth, suggesting that tax cuts had not benefited the state in that area. He asked that the LHHS look closely at child poverty issues, including the following: stop giving away revenue and try to "backfill" services for children and families; increase funding for early childhood education during the extended amount of time it will take to establish adequate child abuse and neglect prevention services; and increase funding for K-12 education. Mr. Jordan also reported that poor families are paying twice the rate of taxes as other families, an unfair tax burden.

Stating that the LHHS should be expanded to a full-time, year-round committee, Mr. Jordan further explained that the state needs to support children and families to promote job growth. He urged the committee to "move the needle" on child well-being in New Mexico.

Committee members addressed questions to Mr. Jordan regarding the relative importance of scoring New Mexico in child well-being measures and whether his references to giving away money referred to tax cuts.

Mr. Jordan asserted that the tax cuts made under former Governor Bill Richardson's administration and corporate tax cuts were at issue and that the corporate tax cuts had eliminated $200 million in tax revenue. In measuring child well-being, he stated, New Mexico has never been above fortieth in the nation, declaring that the state's policies have driven New Mexico to the very bottom in this regard. He urged the committee to recognize the correlation between child welfare and poverty.

LHHS members spoke of the Children's Health Insurance Program (CHIP) proposal for school-based health clinics and proposed that the information on child care program efficacy be shared with the LFC. Members expressed the need to get younger children into better child care and spoke of their concern that these complicated issues be addressed with a spirit of cooperation.

Ruth Hoffman, Lutheran Advocacy Ministry, asserted that poverty is the "elephant in the room" and that moving the elephant out requires programs to meet immediate needs. She suggested public policies to address poverty issues, as well as outreach for the Medicaid expansion effort, explaining that Medicaid expansion can have a huge impact on those in need if rolled out effectively.

Ms. Hoffman echoed the sentiments of other presenters with regard to the relaxed mandate of the TANF oversight committee and lauded placement of that issue in the committee's work plan. She noted that the high rates of hunger and homelessness in the state are a direct result of poverty and hoped to work with the LHHS during the interim to address these issues. Ms. Hoffman joined Mr. Jordan and Mr. Schmidt in calling for establishment of the LHHS as a permanent committee.

A representative of the New Mexico Art Therapy Association requested the committee's support to bring legislation forward to enable reimbursement for art therapists in the behavioral health field. She noted that this would bring compensation for these therapists into line with similarly qualified professionals and expand services to special populations.

Susana Burke, J. Paul Taylor Early Childhood Task Force and PB&J Family Services Inc., spoke about the importance of identifying high-risk children and reducing the risk of maltreatment by mandating follow-up on unsubstantiated reports, in addition to expanding the network of services.

The PB&J program has documented a very good recidivism rate through the services it provides in the Corrections Department, according to Ms. Burke. She also reported that the corrections system is an enormous access point for early intervention in the areas of parenting and child safety. She strongly advocated efforts to promote interagency cooperation to promote child well-being and asked for the committee's support for mental health diagnostic services for very young children.

Committee members acknowledged the importance of hearing from the J. Paul Taylor Early Childhood Task Force and welcomed the opportunity to hear from a panel of child mental health care providers during the interim.

Jeremy Rutherford, representing the March of Dimes, addressed the committee, stating that his sole purpose in attending the hearing was to thank the members for the committee's special support for the March of Dimes.

2014 Legislative Highlights

Mr. Hely opened his remarks by reading a response he had received during the lunch hour from the DOH relative to the committee's concerns about the medical cannabis program rulemaking. The response stated that the draft rules were released per promulgation requirements for the purpose of allowing public comment and that the DOH had been receiving public

comment. Further, the response noted that a public hearing regarding the proposed rule change was scheduled for June 16 from 9:00 a.m. until 12:00 noon in the Harold Runnels Building, 1190 S. St. Francis Drive, Santa Fe. In addition, the response stated that the public comment time frame goes beyond the required 30 days.

Mr. Hely provided a recap of health and LHHS-related legislation from the 2014 regular session. The information memorandum he provided regarding the 2014 legislation may be found in the handouts. A total of 11 health- or human services-related bills, nine of which were endorsed by the committee, were passed by the legislature and signed into law by the governor. Two bills were passed by the legislature but vetoed by the governor. Mr. Hely also reviewed memorials that were passed relating to health and human services and other major pieces of legislation that did not pass.

The committee asked that a correction be made to the summary with regard to legislation sponsored and passed during the 2014 session. Mr. Hely stated that the correction would be made, and the committee asked to move to the proposed work plan.

Mr. Hely reviewed a comprehensive proposed 2014 interim work plan for the LHHS to include hearing testimony from the Human Services Department regarding Medicaid and the Centennial Care program, a variety of issues related to children and families and a range of public health issues. The work plan, which may be accessed in the handouts, also includes a joint meeting with the CCJ.

The committee requested that several additional items be included in the work plan as follows: investigate jurisdictional problems in boarding homes for people living with mental illness; assess network adequacy related to prevention of child maltreatment; outline caregiver roles and policies; hear testimony on the issues of homelessness, dental therapy and sexual assault, including sexual assault in correctional facilities; consider school-based health care legislation; examine allowing confidentiality of health data for children over the age of 14; include health care in all areas of policy consideration; review the Program of All-Inclusive Care for the Elderly or "PACE"; review the issue of advance directives; include the Brain Safe Project in the scheduled University of New Mexico pain-management presentation; and consider the Oregon death-with-dignity model.

The committee also agreed to separate the budget hearings from policy hearings to enable a more timely and effective review of budget items. Members debated what should be included in the letter to the DOH regarding the medical cannabis rule change and agreed to have Mr. Hely draft a letter to the DOH requesting that the public comment period be extended and that the formal process used to develop the rule change be elucidated. It was agreed that member comments for the letter were to be provided to Mr. Hely by Friday, May 30.

The chair agreed to incorporate the proposed changes in the work plan and directed Mr. Hely to proceed with the letter to the DOH as agreed by LHHS members.

Mr. Hely reviewed the proposed meeting schedule. The chair asked that the October 20, 2014 meeting scheduled for Santa Fe be conducted at the nearby Pueblo of Santa Clara. There were no objections, and Senator Ortiz y Pino moved to adopt the work plan and schedule as amended. Representative Gallegos seconded the motion, and the motion passed unanimously.

There being no further business, the LHHS adjourned at 4:15 p.m.

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

July 17-18, 2014
Pueblo of Taos Community Center
220 Rotten Tree Road
Taos

The second meeting of the 2014 interim of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on July 17, 2014 at 9:40 a.m. in the Pueblo of Taos Community Center.

Present
Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Sen. Benny Shendo, Jr. (7/17)

Absent
Rep. Nora Espinoza
Rep. Terry H. McMillan
Sen. Mark Moores

Advisory Members
Rep. Nathan "Nate" Cote
Rep. Sandra D. Jeff (7/17)
Rep. Linda M. Lopez (7/18)
Sen. Cisco McSorley (7/17)
Sen. Bill B. O'Neill
Rep. Vickie Perea
Sen. Nancy Rodriguez
Sen. Sander Rue (7/17)
Rep. Edward C. Sandoval

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. William P. Soules
Rep. Elizabeth "Liz" Thomson

(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 L. Griego, Records Officer, LCS
Nancy Ellis, LCS
Carolyn Peck, 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 portion of the meeting.

Thursday, July 17

Welcome and Introductions

The chair called the meeting to order at 9:40 a.m., welcoming guests and asking members and staff to introduce themselves. He then introduced Pueblo of Taos Governor Clyde M. Romero, Sr., who welcomed the assembly to the Pueblo of Taos and apologized that he had to leave shortly due to the unexpected death of a tribal member. He offered a prayer for the success of the important work of the committee. Representative Madalena commented on unfortunate recent flooding at the pueblo, and he reminded Governor Romero that help is available through the state.

The chair then introduced Ezra Bayles, director of health and community services at the Pueblo of Taos, who gave a brief outline of the Pueblo of Taos' journey to self-governance in health issues and recognition as a "638", or a tribe that administers its own health program pursuant to a provision of the federal Indian Self-Determination Act. Whereas in the past, a bureaucratic patchwork in Albuquerque hampered coordination of care for most treatment, the Pueblo of Taos now controls nearly all of its own health programs, Mr. Bayles said, including behavioral and community health. The availability of transportation and home visiting is integral to success. This year, the Pueblo of Taos received a prestigious Robert Wood Johnson Foundation Culture of Health Prize for $25,000 for its efforts in building a community where getting and staying healthy has become a fundamental social value. Several committee members asked Mr. Bayles about the success of Medicaid expansion at the pueblo, and he responded that reimbursement from the state's four managed care organizations (MCOs) has been a challenge at times, especially for home health care. Asked about behavioral health services, Mr. Bayles said that these services are available through the tribe. Future health goals for the pueblo include the addition of programs in schools that focus on education and prevention of drug abuse and chronic diseases, additional programs to meet needs for veterans and more tribal input on all health issues, Mr. Bayles said.

Review of Legislation for the First Regular Session of the Fifty-Second Legislature

Mr. Hely provided members with a binder containing copies of proposed legislation for committee endorsement (see List A). Members discussed the following legislation.

#1 (197308.3) is a house bill that enacts a new section of the Public School Code to prohibit school personnel from compelling students to use psychotropic medications, and it amends a section of the Children's Code to provide that the refusal to consent to administration of psychotropic medications to a child is not per se grounds for protective custody. Tina Olson,

director of the Citizens Commission on Human Rights of New Mexico, urged endorsement of this bill, saying the issue is one of parents' rights. Some committee members expressed concerns about the bill, especially Section 2 of the bill, which would amend a provision of the Children's Code. The committee voted to table the bill, thus refusing to endorse the bill in its present form.

#2 (197321.1) and #3 (197322.1) are house and senate versions of the same bill seeking to enact a new section of the Public Assistance Act to require an amendment to the Medicaid state plan to provide home visiting services for infants born to Medicaid recipients and for the infants' families. The committee endorsed both bills.

#4 (197379.1) is a senate bill that would require the Human Services Department (HSD) and the Department of Health (DOH) to create a five-year plan for increasing allocations to the developmental disabilities (DD) Medicaid waiver program supports and services, providing for annual reporting to the legislature and making a $25 million appropriation. Members discussed whether $25 million would be sufficient to meet the goals of the legislation. Other members expressed the need to grow infrastructure to accommodate increased numbers of clients. Several members expressed great concern over the current low wages of professional service providers. One member stated an intention to again address this crisis in separate legislation. Jim Jackson, executive director of Disability Rights New Mexico, urged support for this bill, believing that if funding is made available to the DOH, capacity can be grown. The committee endorsed the bill.

#5 (197397.3) is a senate bill amending and enacting sections of the Dental Health Care Act to provide for licensure and a scope of practice for dental therapists. Pamela K. Blackwell, J.D., project director of Oral Health Access, Health Action New Mexico, said that this legislation has new supporters and the only remaining opposition is from the New Mexico Dental Association (see handouts). New data from the dental therapy program in Minnesota show increased access to dental care and reduced wait times, she said, and Minnesota is looking to expand its program. Maine has now become the third state to approve dental therapists, Ms. Blackwell said. This legislation has strong bipartisan sponsorship and is a comprehensive effort to create a New Mexico solution to the dental care crisis. All 33 New Mexico counties are now federally designated as "underserved", and the shortage of dentists is estimated to be between 300 and 400, she said. The committee endorsed the bill.

#6 (197425.1) is a senate bill seeking to assign monitoring and oversight duties and to provide year-round staff to the LHHS, to require compliance with requests for information from the committee and its subcommittees and to confer the power to administer oaths and issue subpoenas. The bill includes an appropriation of $200,000 for fiscal year 2016 to fund staffing and activities. This legislation is an attempt to make the committee more effective, a member stated, and if agencies can be compelled to cooperate, the work of the committee will be much easier. The issues addressed by the LHHS and its subcommittees make up 60 percent to 70 percent of the state budget and are extremely complicated, the member added. The committee's workload is heavy and usually requires multiple extra meetings each interim. The committee endorsed the bill.

#7 (197483.1) is a senate bill making an appropriation to the Board of Regents of the University of New Mexico (UNM) to support the Pain Management Clinic at UNM. A member pointed out that the committee does not yet know what the funding priorities are for UNM, and it might be best to postpone this. Members voted to table consideration of this bill until more information is available.

#8 (197492.1) is a senate bill making an appropriation of $400,000 to the Higher Education Department to increase the number of dental students who participate in the Western Interstate Commission for Higher Education. The committee endorsed the bill.

#9 (197496.1) is a senate bill appropriating $250,000 to the Board of Regents of UNM to fund oculopharyngeal muscular dystrophy research at the UNM Health Sciences Center. The committee endorsed the bill.

#10 (197499.2) is a senate bill making an appropriation of $500,000 to the Crime Victims Reparation Commission for support, advocacy and services for victims of human trafficking. The committee endorsed the bill.

#11 (197500.2) is a house bill making an appropriation of $900,000 to the Children, Youth and Families Department to fund a supportive housing project to provide permanent housing and supportive services for at-risk families and children. The committee endorsed the bill.

#12 is a letter of support from the committee to the Task Force on Work-Life Balance for its Family-Friendly Business Award program, which is helping to promote businesses and institutions with family-centered policies. The committee endorsed the letter.

Public Comment

Joseph A. Martinez, consumer outreach coordinator of Health Action New Mexico, urged support of the proposed dental therapy legislation, describing dental care as a very serious, but solvable, crisis for children, the elderly and working families in New Mexico. He urged committee members to work to pass the legislation.

Mr. Jackson told committee members that there is an urgent need for additional behavioral health services in the state and that more funding is needed for mental health services, housing, outreach and case management for those who are not Medicaid recipients.

Duane Kimble, a New Mexico veteran, spoke of the importance of medical cannabis in the treatment of many disorders, and he described his own rare neurological disease and the efficacy of medical cannabis in controlling his symptoms. Mr. Kimble urged members to consider that most cannabis patients cannot afford the increased costs of the new regulations being proposed by the DOH.

Jennifer Furlow told the committee that she has been disabled since 2010, and she described her seven-year search for relief from pain and the difficulty of finding a physician willing to undergo scrutiny for prescribing cannabis. She urged members of the committee to consider broad legalization of cannabis in the state, such as has recently been accomplished in Colorado.

Wendy Robbins also urged committee members to consider legislation to legalize cannabis in New Mexico. Citing more than $20 million in reported tax revenue from cannabis sales in Colorado, with no credible reports of a single death caused by smoking it, Ms. Robbins said cannabis should be legalized in New Mexico for economic reasons because the state is among the poorest in the nation.

DOH: Proposed Changes to Medical Cannabis Rules (see handout)

Brad McGrath, chief deputy secretary of the DOH, told committee members that the department is very committed to the success of the rules for New Mexico's medical cannabis program (MCP). He asserted that public input on the department's proposed rule changes to the program has been significant, with more than 500 persons attending the June 16 hearing in Santa Fe and approximately 900 written comments received within the period of public comment, extended by the department from June 20 to July 1, 2014. The DOH is open to listening to people's concerns, Mr. McGrath said.

The proposed rule changes will triple the supply of medical cannabis available to patients, Mr. McGrath said, adding up to 12 producers to the 23 currently licensed in the state and allowing all licensed nonprofit producers to as much as triple their current output. The DOH is proposing a $50.00 patient registry fee and a staggered fee structure for producers, with funds generated earmarked for additional DOH staff to help operate the program. The proposed rule changes will expand criminal background checks in order to assure integrity, he said, and will decrease the plant count for personal production licenses. The MCP has approximately 11,300 patients currently registered, Mr. McGrath said, with nearly 8,000 of those diagnosed with posttraumatic stress disorder. The DOH is prepared to make additional changes to the proposed regulations based on public input, he said, and will probably finalize the new rules by September 2014.

Concerns About the DOH Proposed Medical Cannabis Rules

Joel White, vice president of the New Mexico Medical Cannabis Patients' Alliance, told committee members that he was diagnosed with multiple sclerosis 25 years ago but is vastly improved today, with cannabis as his only medication. Mr. White described his initial reluctance even to try cannabis and his later difficulty in finding a physician to prescribe it. He believes that most physicians remain unaware of the benefits of medical cannabis. Mr. White criticized what he called "punative" rule changes being proposed to the MCP by the DOH. Cannabis is a safe and effective medicine as opposed to the many prescription pain drugs now causing deaths from overdoses, he said. Patients were not involved in discussions with the DOH before these rules came out, Mr. White asserted, and they knew nothing of the rules until they were published. He asked how the new fee structure will help patients, who likely will be driven outside the program

to the black market. Mr. White urged committee members to protect the MCP from being destroyed by politics.

Emily Kaltenbach, state director of the Drug Policy Alliance, told committee members that the DOH's proposed rule changes were crafted by the department "in isolation", with stakeholders, patients and producers not consulted, and that these changes will undermine the purpose and the intent of the state's Lynn and Erin Compassionate Use Act (see handout). New Mexico has had a model program since its inception, Ms. Kaltenbach said, but these proposed regulations will put it 10 years behind other states. Her organization has concerns about the proposed rules limiting a caregiver's right to grow cannabis, about the fact that any medical provider could now veto a patient's use of cannabis, about the lack of input from the MCP's medical advisory board, about increasing fees and about the elimination of the DOH's annual assessment of the MCP.

Steven Jenison, M.D., a former DOH medical director and past member of the MCP medical advisory board, told the committee he was "very surprised" by the proposed new rules. The frequently asked questions published by the DOH state that "the information was obtained from the medical advisory board", but members of that board told him that no information was provided by the board to the DOH and no consultation was solicited by the DOH from the board. In response to this point, Mr. McGrath told committee members that the medical advisory board will hold a hearing in late August to review the proposed rule changes.

Len Goodman, chairman and executive director of NewMexiCann Natural Medicine, Inc., told committee members that there is not a functioning market for medical cannabis in New Mexico because of a chronic shortage in supply (see handout). The DOH conducted a survey in 2013 that clearly identified this shortage, he said, and now that the industry is about to expand, producers need to work together as partners to help bring down costs for their patients. Mr. Goodman was critical of what he sees as a lack of effort by the state to educate medical practitioners and the public about the safety of cannabis as an alternative to dangerous opiates, and he asserted that there were many more New Mexicans who could benefit from the program. The DOH's proposed rules will increase costs significantly for cannabis testing and production, Mr. Goodman said, and they will require financial statements from producers that are beyond the DOH's authority. He touted the combined expertise of New Mexico producers, who were ignored by the DOH, he said, as well as the MCP board of advisors.

Questions/Concerns

During a discussion following the presentations, several committee members stated they had never received so many constituent concerns on any issue as they have received on these proposed changes to the MCP, and it was clear that most constituents felt they would be negatively affected. Asked what the purpose is of these changes, Mr. McGrath responded that the new regulations are intended to address the supply issue. Another member asked if the DOH intends to request legislation to codify these changes to the MCP. Mr. McGrath responded that the DOH does not. One committee member, critical of the apparent lack of public input in the DOH formulation of proposed changes, cautioned Mr. McGrath against raising prices for

patients, many of whom are veterans on limited incomes. A typical retail price for an ounce of medical cannabis at present is $325 plus tax, producers who were present agreed, and it is not covered by insurance. Medical cannabis is subject to gross receipts tax, Mr. McGrath said, with projected sales of up to $18 million this year; the tax receipts go into the general fund. He maintained that the MCP is essentially an unfunded mandate for the DOH, and the increased fees are needed to add employees, increase education statewide and purchase special software to track the program. This past year, a $150,000 surplus from the MCP was returned by the DOH to the general fund.

Other committee members expressed concern to Mr. McGrath about a proposed change in the standard definition for participation in the program, additional background checks for consumers, increased requirements for financial audits that may be burdensome, if not impossible, for smaller producers and an increase in pricing that discriminates against the sickest patients. Members strongly urged the DOH to conduct a second public hearing, listen to advice from the MCP medical advisory board, be willing to make changes to its proposed rules and consider possible statutory changes. The MCP program should be all about the patients, a member concluded, not about politics.

Recess

The committee recessed at 4:45 p.m.

Friday, July 18

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:20 a.m., welcomed those assembled and asked members and staff to introduce themselves.

Advocates on the HSD's Income Support Division (ISD) and Public Benefits Case Management

Gail Evans, Esq., legal director of the New Mexico Center on Law and Poverty (NMCLP), told members of the committee that the HSD continues to experience severe difficulties and dramatic delays processing New Mexicans' applications for benefits, and she offered three real-life stories of applicants who fell into the backlog at the HSD. There are long lines outside ISD offices that form as early as 6:00 a.m., Ms. Evans said, and despite the law requiring the ability to apply the same day, by 10:30 a.m., people are being told to come back another day. New Mexico is ranked at the bottom of states having the hungriest adults and children, she said, and the best way to combat hunger is with general assistance (GA) and the Supplemental Nutrition Assistance Program (SNAP).

Ms. Evans described what she called an alarming decrease in the processing rate for these benefits, citing a drop of 30,000 SNAP beneficiaries between August 2013 and March 2014, according to the HSD's numbers. There were 3,500 people on GA, now that number is down to 2,900 people during that same time period, and Temporary Assistance for Needy Families (TANF) beneficiaries also declined, from 15,000 to 13,000. The department's application

processing rate is down by as much as half, she said. In 2011, the department's negative error rate (incorrect denial of benefits) was 3.9 percent; in 2013, that rate was 43 percent.

Ms. Evans said that the HSD is still "auto-suspending" food benefits for those whose renewals have not been processed.

Ms. Evans said that the NMCLP represents plaintiffs who filed a motion in U.S. district court to enforce compliance with a federal court decree from two decades earlier demanding that the HSD remove "systemic or programmatic barriers" from the food stamps and Medicaid programs (see handout). In May of this year, the judge granted the plaintiffs' motion to enforce compliance and ordered the HSD to immediately create a mechanism to prioritize expedited SNAP applications, suspend the auto-denial and auto-closure functions in its computer system and cease other procedural denials and required that SNAP applications be processed by the HSD within 30 days and Medicaid applications within 45 days. The judge also ordered monthly reports from the HSD and meetings to be held between the department and plaintiffs to discuss how terms of the decree are being affected. Ms. Evans reported that the HSD automatic denials are still being reported for food benefits six weeks after the judge's order, and plaintiffs will be going back to the judge on Monday.

Public Benefits Case Management Through the ISD

Brent Earnest, deputy secretary, HSD, told the committee that the HSD is concerned about reported problems and the backlog, and he said that 40 field offices and his staff are working overtime with individuals and the system to improve service. He provided an overview of how the ISD determines eligibility for the various benefit programs (see handout). The department's 25-year-old software system was replaced by a new program, ASPEN, which was rolled out successfully in waves starting in July 2013, Mr. Earnest said, with the last wave in January 2014. New Medicaid and federal Patient Protection and Affordable Care Act of 2010 (ACA) requirements have been integrated into the ASPEN system and into the single, streamlined application. A web-based self-service portal — YES-New Mexico (www.yes.state.nm.us) — is available to all New Mexicans online, and there are self-service kiosks in the lobbies of county ISD offices, and a 24/7 customer service information phone line is also available.

Mr. Earnest described the department's successes: transitioning 65,000 applications for Medicaid from other programs; moving 80,000 applicants to the federal health insurance exchange; hiring 75 new employees to help process applications; extensive training of more than 1,000 employees; and requiring mandatory overtime for staff of five hours a week since February. The HSD has double-filled positions, he said, and has created a team of top producers. The department's goal is to get to a two-week application processing time. Mr. Earnest commended staff members for their commitment and for working under pressure from many new and sometimes conflicting federal and state requirements.

Many challenges remain, Mr. Earnest admitted, especially with confusing notices being issued. Federal requirements and the consent decree requirements have made these notices cumbersome and confusing for applicants and recipients. A triage system has been implemented to

address the long lines in ISD office lobbies, he said, and the department has nearly eliminated the backlog of overdue applications. Customer support center services are being enhanced, as is the YES-New Mexico web site, and preparations are under way for the next open-enrollment period on the New Mexico Health Insurance Exchange (NMHIX).

Questions/Concerns

Members of the committee had numerous questions for the presenters, generally categorized as follows.

Lack of current data, i.e., less transparency than in the past. Several members asked Mr. Earnest if data were available by county. He responded that the HSD has not been able to produce the data because the HSD was operating two different systems and there have been problems with Medicaid reporting. Additionally, a software glitch resulted in children not being "broken out" in the numbers, and thus it appears that some were dropped. In January, the HSD put out a report that summarized the past six months, but it did not include the breakout of information the HSD used to get, Mr. Earnest said. The HSD is working on a new Medicaid report format, which will be presented to the Medicaid advisory committee. The department would like to move toward more real-time enrollment data on a monthly basis, he said — hopefully by August. A member asked whether the new report would break out the SNAP numbers by county for Native Americans, and Mr. Earnest said this would be possible because the Medicaid program reports specifically for Native Americans.

Continuing problems with auto-termination. A member stated that it appears that auto-termination is still a big problem, and if applicants are dropped from one service, it appears they also are dropped from others. Mr. Earnest assured members that auto-denials have been shut off, but some benefits have been suspended because of federal requirements not to pay those who are not eligible. Ms. Evans responded that as of this week, the department is still auto-suspending SNAP benefits for those whose renewals have not been processed. The department is out of compliance with federal law, Ms. Evans continued, because if an applicant applies for renewal and that renewal has not been processed, the applicant must receive notice about whose fault the denial is. This has not been happening, she said.

The HSD's increase in a negative error rate (frequency of incorrect denial or terms of benefits). The federal government changed how it looks at this, Mr. Earnest said, and there has been difficulty with the new system. Prior years' calculations did not include notices, he said, and poor notices are driving the HSD's error rate higher. Other states are experiencing much higher rates as well, he said. Ms. Evans agreed that poor notices are part, but not all, of the problem. New Mexico's error rate is the third worst in the county, she said. Department delay notices that were supposed to be ready by June have been delayed until September, Ms. Evans said.

Staffing issues at the HSD. A member asked if the HSD had properly anticipated the numbers of newly eligible applicants. What the HSD did not anticipate, Mr. Earnest responded, were problems with the federal exchange and the way the data eventually came into the department. The ISD has 110 authorized positions, and 130 positions are currently filled, but there

is high turnover, he said, due primarily to low pay. Recruitment is ongoing and continuous. These are very demanding jobs, and hourly rates now have been raised from $13.00 per hour to $15.30. A member asked why the Secretary of Human Services Sidonie Squier did not attend this meeting. Mr. Earnest replied that she was attending a tribal summit.

Minutes Approved

A motion was made and seconded, and the minutes from the first LHHS meeting on May 23, 2014 were approved.

Public Comment

Santanita Grogg is a caregiver for a Mi Via client who frequently gets closed out by the system. Then, as the caregiver, she cannot get paid and must requalify with Mi Via all over again, which takes four to six weeks. Her client, who is attending college, is completely stressed out. The client's budget finally passed. She used to work for him 10 hours per week for $20.00 an hour, but Mi Via has cut her time with him to six hours and cut her pay to $14.00. Ms. Grogg asserted that the whole system is "screwed up".

Althea McLuckie spoke of systemic problems in Mi Via with the transition to Centennial Care (CC). Her daughter has been in Mi Via since the program's inception, but now there are chronic denials of typically approved services, forcing her to go to hearings, which rule in her favor but are costly in time and money. The MCOs under CC are required to establish advisory boards, but she has contacted all four MCOs and was told that the annual public forum in Albuquerque satisfies that requirement. This is certainly no help for those who live in rural areas, Ms. McLuckie said. Under CC, access to long-term care services has been delayed; she finally got an assessment in January and submitted all paperwork by March 1, 2014. She reported that after 17 phone calls, including one to Secretary Squier, HSD personnel told her that the HSD had no influence over the MCOs and that she should contact the superintendent of insurance. Finally, two weeks ago, Ms. McLuckie said she finally received a determination. She expressed shock that the state does not have any influence to enforce MCO contracts.

Stevie Bass has a daughter who has been in Mi Via for long-term care services, and the program has served her well. On December 13, 2013, her daughter received the following notice of case action from the ISD office in Taos saying that her services would be closed as of January 31, 2014: "Your DD waiver is pending closure. In order to continue benefits, you need to reapply. Please complete the attached application.". There was no application attached, Ms. Bass said, asking why clients are approached this way. This letter is so cruel, she asserted. Why not say simply, "You need to reapply"?

Dereck Scott, who appeared with his wife, Melody, said he is very ill, is in a wheelchair with acute pancreatic disease and now has to go to Arizona for treatment (see handout). Mr. Scott related a long litany of difficulties, including being accepted on Coordination of Long-Term Services, Medicaid and Medicare, and then being inexplicably dropped from Medicaid with no warning. After many phone calls, the Scotts were told that the computer had dropped him for no reason, and now he is on a work program for which he did not apply. He must reapply for

Medicaid, for which he says he always qualifies, but this time there will be a 20 percent copay — more than they can afford. Mrs. Scott asked committee members why Medicaid is paying for people to be on WeightWatchers when there are folks out there who need medicine and regular medical care.

Candyce S. O'Donnell, District 5 candidate for the Taos County Board of Commissioners, spoke of the need for transportation for the elderly in rural areas of northern New Mexico and asked that the HSD consider sending staffers to remote areas periodically to assist the elderly and those who do not have the means to get into Taos to apply for income support and assistance with utilities.

Concerns About Benefit Cuts, Enrollment and Work Force Education and Training Components of the TANF Program

Ruth Hoffman, director of Lutheran Advocacy Ministry-New Mexico, presented committee members with a brief background of the TANF program, enacted at the federal level in 1996 and governed at the state level by the New Mexico Works Act in 1998. The 2005 reauthorization of TANF included new work program requirements. States are allocated an annual TANF block grant ($110.5 million this year in New Mexico), and participants are held to a lifetime limit of 60 months of cash assistance. States are required to have 50 percent of their caseload in federally countable work activities each year, and all benefit groups must include a dependent child. In early 2011, a "transition bonus" to help working families transition off public assistance into family-sustaining employment was suspended by the state, along with two annual school clothing allowances, and the cash assistance was cut by 15 percent. Ms. Hoffman urged legislators to restore these bonuses and to increase the amount of cash assistance (now at $380 for a family of three) to its former level. She also urged close examination of limited work participation activities and requirements, and asked legislators to require the HSD to provide detailed reports. The overall poverty rate in New Mexico remains very high, at nearly 21 percent, and TANF is a crucial part of the safety net, Ms. Hoffman concluded.

Susan Thom Loubet, executive director of New Mexico Women's Agenda, also urged legislators to demand more detailed reporting about support services for TANF clients (see handouts), as well as long-time job placements, salaries and prospects. Ms. Loubet stated that more data are needed from SL Start, the company holding the state contract to provide services under the New Mexico Works Act, in order to judge whether the program is succeeding.

Sovereign Hager, a staff attorney with the NMCLP, said that TANF participation continues to decline despite extreme poverty in New Mexico (see handout). Twenty-nine percent of children in New Mexico live in poverty, she said, and the state has the highest rate of child food insecurity in the country. Ms. Hager maintains that benefit processing has fallen dramatically since the implementation of the HSD's new ASPEN computer system. A table of information provided by the HSD shows that processing has fallen by 60 percent and SNAP application processing has fallen by 37 percent since July 2013, she said. Enrollment in both programs has fallen in the past six months due to processing delays and automatic closure of unprocessed renewals.

Ms. Hager said she is concerned about 2012 changes to the New Mexico Works Act requiring TANF participants to engage in certain activities or be subject to sanctions. People are having difficulty accessing alternative work participation arrangements, and it is difficult to document compliance. The state is not providing any follow-up information on those who have been sanctioned at an alarmingly high rate of more than 47 percent, she said. Ms. Hager pointed out that New Mexico is no longer facing budgetary restraints, yet SNAP benefits also have been cut, making New Mexico one of only six states to reduce benefits since 2010. She urged legislators to require the HSD to report on activities of SL Start in administering work supports and to restore earlier TANF and SNAP benefits amounts.

Update on TANF Eligibility, Enrollment and Work Force Education and Training; Update on Transition to CC Medicaid Waiver Program

Mr. Earnest provided committee members with a description of the TANF program, including charts and graphs (see handouts) of caseloads, expenditures and the projected expenses of the 2015 TANF appropriation of $120.8 million. He was accompanied at the presentation table by Lisa Roberts, vice president of operations for SL Start, who gave members copies of her presentation (see handout) on the New Mexico Works Program. SL Start is a for-profit company founded in 1979 that has held a contract with the HSD for the past four years to manage the TANF program. SL Start is charged with engaging participants to achieve higher self-sufficiency outcomes by improving families' financial situations, Ms. Roberts said. Her presentation described program objectives, processes and results of SL Start activities, including assessments, work participation, field screening for substance abuse and noncompliance issues.

Questions/Concerns

Mr. Earnest admitted that problems with reporting data have affected TANF, as well those programs previously discussed. Several committee members urged Mr. Earnest to restore the transition bonus and clothing allowances, as well as cash benefits to previous levels. A member noted that benefits have not been adjusted for inflation. Another member asked Mr. Earnest to provide numbers of TANF participants who have hit the five-year cap.

Ms. Roberts was asked for further information about SL Start. The company is based in Spokane, she said. SL Start has contracts in Washington, Idaho, Nevada and California, as well as in New Mexico. This contract was awarded through a competitive bid in August 2011, Ms. Roberts said, and was recently renewed for up to four years. SL Start also has a contract for management of SNAP.

Update on the NMHIX

Jason Sandel, member of the NMHIX board of directors, said this is his fourth presentation (see handouts) in two weeks in a quarterly reporting to the community on the first open-enrollment period. The NMHIX is vital in putting New Mexicans in the "driver's seat" on the ACA, Mr. Sandel said. A review of accomplishments include setup of the small business portal (the "SHOP") in October, and significant outreach efforts in the Native American community, including assisting with education and enrollment of nearly 4,000 individuals. The NMHIX's 13-member board of directors is completely committed to the organization's mission to operate a transparent

and user-friendly exchange, Mr. Sandel said, and to monitor and continuously improve the NMHIX to ensure a financially viable and sustainable exchange.

For every person enrolled through the exchange, approximately eight to 10 persons were guided to Medicaid, which had more than 130,000 new enrollees, Mr. Sandel reported. The NMHIX did not get nearly as many people enrolled as anticipated (34,000); the goal is 82,500, Mr. Sandel said. The board will be conducting research to find out why people did not enroll. It will use interest group feedback sessions across the state to identify opportunities for improvement. It will also be reevaluating the existing media plan and vendor relationships; it is important to make this happen sooner rather than later, he said. An immediate and critical challenge is whether the individual enrollment platform will be ready for the next open-enrollment period, beginning November 15. Mr. Sandel said that, currently, the federal government is requiring all existing federal enrollees to disenroll and then re-enroll in the NMHIX. The board will discuss whether to move forward with implementation of the individual platform at its next meeting on July 25. Financial sustainability of the NMHIX is a constant concern, Mr. Sandel admitted, but the board is very focused, and all members share the same goals.

Questions/Concerns

A member asked if enrollment figures had been released; Mr. Sandel responded affirmatively, saying that the superintendent of insurance has announced enrollment by carrier. Another member asked about applicants who are making too much income to qualify for Medicaid but not enough to buy insurance on the exchange. Mr. Sandel agreed that this is a problem, but he said it is not under the control of the exchange; it is up to the superintendent of insurance to look more deeply into these issues, he said. Asked by the chair if the NMHIX has thought about asking the HSD for funding, Mr. Sandel said no, but he promised to put that question on the agenda for the next board meeting.

Mr. Hely informed the committee that he has asked the federal Center for Consumer Information and Insurance Oversight (CCIIO) whether funding is available to pay the exchange for Medicaid enrollments, but he has not yet received an answer. Mr. Sandel said he requested that CCIIO representatives attend the next NMHIX board meeting via teleconference.

Adjournment

There being no further business, the second meeting of the LHHS for the 2014 interim adjourned at 3:45 p.m.

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

August 5, 2014
Room 1500, Barbara and Bill Richardson Pavilion
University of New Mexico Hospital
Albuquerque

August 6-7, 2014
University of New Mexico School of Law
1117 Stanford Dr. NE
Albuquerque

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Tuesday, August 5, 2014, at 9:15 a.m. in Room 1500 at the Barbara and Bill Richardson Pavilion at the University of New Mexico (UNM) Hospital in Albuquerque.

Present
Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair (8/5, 8/6)
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan
Sen. Mark Moores

Absent
Sen. Benny Shendo, Jr.

Advisory Members
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria (8/7)
Rep. Nathan "Nate" Cote (8/5)
Rep. Miguel P. Garcia
Rep. Sandra D. Jeff (8/5, 8/7)
Sen. Linda M. Lopez (8/5, 8/6)
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Rep. Vickie Perea
Sen. Nancy Rodriguez (8/7)
Sen. Sander Rue (8/6, 8/7)
Rep. Edward C. Sandoval (8/7)
Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Rep. Daniel A. Ivey-Soto
Rep. Paul A. Pacheco
Sen. William P. Soules

Rep. Elizabeth "Liz" Thomson

Guest Legislators
Rep. Rick Miera (8/7)
Sen. Michael Padilla (8/5)
Rep. Patricia Roybal Caballero (8/5)

(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

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written material are in the meeting file.

Tuesday, August 5

Welcome and Introductions

Representative Madalena called the meeting to order at 9:15 a.m., welcomed legislators and guests, and asked staff members to introduce themselves. He then thanked UNM for hosting today's meeting, and introduced Paul B. Roth, M.D., chancellor of the UNM Health Sciences Center (HSC).

This year is the fiftieth anniversary of the School of Medicine at UNM, Dr. Roth said, presenting each committee member with a folder containing information and a DVD highlighting the school's history and accomplishments. He noted that the first appropriation to the school from the legislature was $25,000. In an overview (see handout), Dr. Roth described the UNM HSC's current vision and goals, which include improving public health for all New Mexicans, building the state's health care work force and fostering innovation in research and diversity in health care delivery. Members were updated on two state-funded initiatives: increasing the size of nursing classes (there are 24 additional nurse practitioner students this fall) and recruiting and filling graduate medical education positions to include nine additional residents (five in internal medicine, one in family medicine, two in psychiatry and one in general surgery). Dr. Roth also described progress on the 2014 Health Care Workforce Initiative, a statewide work group tasked by Senate Joint Memorial 6 (2014) to formulate key recommendations based on best practices for recruitment and retention of health professionals.

Because the intermediate level of care has disappeared in New Mexico, behavioral and mental health services are a high-profile priority for the UNM HSC, Dr. Roth said. With the projection of shortages and lack of funding for behavioral and mental health services, the UNM HSC is seeking to enhance its coordination with primary care providers and plans to use care teams and networks to help bring this constituency back into society, he said. The child maltreatment program and the UNM Pain Center are other top priorities for the UNM HSC. A committee member asked Dr. Roth if the UNM HSC provides indigent care for undocumented persons. Financial assistance is the issue, Dr. Roth explained, noting that the UNM HSC is a public institution and would be eager to extend assistance through indigent funding, but current federal law restricts payment for such care; state-enabling legislation would be required.

Advocates and Child Care Providers on Proposed Child Care Reimbursement Rates

A presentation by Joy Losey, president of the New Mexico Child Care and Education Association, a statewide organization of licensed private child care programs (see handout), provided context for a discussion of challenges created by new requirements and reimbursement rates proposed by the Children, Youth and Families Department (CYFD). Ms. Losey objected to a narrowing of allowable accrediting organizations and described negative financial impacts of new regulations and unfunded mandates to child care businesses in New Mexico. While her membership supports quality improvement, it is vital that child care centers not be unintentionally forced to close, she said, thus sending children back into unlicensed care.

Ellen Gore, director of Guadalupe Montessori School in Silver City, spoke as an advocate of access to child care for all families regardless of ability to pay. Ms. Gore said that many families do not qualify for subsidies and are spending upwards of 25 percent of their income on child care. The federal government recommends that states pay 75 percent of the cost for early education for those who earn up to 150 percent of the federal poverty level, but New Mexico is paying 30 percent below that. Because Montessori schools have their own accreditation, which will not be recognized by the state under the new rules, they will not be able to qualify for their current rating and would be forced to raise rates or close, Ms. Gore said. Several coalitions are bringing parents, educators and child care business owners together to improve early education, including PEOPLE for the Kids, Early Educators United and OLÉ Working Parents Association (see handouts).

Raquel Roybal, a parent representing OLÉ, said many centers will no longer accept subsidized children, and it seems that the CYFD is setting up barriers that discourage participation. Ms. Roybal noted that last year, the CYFD returned $7 million to the general fund that was intended for early child care. She urged that a "Parent Bill of Rights" be posted in all CYFD offices. Carmela Salinas, president of PEOPLE for the Kids, is a preschool teacher and a single mother who is also a student working toward her degree in teaching. The average preschool teacher makes $8.75 an hour with no benefits and no health insurance, she said, and it is no surprise that there is high turnover. A culture shift is needed to allow preschool teachers to be paid as professionals and to lighten the unpaid burden of additional paperwork.

Rebecca Dow, founder and chief executive officer (CEO) of AppleTree Educational Center in Truth or Consequences, said the child care industry is very volatile and needs to be stabilized before considering policy changes. Parents, many of whom are paying more for child care than for rent or college tuition, cannot take on additional costs, nor can the child care centers. Reimbursement rates need to be raised, and owners, directors and educators should be leading the process of change, she said. A multidimensional market rate study should be conducted that reflects the true cost of providing early child care services.

Questions/Concerns

A member asked the presenters if any of them had been engaged by the CYFD in the development of the new quality standards. The answer was unanimous: no. The plan had been fully developed by the time it was presented, they said. Many five-star-rated facilities have already dropped to a two-star rating, Ms. Losey asserted, and now the clock is ticking, and some providers are realizing they will be going out of business. Accreditation is a major hurdle for many child care businesses because of the cost. Victoria Pruitt, executive director of St. Marks in the Valley Day School in Albuquerque, who was in the audience, said her organization budgeted $15,000 for its site visit, and it was also required to pick up the tab on all expenses.

Another member commented that there seems to be a wall, with the CYFD refusing to come to the table. It is not a partisan issue; everyone wants what is best for the kids.

Child Care Providers and the Proposed Rules for Child Care Reimbursement

Yolanda Berumen-Deines, secretary of the CYFD, was scheduled but did not attend today's meeting. Steve Hendrix, director of the Early Childhood Services Division (ECSD), CYFD, and Dan Haggard, deputy director of the ECSD, provided members with a 38-page brochure on FOCUS, the name of New Mexico's new tiered quality rating and improvement system for early childhood education, and a PowerPoint presentation describing the recent changes to the child care assistance regulations (see handout).

The CYFD, the Public Education Department and the Department of Health (DOH) partnered in a Race to the Top Early Learning Challenge federal grant for $37.5 million to be invested over four years, Mr. Hendrix told committee members. Within this grant application, the CYFD committed to development and implementation of a new tiered quality rating and improvement system, which it has named FOCUS on Young Children's Learning. It is a pilot program based on the success of New Mexico's pre-k program and on other research-based criteria. Of the approximately 700 licensed programs in New Mexico, there are 143 participating in the pilot, 130 at the two-star level and 13 at the three-star level. There are 22 programs currently in the process of enrollment and 28 programs on a waiting list. The FOCUS brochure describes in detail the requirements for the different star levels.

Providers have two options to attain a five-star rating, which provides the highest rates paid per qualifying child, Mr. Haggard explained: participate in FOCUS and achieve the five-star criteria or become accredited by one of the five national accrediting bodies recognized by the

CYFD. Affected providers have until December 2017 to achieve the five-star level or become accredited based on national standards. FOCUS is a voluntary quality improvement program, he said, and is not required in regulation. Child care is an essential industry in New Mexico, which is in transition from babysitting to daycare to early childhood education, and FOCUS is a viable way to expand what is already happening, Mr. Haggard said. The department is sensitive to the expense of accreditation, and with FOCUS, providers can work their way up as an alternative.

Upon questioning of Mr. Hendrix and Mr. Haggard, committee members addressed the following topics.

Concerns about providers being excluded in the development of FOCUS criteria. Mr. Hendrix said a number of FOCUS town hall meetings have been conducted around the state, and he added that the CYFD will meet soon with some of the providers. A committee member pointed out to Mr. Hendrix that those providers are here today and can be listened to now. These are the CYFD's consumers, the member continued, urging Mr. Hendrix to set up formal meetings on a regular basis with representatives of these associations. Another member commented that FOCUS was created as part of a grant proposal, and planning clearly has been from the top down. Reviewing a list of the five accrediting bodies approved by the CYFD, another member noted that two of these — 40 percent — are Christian organizations.

Questions about the CYFD's authority to change the regulations. One member pointed out to Mr. Hendrix and Mr. Haggard that they are not policymakers; that is the job of the legislature. The FOCUS program was created without any legislative input, the member noted. There are 2,000 fewer children receiving state benefits for child care today, yet people are in dire economic straits, another member observed. By 2017, this disconnect will be even larger. The member hopes that the CYFD has heard this committee and understands that those persons who need to be here are not. Mr. Hendrix and Mr. Haggard assured members that Secretary Berumen-Deines is very much engaged, that she will hear their concerns and that the department will do its best to make sure agencies are not negatively affected by the new regulations. If FOCUS does not work, it will be changed, they promised.

Questions about inclusion. The method used by the CYFD has bypassed major elements of the process, another member noted. The approach is developmental, not educational, and these are two very different things. The town hall meetings were meant for a specific purpose. The entire approach to FOCUS was not done inclusively, the member continued. It is not certain to this member that the state can enforce or mandate something that is part of a grant, especially when the key players — the parents — were not even involved. The project is not viable at this point, the member concluded, and the CYFD needs to stop and conduct a complete evaluation internally. FOCUS can be turned around and worked into an improvement plan.

Comments about the FOCUS brochure. A member asked who the target audience is for the expensive-looking brochure and was informed that it is for teachers and parents. The member noted a disclaimer on the back of the brochure stating that no part of the document can be

reproduced without prior written permission of the CYFD. The member is disturbed that taxpayer dollars are being used to produce a proprietary brochure. The committee chair stated that New Mexico is a unique state and language is so important. The FOCUS brochure does not reflect that; it could be from the State of Iowa.

Concerns about tracking the data. Committee members had many questions about data reporting and how the CYFD will measure outcomes. Mr. Hendrix agreed that there are challenges with reporting. The department is experimenting with methods to provide quick-look sheets but does not yet have a mechanism to transfer the data. Another member expressed concern that due to lack of data, the FOCUS project could run out of money without the department knowing it. Mr. Hendrix assured members this could not happen.

Public Comment

Peggy Lopez told the committee that she knows of a lot of really good child care centers that have given up, and she hopes something can finally be done. She is a caregiver at a center with 24 children and said it is essential that everyone works together to bring about positive change.

Roxanne Rosa is director of a Montessori school that now has a four-star rating. The school cannot afford accreditation, so she will have to go back to school for FOCUS. Otherwise, the school will be taken back to a two-star level and will lose funding.

Denise Tapia, who teaches at a Montessori school, said her commitment is to the children. The higher teacher-to-pupil ratios mandated in FOCUS mean that many teachers will lose their jobs. Ms. Tapia noted that the CYFD does not recognize her Montessori certification, which took three years to achieve. The CYFD staff does not even take notes at their meetings, she said.

Rebecca Dow thanked the LHHS for taking the time to understand these complicated issues and urged legislators to require the state to fund its mandates before they are implemented.

Lucy Gant spoke of issues with parents' contracts for child care assistance. One month they have a contract, the next month they do not, she said. There are parents who lose their jobs and immediately lose their contracts. There are no exemptions for a parent with a restraining order, and that parent is forced to file for child support in order to keep a contract, she said. The Parents Bill of Rights should be posted in all CYFD offices. Another speaker noted that small changes can drastically impact a child care business. Ms. Gant said that there are three-, four- and five-star businesses shutting down; more than 200 two-star businesses are the new ones now opening.

Ellen Gore said that her school is already accredited by a respected international agency and does not want to invest the time and expense to be re-accredited.

Bret Meyrick thanked the audience for its comments, saying that this conversation is really all about the children.

Carol Peck, a parent and employee of Southwest Child Care in Albuquerque, said that parents have received copayments that have actually doubled.

Victoria Pruitt's school, St. Marks, was one of the first in Albuquerque to be accredited by the National Association for the Education of Young Children. The school went through accreditation again last week because of an appeal, and the process is extremely stressful, Ms. Pruitt said. For St. Marks, paying teachers is a top priority. If changes are to be made to the system, it is important to do it right.

Anna Otero Hatanaka spoke to committee members about the value of the UNM Pain Center. She has suffered for about 10 years with chronic pain and eventually ended up at the center for treatment. The UNM Pain Center is an important service to the state of New Mexico, and she is hopeful that the committee will support it.

A committee member informed the committee that he had just received an email confirming that three child care centers in Taos have closed in the last two weeks.

Another committee member moved that the LHHS write a letter to the Legislative Finance Committee (LFC) seeking a study on the costs of implementing FOCUS. The motion was seconded and approved unanimously.

UNM Pain Center

Senator Padilla, a guest legislator at the LHHS meeting, distributed copies of his proposed bill, bearing the indicator number 202.197483.1, which is an appropriation of $1.1 million to the UNM Board of Regents for the UNM Pain Center. He is seeking endorsement of this legislation.

Joanne G. Katzman, M.D., a neurologist who is the director of the UNM Pain Center, told committee members that the clinic has nearly 6,000 patient visits per year, referred by primary care providers and treated regardless of ability to pay (see handout). New Mexico leads the nation in unintended opiate deaths, Dr. Katzman said. Most physicians have not had much education about chronic pain and addiction. Clinical outreach and continuing medical education are primary goals of the UNM program. The clinic also aims to increase access to care and, in collaboration with the DOH, monitor health outcomes. Unfortunately, wait times for an appointment at the clinic can be as long as four to six months. There are seven physicians employed part time at the clinic, with a 1.3 full-time-equivalent (FTE), providing what Dr. Katzman called a "skeleton crew".

The UNM Pain Center's approach is interdisciplinary and culturally sensitive and utilizes best practices from physicians, psychiatrists and other mental health providers, Dr. Katzman explained. Chronic pain affects an estimated 100 million adult Americans and costs up to $635

billion per year in medical treatment and lost productivity (see handout). Prescription opioid abuse is now a major public health crisis. There are five New Mexico counties that have four to six times the national average drug overdose death rates. A trial was begun in July offering naloxone to every UNM Pain Center patient with an opioid prescription as a risk reduction measure for opioid overdose deaths.

A member moved that the committee endorse the appropriation for the UNM Pain Center and that it be included with the budget requests to the LFC. The motion passed unanimously.

UNM Center of Excellence in Child Maltreatment and Abuse

Leslie Strickler, D.O., calls herself "the doctor no one wants to come see". As medical director of the Child Abuse Response Team (CART) at UNM, she provides medical evaluations for alleged victims of physical abuse or neglect. The stakes are high because repercussions are dramatic: failure to recognize abuse places children at risk for ongoing and escalating maltreatment, and unfounded allegations of abuse have devastating consequences for families (see handout). UNM houses the only multidisciplinary clinical services in New Mexico dedicated to the medical evaluation of child abuse and neglect. There are two board-certified child abuse pediatricians in New Mexico, both at UNM. The CART provides medical evaluation for alleged victims of physical abuse or neglect and conducts 300 to 350 evaluations annually, while Para Los Ninos provides medical evaluations for alleged victims of sexual abuse and conducts 300 to 400 exams each year, Dr. Strickler said.

Professional collaboration is central to the services provided by the center, which accepts referrals for evaluation from health care providers, the CYFD and law enforcement and provides expert testimony in civil and legal matters. Education and advocacy are also vital components of the program. There are many challenges for child maltreatment providers, Dr. Strickler explained, including limited capacity to sustain small programs to areas outside of Albuquerque. Future goals include the expansion of clinical and educational services statewide through telehealth models by training health care providers to perform high-quality medical assessments with guidance from pediatricians trained to evaluate child abuse. The requested $779,000 appropriation from the legislature for fiscal year 2016 will fund new staff positions to sustain local service and expand the network statewide.

A committee member asked Dr. Strickler how legislators could best direct their efforts to make the biggest difference in preventing child abuse and neglect. Identify families in need, she responded, and those who are living in poverty, with women who are being abused or family members who have mental health issues that are not being addressed. It is important to do a better job of recognizing abuse, she said.

Brain Safe Project

The Brain Safe Project is an innovative program designed to study and minimize the effects of concussions and other forms of mild and traumatic brain injury, according to Kent A. Kiehl, Ph.D., director of mobile brain imaging and a professor of psychology, neuroscience and

law at UNM (see handout). Dr. Kiehl described the prevalence of sports-related traumatic brain injury in the United States as upwards of 300,000 each year. The concussion rate is greater than 8,500 annually for college athletes.

The Brain Safe Project is a longitudinal study utilizing baseline magnetic resonance imaging (MRI) scans, post-injury scans and annual scans. The goal is to use advanced data analytic methods pioneered by scientists from UNM and The Mind Research Network, an Albuquerque scientific nonprofit, to identify hidden patterns and help evaluate risk. It is a noninvasive study that is pushing the boundaries of current knowledge, Dr. Kiehl said. To date, 253 athletes from UNM have been scanned in the first phase of the project. Eleven percent of these athletes had incidental findings indicating the potential for problems following concussion, and in two cases, those findings were significant enough that they contributed to a decision to withdraw from play. Dr. Kiehl anticipates that the program can be expanded to other universities and to high schools.

New Mexico Health Insurance Exchange (NMHIX) Update

In testimony before the committee, J.R. Damron, M.D., chair of the board of directors of the NMHIX, described accomplishments and challenges of the exchange, whose board of directors began its work in April 2013 (see handout). The NMHIX has received $122 million in federal funds and has implemented a financial reporting system and monthly and quarterly regulatory reporting processes for grant expenditures. After a year-long search, the board has just hired a CEO for the NMHIX: Amy Dowd, currently CEO of the Idaho Health Insurance Exchange. At its most recent meeting, the NMHIX board of directors voted to continue use of the federally facilitated marketplace (FFM) for the next enrollment period beginning November 1 rather than attempt a switch to the state site. This is due to some delays in state system development and because the federal government would require the 34,200 New Mexicans who have enrolled on the FFM to reapply. In addition to individual enrollments on the FFM, the NMHIX enrolled 126 employers on the small business portal, the SHOP, insuring 447 employees and 202 dependents. The expansion of Medicaid brought in 140,000 new enrollees.

One committee member expressed surprise at these numbers and queried Dr. Damron why so few businesses have signed up on the SHOP. This is a transition year, Dr. Damron replied, admitting that the board was disappointed as well and felt that a lot of people held back. Another member remarked on the millions of dollars that have been spent for this slim result, granting that many of those dollars were purely educational. When asked about next year's budget for the NMHIX, Dr. Damron said he did not have the financials with him today but that he would get them to the committee. The board has discussed what will be needed for the NMHIX to become financially sustainable, Dr. Damron said, but the board wants to have the new CEO in place to offer insight and guidance on this important issue. The NMHIX is essentially a start-up company, he continued, and it has been a major push for board members. The original goal was to reach 95 percent insured in the state, but 23 percent remain uninsured as of October 1, Dr. Damron said. If the exchange adds another 50,000 during the next enrollment period, the number of uninsured could be cut to 15 percent, he noted.

Dr. Damron had praise for the work of Native American Professional Parent Resources, Inc. (NAPPR), a nonprofit organization that holds the contract for education and enrollment of Native Americans in the health exchange. The NAPPR provided outreach to more than 30,000 individuals and enrolled 4,015 in a health plan through the NMHIX or on Medicaid. The contract with NAPPR has been renewed, Dr. Damron reported, and its work extended into the Navajo Nation.

The meeting recessed at 6:00 p.m.

Wednesday, August 6

The committee reconvened for a joint meeting with the Courts, Corrections and Justice Committee (CCJ) in the lobby of the UNM School of Law in Albuquerque.

Call to Order and Introductions

Representative Madalena called the meeting to order at 9:20 a.m. and introduced Representative Gail Chasey and Senator Richard C. Martinez, co-chairs of the CCJ. Representative Madalena welcomed members and guests and asked legislators on both committees and LCS staff to introduce themselves.

Assisted Outpatient Treatment Panel

Brian Stettin, policy director for the Treatment Advocacy Center in Arlington, Virginia, was an assistant attorney general for New York in 1999 and drafted Kendra's Law, which provides for court-ordered assisted outpatient treatment (AOT) for certain individuals with a history of mental illness to receive a specific regime of outpatient treatment. Mr. Stettin noted that New Mexico is one of only five states that does not have AOT.

Non-adherence to treatment is the single reason for repeated incarceration and hospitalization of a very small subset of individuals who consume a large amount of scarce resources, Mr. Stettin said. New Mexico has three times as many mentally ill persons in jail as any other state. He described a condition common to this group of individuals called agnoscenosia, which is a lack of insight into one's illness. It is not denial, he asserted, but rather a brain-based inability to recognize one's own illness, resulting in lack of adherence to medication and treatment. AOT is a proven, evidence-based approach that provides family members and the community a means to obtain a court order for a plan of treatment for these individuals.

Despite studies showing its success, AOT remains controversial, Mr. Stettin admitted, with advocates of self-direction asserting that it is amounts to forced treatment. However, punishment plays no part in AOT, he said, nor does AOT allow for the restraint or forced medication of a patient. According to Mr. Stettin, court-ordered AOT works in the following ways: 1) it motivates the person who is mentally ill by indicating the seriousness of need (the "Black Robe" effect); 2) it provides for court oversight of providers of services; and 3) it allows for continuous monitoring of

both patient and provider. AOT has been shown to improve outcomes for this small, highly vulnerable population, and it is long overdue in New Mexico, according to Mr. Stettin.

Nancy Koenigsberg, legal director of Disability Rights New Mexico (DRNM), said she agrees with many of Mr. Stettin's points and that AOT is working in New York, where the state provided funding of $32 million to get the program off the ground (see handout). She noted that there are still small and rural parts of New York that do not use AOT due to lack of infrastructure and support. New Mexico no longer has a community-based behavioral health treatment system, Ms. Koenigsberg said, and thus has no infrastructure to implement AOT. Her organization is also very concerned with the lack of case management in New Mexico. The four managed care organizations (MCOs) that operate under Centennial Care are mandated by the federal Patient Protection and Affordable Care Act (ACA) to provide behavioral health services, but even with the highest level of need, she pointed out, care coordination consists of just one phone call a month.

Ms. Koenigsberg reviewed a copy of AOT legislation being proposed to the committees today for endorsement (see handout under #4) and said she had many concerns, including the amendments to the Mental Health and Developmental Disabilities Code that may undermine confidentiality and privacy, questions about how treatment guardians would be affected, inconsistent definitions and the ripple effect of these changes. The bill's $3 million appropriation to the DOH for surveillance of the program is confusing, Ms. Koenigsberg said, especially since no funding is designated for services. With no connection to services, the bill is "an empty promise".

On questioning, Mr. Stettin, Ms. Koenigsberg and committee members addressed the following topics.

Legal representation for those brought before the court. Mr. Stettin said that every AOT program provides for this representation, even though the action is civil. In New York, it is part of the administrative cost of the program through the budget of the court.

Disappearance of behavioral health services in New Mexico. Ms. Koenigsberg noted that managed care has eroded the behavioral health system in that it has undergone multiple transitions resulting in very few intermediate services and supports left in the system. In July, it was reported in the newspaper that La Frontera, the new agency from Arizona, had laid off 87 staff in southern New Mexico. She pointed out that there is no intensive case management in Medicaid's behavioral health benefits package — a service that is a cornerstone of any AOT program, she said.

A committee member expressed frustration with the millions of dollars designated for behavioral health care delivery by New Mexico's Medicaid MCOs. These funds have gone into the pockets of the MCOs through the capitated rates, and the MCOs face no consequences for the lack of services, the member asserted. In the 1990s, there were several psychiatric facilities in Albuquerque. Now, many mentally ill individuals are in hospitals and in jail, with the expense borne by local governments.

Fate of legislation establishing community engagement teams (CETs). Governor Susana Martinez vetoed House Bill 588 in the 2013 regular session because she felt it was unconstitutional, Ms. Koenigsberg said, but she promised four pilot programs that have not yet materialized. A committee co-chair noted that a representative from the Office of the Governor was in the audience and asked that person to take these concerns back to the governor. Another committee member moved that a letter be drafted from both the LHHS and the CCJ to the governor asking what CET legislation she would support. The motion was seconded and passed unanimously.

Court-Supervised Outpatient Treatment

Oscar Kazen is a probate court judge in Bexar County, Texas, serving an area (including San Antonio) with a population of 1.8 million people. Texas is forty-ninth in the nation in mental health spending, according to Judge Kazen. He is a former criminal court judge and is also a trained drug court judge. He alone presides over the county's AOT program.

Judge Kazen, along with a behavioral health services provider, monitors between 60 to 80 individuals at any given time in his AOT program, meeting weekly to take stock of how things are going. The person is encouraged to participate and take medications and is told what to expect. These meetings also ensure that providers are actually providing the needed services, Judge Kazen said. The results indicate that hospitalizations among this group have been reduced by 50 percent to 75 percent. He reported that 100 randomly chosen participants were responsible for 67,000 lifetime hospital bed days before coming into his program. In just the year prior to participation in his AOT program, this cohort was responsible for 8,800 hospital bed days. In the year during the cohort's participation in the AOT program, hospitalizations decreased by 62 percent. After this cohort was no longer in the AOT program, "wellness became their pattern", according to Judge Kazen, with only 38 admissions for a total of 3,400 hospital bed days.

Judge Kazen emphasized that AOT is not punishment; instead, it is a jail and hospital diversion program. The treatment plan can involve the judge, patient, physician and family members, all in the same room, talking to each other. If there is a problem with a plan, it is caught early. Most of the persons in his AOT program are on Medicaid, and the MCOs are eager to work with the program, whose participants are already at level 3 for care management. Judge Kazen concluded by strongly urging committee members to consider AOT for New Mexico, noting that funding for AOT and funding for services are not mutually exclusive. He reported that his AOT program has saved $3 million in hospital bed days.

On questioning, Judge Kazen and committee members addressed the following topics.

Financial burden on the court. The judge is already there, but there does have to be an attorney representing the respondent, Judge Kazen responded. The "potentially harmful to self or others" threshold has to be laid out in the affidavit, and while this broadens the group of people that can be covered by AOT, there is always the safety in appellate courts. Every 90 days, the order is reevaluated.

Could AOT be made available to Native Americans? Not in Texas and not on tribal lands, Judge Kazen said. But if there is already jurisdiction to have Native Americans in court, then one could proceed or try working with the tribes themselves, he advised. Perhaps this bill could be a springboard to start those discussions.

More data on results. A member asked Judge Kazen to send more data to the committees about the AOT treatment results and budget numbers for the program in Bexar County; he agreed to do so.

Where does the team physician come from? A local mental health authority has public clinics, and within these there are psychiatrists, Judge Kazen said. But when the program began, it was just one judge and one liaison officer following up with the patient, asking, "Did you go to your appointment today?", and "If not, you will have to see the judge". It can work by empowering a local judge, he said. Another member countered that Judge Kazen does not understand how New Mexico is utterly devoid of services. Judge Kazen responded that he still recommends passing empowering legislation. "There is a fire out there", he said. "Do not wait until everything is perfect before trying it."

Measuring the success of AOT. Success is having people graduate from the program, Judge Kazen explained, and success is when a person looks him in the eye and says, "Thank you". He had someone in the program who once could not even talk who now is attending college, and another who had two guns and was living in the back of his car and who is now a licensed counselor. "A day out of the hospital is a success", he concluded.

Behavioral Health Panel

Nils A. Rosenbaum, M.D., an Albuquerque psychiatrist who often works with police and social workers, is supportive of the proposed AOT-enabling legislation. He gave committee members several examples of patients who refused treatment and could have benefited from such a program. If this bill passes, Dr. Rosenbaum said, the program should grow organically based on what resources the community has and can deliver. He recommended including peers and increasing engagement as much as possible. In every community, he said, there are people who want to help.

Mauricio Tohen, M.D., chair and professor in the Department of Psychiatry at the UNM HSC, had a background in public health in Massachusetts and Texas before coming to New Mexico. The ACA has provided a window of opportunity, Dr. Tohen believes, because all insurance now must cover mental health services. While assessments indicate a need for more hospital beds, Dr. Tohen said what is needed is more services other than inpatient care. Mental health conditions are lifelong, and hospitalization represents an acute phase. In the past, New Mexico had more intermediate services, but these have disappeared. Dr. Tohen used to practice in Texas, has been in Judge Kazen's courtroom on several occasions and is supportive of AOT. It does not work all by itself, he noted. What is optimal is more AOT and specialized residential treatment.

Dr. Tohen explained that the main purpose of AOT for noncompliant patients is not about protecting the public, but rather about protecting the mentally ill from violence and from the inability to take care of themselves. They need to be protected with treatment, he continued, not just medication. Case management is one of the most effective interventions. In addition to AOT, the state needs to look at providing other intermediate level services and a triage center for first responders to take people to in crisis.

A committee member asked Dr. Tohen if he saw any improvement in New Mexico's behavioral health services. He responded by noting that New Mexico leads the nation in telemedicine. Another member noted that the MCOs use behavioral health dollars in a much stingier way than private insurers. Administrative burdens upon patients and providers have been increased by the MCOs to save money, the member continued, and financial decisions have been made to restrict services. The member noted that case management services should be reimbursable. Dr. Tohen agreed and added that profit can be made in ways that benefit the patient when profit is tied to outcomes.

Review of AOT Legislation

Senator Papen presented a discussion draft of a senate bill, 202.197295.1, enacting the AOT Act. The bill provides for AOT proceedings, requires public health surveillance and oversight, provides for sequestration and confidentiality of records, provides for penalties, amends the Mental Health and Developmental Disabilities Code to require data collection for certain proceedings and makes an appropriation (see handout).

Ms. Mathis, who drafted the bill for Senator Papen, told committee members that the AOT Act is based on New York's law. It is a civil proceeding that will affect fewer than 300 persons in the state who now, without AOT, must become very ill or violent before they are placed into treatment. The AOT Act does not allow for forcible treatment, includes treatment guardians and has many layers of due process, Ms. Mathis said, offering highlights of certain sections of the bill, copies of which had been distributed to committee members.

The AOT Act does not hinge on a determination of incompetency, Ms. Mathis emphasized, and is not meant to circumscribe any statewide standard treatment — this is left to the community providers and the judge. The bill is written very broadly to allow flexibility in fashioning an individualized treatment plan, but it requires services for any particular individual to be specified in the order for AOT.

After a short period of question-and-answer, committee members discussed whether parts of the bill should be reworked or whether to endorse the legislation as presented. Observing that the bill will be vetted continually as it moves forward, a member moved to endorse it. The motion was seconded and passed 4 to 1.

Supportive Housing Panel

Dennis Plummer, CEO of Heading Home in Albuquerque, described the success of this evidence-based model of permanent supportive housing for individuals and their families who are medically vulnerable and have been homeless for an average of 7.5 years (see handout). It is composed of a collaboration among many local and state organizations and has achieved a retention rate of 81 percent.

The program has reduced jail costs by 39 percent and emergency room visits by 36 percent among this group, and the program has been nationally recognized, Mr. Plummer said. Research of this model by a UNM study has shown that it is less expensive to provide housing with supportive services than it is for those same people to live on the streets. Heading Home would like to expand to other parts of the state, and Mr. Plummer urged legislators to consider housing appropriations and systemic change for which a model already exists.

Paula Harper, executive director of the Supportive Housing Coalition of New Mexico, described her organization's efforts to create and preserve permanent and affordable supportive housing through housing development and rental assistance programs since 1996. The group pioneered the use of a "Housing First" model of permanent supportive housing that has housed over 700 individuals and families (see handout). This is not only the most compassionate thing to do, it is also the most cost-effective, Ms. Harper said. The program has enlisted 112 landlords who have a standard lease. It costs $40,000 to $150,000 annually in emergency room services, incarceration, shelters and hospitalizations for someone to live on the streets, while a housing voucher is just $6,600 per year. A shelter bed is $8,000 per year. Estimates are that Heading Home has saved the City of Albuquerque $3.2 million over the past three years, Ms. Harper said. The coalition plays many roles in the development of affordable housing by serving as developer, general partner, owner and manager through new construction and acquisition and rehabilitation. One new project will provide 60 units of housing in Albuquerque for Native Americans who have behavioral health issues. Housing is not a one-size-fits-all proposition, Ms. Harper said; there have to be different options.

KC Quirk is executive director of Crossroads for Women, which provides housing and intensive support services for homeless women with co-occuring mental and addictive disorders who are working toward self-sufficiency. The agency operates two programs: Crossroads, a permanent supportive housing program utilizing scattered-site housing throughout Albuquerque for women who are cycling between homelessness and incarceration, and their children, and Maya's Place, a highly structured 15-bed transitional housing program for homeless women who are exiting jail or prison, substance abuse treatment or a shelter or living on the streets. Ms. Quirk brought several women with her to illustrate the success of the programs. Tina, a former crack addict who was incarcerated more than 20 times, found help and support at Maya's Place and is now a student at Central New Mexico Community College (CNM). Gina spent 20 years incarcerated and one year at Crossroads and has now been clean for 16 months. Not once in those 20 years did anyone offer her any education, but now she is in business school. Rhonda was an addict and was homeless for many years with behavioral health problems and then became a client

at Crossroads. Now she is a student at CNM and will soon be graduating with a communications degree. Tracy, another Crossroads client, was an addict, had been arrested 40 times, has graduated from CNM and UNM and is now working on her master's degree; she also has become a staff member at Crossroads. There is much conversation about the lack of mental health services, Ms. Quirk said, but it is not enough to just pay for more services. It is also important to identify programs that work.

Elizabeth Simpson's task with Bernalillo County is to develop long-term initiatives for alternatives to incarceration. There is a strong correlation among mental illness, homelessness and incarceration. People end up in jail because they have nowhere else to go, and first responders have very few options (see handout). These problems have been studied by several task forces and the recommendations are the same: 1) crisis triage center as an alternative to jail to assess, stabilize and connect to services; 2) supportive housing; and 3) specialized services for those exiting jail and prison. Current Medicaid care coordination consists of just one phone call a month and one face-to-face meeting, Ms. Simpson pointed out. The intensity of services needs to be increased. There is potential to use Medicaid funding for these services, she said; right now rehabilitation services in New Mexico are limited to speech therapy. In Maine, Medicaid funding has been used to finance a statewide system of permanent housing. She described nine months of weekly planning with city and county officials and service providers culminating in a model for delivery of behavioral health and wraparound services. Funding of $1.1 million has been allocated by the county, and a similar allocation is pending at the city. Her job is to look for significant cost savings to the system, but individual outcomes are what is really important.

There are so many categories of homelessness, one member commented after hearing the panel presentation. The public really needs to be educated about the costs of not providing services. Another member suggested the potential of additional collaborations for these various groups and urged a closer look at the benefits of sharing administrative costs and securing regional funding. This is a national trend, the member pointed out, and sources of funding look more favorably on those who are sharing under one roof.

Substance Abuse Treatment and Rehabilitation Panel

Miriam Komaromy, M.D., associate director of the Project ECHO Institute at the UNM HSC, spoke to the committees about substance use disorders and their high cost: $500 billion a year in the United States (see handout). There are effective medications to help prevent relapse for opioid and alcohol use disorders, she said, but they are underutilized. Studies have shown that the impact of medication treatment for opioid addiction far outweighs the impact of counseling, yet drug courts, probation and parole do not consistently support medication-assisted treatment (MAT), perhaps over concern about diversion of these medications. For post-incarceration treatment, counseling and intense case management are crucial to prevent overdose deaths or recidivism, said Dr. Komaromy. She also runs a grant-funded initiative to treat mental health and addiction through Project ECHO telehealth. Many with mental health and addiction problems walk in the door of a primary care setting, she explained, so Project ECHO helps train and support nurse practitioners teamed with community health workers who get specialty support from UNM.

There are eight primary care sites where screening, diagnosis and treatment are being provided for hundreds of patients every month who would not otherwise get treatment. Dr. Komaromy also described another grant-funded pilot project to engage primary care physicians in providing MAT for opioid-addicted patients through the Project ECHO model and a proposed plan to incentivize statewide training with Medicaid funding, utilizing Project ECHO to enable low-cost treatment in home communities.

John J. Romero, presiding judge, Children's Court, Division VII, Juvenile Justice Center, is one of three judges in Bernalillo County who specialize in children's court with youth who are alleged to be delinquent, neglected or abused. Mental health issues in his court are alarming, he said, estimating that 70 percent of participants have at least one mental disorder. For those with substance abuse problems, mental issues and addiction both need to be treated, Judge Romero said. It is folly to treat youth without talking about families, and judges need to look at ways to engage and empower parents. In Bernalillo County, detox has to take place before treatment, which is funded by a grant. Supportive housing is needed for kids who cannot go home, he said, and treatment that is not connected to the living situation is difficult to get to for kids who do not drive. What is needed is a transitional living program with services inside. Heroin is a serious problem in Bernalillo County, he continued, and is cheaper to buy than a six-pack of beer. New Mexico is second in the nation in accidental death from heroin overdose, and New Mexico's kids are twice as likely to experiment with heroin than kids in any other state. Girls who have trauma in their backgrounds are prone to medication and substance abuse and have diagnosable rates of posttraumatic stress disorder higher than those of returning war veterans. Hogares used to have a treatment facility, Judge Romero lamented, but now the county has entered into a deal to buy the property, and Healing Addiction in Our Community will provide services there with private money. Kids are assessed and referred to a resource provider if they qualify for Medicaid; otherwise, most health insurance will not pay for a single day of substance abuse treatment for youth. There is a school-to-prison pipeline: kids who get in trouble at school are arrested, sent to detention and then released with no consequences. It is important to partner with schools, Judge Romero said, since they serve as the early warning system for youth who have behavioral health problems.

Jolene Schneider is executive director of Four Winds Recovery Center in Farmington, which offers residential detox, including protective custody detox, to residents from around the state. Ninety percent of its 39-bed population comes from court referrals, she said, and is 80 percent male and 90 percent Native American. None of Four Winds' services are covered by Medicaid, she said, and reimbursement has been through the County Indigent Hospital Claims Fund, which was cut last year with a change in the way hospitals are funded. Ms. Schneider said the cut of one-fourth of its operating budget — a loss of $225,000 — in the intensive outpatient program is likely to close the clinic, with a loss of 17 full-time jobs and a likely increase in violence and deaths in the community.

Jennifer Miller, administrator of the San Juan County Alternative Sentencing Division, provided committee members with background on the San Juan 28-Day Jail-Based Treatment

Center, which was created as the result of extensive community input (see handout). Incorporating a mix of incarceration, treatment and aftercare, the program has served more than 11,000 convicted offenders since 1994 and was proven twice as successful as other programs in a study by UNM, Ms. Miller said. When indigent funds were redirected last year, it was assumed that the program could now bill Medicaid, but claims were denied because they were considered incarcerated treatment services not eligible for reimbursement. Now the program has had a significant cut — $700,000 — and services have been curtailed.

Following the conclusion of the panel discussion, a committee member asked Dr. Komaromy why physicians are reluctant to do MAT. Providers in small communities do not want to deal with this population, she responded. There is a stigma of caring for the addicted population, but MAT needs to be made the norm for all primary care practices. Another member asked her how many beds are needed in Bernalillo County for detox. A 28-day program is needed for the sickest individuals, Dr. Komaromy said, but this number is small. Care plus detox can work, and for those who have housing, they can detox at home; for those without housing, there needs to be a place for medically managed withdrawal.

Public Comment

Dan Matthews, president of the New Mexico Psychological Association, said his organization has been looking at AOT for a number of years and is not opposed to it. His members are "bulldogs" when it comes to confidentiality, and they are concerned with changes to the Mental Health and Developmental Disabilities Code that will affect everyone.

Sherry Pabich said she was here nine years ago when AOT was introduced. She urged members to pass it in time for the budgeting process. AOT is like a hospital without walls, and hopefully, it will also bring housing along.

Estella Martinez told committee members her daughter died because she had diabetes and was mentally ill and lacked self-awareness. Ms. Martinez said if she had been able to petition for an AOT order, her daughter would not have died at age 23.

Felicia Barnum, a member of the National Alliance on Mental Illness, said that it is time for change. Ms. Barnum has a son who was hospitalized and jailed multiple times. She said she would have preferred AOT to seeing her son arrested and shackled. She is thankful for the mental health court; without it, her son would not be alive today.

Steve Bringe, president of the Depression and Bipolar Support Alliance, said he has no opinion or view on the bill discussed today. He thinks legislators would benefit from hearing testimony from informed groups of peers, who are available, he said.

Jim Jackson, executive director of DRNM, commented that if New Mexico had the same system as in San Antonio, maybe the state could be serving a lot of people and might not need AOT. Mr. Jackson said it is the mission of his organization to protect the rights of those who are

competent to make their own decisions who have not been accused of a crime or shown to be a danger to themselves or others. Look carefully at the specifics of the bill, he urged members. If a treatment guardian is already appointed to act for a person, why do we want to second-guess that person? This bill does not restrict a judge to services that are available in the community. Mr. Jackson said he objects to any characterization that his agency just "kills bills". DRNM helped promote the mental health parity bill and has supported CETs, and DRNM has consistently supported expansion of services. Mr. Jackson told committee members not to feel pushed into supporting the AOT bill; there are a lot of options.

Mr. Stettin commented that he was not hearing other ideas about this small group of people who do not believe they are ill. At the end of the day, there is a need, and treatment guardians cannot provide the kind of monitoring that is required.

Donald Hume is a consumer who has been in recovery for 21 years. He will not follow treatment plans given to him by others, but if he decides on it himself, he is far more likely to follow it. The medications he has taken have some serious side effects, Mr. Hume said, sometimes more severe than the symptoms themselves. He was always labeled noncompliant. He was shown by a peer that he could lead a different life and that recovery was possible. His life became so unmanageable that he was finally willing to do something about it. Mr. Hume said that this AOT bill could put him back in the hospital. For the few people it might help, others will be put at risk.

The joint meeting of the LHHS and CCJ recessed at 6:30 p.m.

Thursday, August 7

The committees reconvened for the final day of a joint meeting in the lobby of the UNM School of Law.

Call to Order and Introductions

Representative Chasey called the meeting to order at 9:15 a.m., welcoming members and guests and asking legislators on both committees and LCS staff to introduce themselves.

Health Care for Inmates

Gabriel Eber, staff counsel with the American Civil Liberties Union (ACLU) National Prison Project and adjunct professor at Georgetown University, provided committee members with a presentation on the right to health care in prison (see handout). Mr. Eber specializes in prison health care cases, most of which arise out of constitutional challenges and are usually class actions to ensure that prisoners receive adequate health care. There are three propositions to keep in mind, he said: 1) there are a lot of prisoners; 2) each needs health care; and 3) they cannot seek care elsewhere and have no control over chronic conditions. Mr. Eber said he cannot emphasize enough the importance of #3. A prisoner is forced to rely on others.

Denial of medical care is cruel and unusual punishment and an unnecessary and wanton infliction of pain, Mr. Eber said. The government has an obligation to provide medical care to those it is punishing. Prison health is public health. Mr. Eber described the graying (age 55 and over) of the prison population and the special needs that arise from functional and cognitive impairment and complex chronic medical conditions. The rate of hepatitis C infection is high in New Mexico prisons, he said, and there are now miracle drugs to treat it but they are extremely costly. Independent monitoring of correctional health care is essential to ensure access and proper health care treatment of inmates and to prevent litigation or federal Department of Justice (DOJ) action. The monitoring must be done on a regular basis, and reports need to be made public. This is especially important with private, for-profit companies that own prisons or provide health care services on contract and are beholden to hedge fund managers rather than the public.

Paul Wright, director of the Human Rights Defense Center in Lake Worth, Florida, is also editor of *Prison Legal News*, the longest running prisoner rights publication in U.S. history. He had co-authored three anthologies, and his articles have appeared in over 80 publications, including *CounterPunch* and *USA Today* (see handouts). He agreed with Mr. Eber's observation about being wary of the business practices of private, for-profit companies. These companies view the prison system, not the prisoner, as the customer. Prisoners cannot go to a different doctor if they are not receiving care, he noted; they cannot call 911 or go the emergency room. There is a lack of transparency with private companies and no oversight of what is actually going on. Audits have shown that many private companies are not providing what they are being paid for, and many refuse to provide information to the public. Many companies give bonuses on how little health care they provide, and scandals often follow them, Mr. Wright said (see copy of *Prison Legal News* and handout on Corizon lawsuits), and they often employ doctors with disciplinary issues who are uninsurable. The biggest need is to monitor them, and this is best done by the government. The state corrections chief is accountable to the public, but accountability is hard to come by with private companies claiming that their information is confidential and proprietary.

Secretary of Corrections Gregg Marcantel said he appreciates points made by the previous presenters. Since inmates are not able to vote, they can be marginalized, and this is not in the interest of public safety, he said. The state's contract with a private company provides for oversight, and if he, as secretary, is not willing to police the contract, then problems certainly can develop. Secretary Marcantel said he does not want to lead corrections as a closed institution, since 96 percent of inmates will return to their communities. Joe W. Booker, Jr., deputy secretary of operations for the Corrections Department (NMCD), who was seated next to the secretary, oversees the state's medical contract.

Upon questioning of Mr. Eber, Mr. Wright and Secretary Marcantel, committee members discussed the following topics.

History of New Mexico's contract with Corizon. Corizon, the state's contractor for medical services in 11 facilities serving approximately 7,000 inmates, is the largest private provider of such services in the country, Secretary Marcantel said. Corizon is paid on a per-member-per-month

basis and won a $33 million renewal of its previous 2007 contract in a procurement bid process in 2012. Asked who held the contract before that date, Secretary Marcantel did not know — he is new to this position — but his deputy secretary, Paul Montoya, determined that it was Corizon, under a previous business name, at least since 2000. A member asked who was on the hook, the state or the contractor, for liability for malpractice or not providing care. Secretary Marcantel and Mr. Montoya were unsure and said they would get back to the committees with that information.

Private for-profit company versus nonprofit provider. A member strongly objected to the NMCD contracting with a Wall Street firm instead of a state nonprofit provider. Corizon won the bid, he was reminded. Another member noted that New Mexico has a top-notch medical school and a public health agency that are geared to complementing the public sector and state government, and there are job shortages in New Mexico. All of this should go into the bid equation, the member noted. Another member added that it seems the state is contracting away its public records obligation; something needs to be put in place to ensure transparency and accountability.

Experience with hepatitis C and costs of treatment in New Mexico prisons. Secretary Marcantel said he does not have data on costs with him today, but will provide this to the committees. Approximately 8,200 inmates have been screened for, and 1,908 diagnosed with, hepatitis C, he said. Those affected are treated with the most up-to-date drugs, Secretary Marcantel said, but there are guidelines (he will provide these to the committees, as well). Another member asked about a new drug that actually cures hepatitis C, which costs $84,000 for a course of treatment. The combined purchasing power of the state and federal Medicaid funding should be able to affect this price, which many consider to be outrageous, the member noted, and Congress is planning hearings on this. A member asked about efforts to prevent the spread of hepatitis C and was informed that UNM's Project ECHO is training inmates to function as community health workers within the prisons.

What is being done to provide for the state's aging prison population? These folks are not very healthy when they come in, Secretary Marcantel noted, and studies show they age more quickly in prison than in the general population. He noted current programs for inmates with functional impairments, a hospice program and the use of compassionate release.

Remarks to the Joint Meeting

Maggie Hart Stebbins, Bernalillo County commissioner from District 3, reported that there has been progress with criminal justice reform in reducing the population from 3,000 to 2,100 at the Metropolitan Detention Center (MDC). Since one-fourth of detainees are waiting for a probation violation hearing, the county is paying for a judge to expedite these, with 65 percent of cases resolved at that time. There still are significant problems with alternatives for the mentally ill population at the MDC, Commissioner Stebbins said. She provided members with detailed consensus findings regarding this group and a proposal for funding of regional mental health crisis triage and respite bed facilities throughout the state (see handout). The impact of incarcerating the mentally ill is profound on the system and the individual, Commissioner Stebbins said.

With the behavioral health system in crisis, the MDC has become the largest provider of behavioral health services in New Mexico, Commissioner Stebbins said. Rates paid to behavioral health providers lag behind the cost of services, criteria for access are too narrow, many services no longer exist and MCOs have been incentivized through capitated rates to limit care in order to maximize profits. The results of research and multiple task force findings are identical: what is needed most are regional triage centers and respite care facilities to provide alternatives to far more costly incarceration/hospitalization. Mobile crisis teams are needed to support first responders, who have only two choices for someone in crisis: hospital or jail. Commissioner Stebbins said she believes it is possible to help rebuild New Mexico's intermediate care services system by utilizing federal Medicaid dollars, as is being done in some other states. Bernalillo County has dedicated $1.1 million to a supportive housing initiative and is seeking matching funds from the City of Albuquerque and the state, and the county also will be asking the legislature to fund a statewide CET program. Commissioner Stebbins said the county wants the state to partner in these efforts and to help with Medicaid enrollment of detainees upon release. The estimated budget for the project is $2.9 million, she said, adding that there is political will for this now.

On questioning, Commissioner Stebbins and committee members addressed the following topics.

Medicaid funding to help rebuild community services. Commissioner Stebbins elaborated on the 1915(i) benefit that can help states fund the establishment of acute medical care services and long-term services like respite care, case management and employment services. It is a remarkable opportunity to fully utilize federal dollars, she said. A member agreed and asked Commissioner Stebbins if she could provide legislators with a list of projects that might be funded through this resource, including behavioral health services in the schools. The effort may require discussion with New Mexico's congressional delegation, the member said.

Savings from a new triage crisis center. A member recapped statistics proffered in earlier testimony about cost savings for persons with mental illness who are placed in jail and asked if there are any studies yet about how much will be saved with a triage center. New Mexico has been dealing with public health issues in a criminal setting, the member said. Another member thanked Commissioner Stebbins for bringing economic factors into the discussion, adding that a hospital is one of the most expensive places for treatment. Perhaps jail money could be redirected to expand these programs, offered another member.

Assistance for inmates to apply for Medicaid before release. It is prohibited by the state to put in the Medicaid application before release, Commissioner Stebbins said, and there is a six- to eight-week waiting period after the application is submitted. The most critical time for behavioral health patients is the first two to three weeks after release, and they are released with just three days of medications. Commissioner Stebbins said that the county was able to train folks recently on presumptive Medicaid certification, but individuals still have to complete the regular enrollment and there is no follow-up to ensure that the enrollment goes through.

Issues with pretrial release. A committee member complained that pretrial release works well for the wealthy, but poor people do not have the ability to bond out. Commissioner Stebbins agreed that this is an important issue. Decisions about bond are made by the courts, she said, and there are objective tools available to measure risk that soon will be implemented in Bernalillo County.

Criminal Justice and Behavioral Health: The Sequential Intercept Model

Dave Webster, M.A., L.I.S.W., is co-clinical director of St. Martin's Hospitality Center in Albuquerque, which has provided programs and services for homeless individuals and families since 1985. People who work in mental health know that no matter where they are located, treatment is always less expensive than incarceration, Mr. Webster noted. He provided committee members with a presentation of a sequential intercept model he has developed that provides a conceptual framework for communities to organize target strategies for justice-involved individuals with behavioral health disorders. The model helps identify gaps in the system and what services are needed. It also can track the results over time (see handout). This model is being utilized by Bernalillo County and Albuquerque during weekly meetings, and results will be presented in September or October, Mr. Webster said. In Albuquerque, there are three ACT teams but no statewide mobile crisis unit for de-escalation of an incident prior to police intervention.

Everyone is identifying the same issues, Mr. Webster said. Diversion instead of jail is sorely needed but does not exist. All of the strategies identified in his model are in use in many places throughout the country, he said, and are known to be effective; they are not pie-in-the-sky ideas. There are many "frequent flyers" in the behavioral health and corrections systems, he said, and the use of AOT would go a long way toward solving some of these problems. The bottom line is that treatment is less expensive than incarceration — end of story, Mr. Webster concluded.

Prison Rape Elimination Act (PREA)

The federal PREA was signed into law in 2003, but it took many years for the government to establish guidelines and auditing criteria to grade a state's compliance. The NMCD had already taken steps to ensure compliance, according to Secretary Marcantel, including creating a required video that describes a prisoner's rights, how to ask for help and what the reporting process entails (see handout), posting sexual abuse hotline numbers and training staff to recognize and respond to PREA allegations. The department also trained PREA-certified auditors to assist with a circular audit process among 10 western states that ensures an audit of each facility at least once every three years.

Robert Mitchell, deputy director for facilities, Juvenile Justice Services, CYFD, works with the New Mexico Association of Counties (NMAC) to quantify compliance with performance-based standards. Most new employees are trained within a week. The PREA is culture-changing, Mr. Mitchell said, and it also is improving safety. Manuel Romero, a detention specialist with the NMAC, assists counties with implementation and compliance. Mr. Romero also works with the U.S. Civil Rights Division in Washington, D.C., and the DOJ.

May Sagbakken, director of the Rape Crisis Center of Central New Mexico, explained to committee members that the PREA requires collaboration between correctional facilities and local rape crisis centers in order to provide inmates access to "outside confidential support services" (see handout). Audits are now hitting the counties, but there is no additional funding for compliance. Ms. Sagbakken said that her organization has been asked to provide services, and while it has a good relationship with the NMCD, it does not have enough funding to do this. The Rape Crisis Center of Central New Mexico has not been informed of any PREA hotlines and does not have the required confidential setting, she said. There is a high rate of women incarcerated in New Mexico. State funding is needed to create an infrastructure for these specialized services, Ms. Sagbakken said, and she is requesting an appropriation of $750,000 to coordinate these efforts and determine training and best practices for rape crisis centers.

Donna Richmond, executive director of La Pinion Sexual Assault Recovery Services of Southern New Mexico, said she is one of those working the cases. Her organization serves children and adults, but she is concerned how trauma treatment would be delivered to someone inside a prison. That person would need specialized training, and if the center is being asked to serve a larger population, it would need more funding.

Steven Robert Allen, director of public policy for the ACLU of New Mexico, said sexual assault has been a big problem in detention centers and needs to be taken seriously. He also noted that persons just being released may need services. Other states are looking into state-based legislation, and the ACLU feels this is worth considering. Mr. Allen cautioned that audits need to be truly independent and should include the Adult Probation and Parole Division of the NMCD as well as detention centers.

Asked for more details on the $750,000 request, Ms. Sagbakken said it would fund 1.5 to two FTE staff at 10 centers throughout the state. The Rape Crisis Center of Central New Mexico does have its own hotline — a local number that provides immediate assistance — but there is no official collaboration with the NMCD; the center is a check box on the audit list. Secretary Marcantel explained that the way the new federal requirements were rolled out put a lot of people in a bind. Asked what an audit looks like, committee members were told that it includes 52 standards with 200 subcategories. It involves a preview of the facility, then a tour, random interviews, a review of files and a post-audit, with a 30-day window to fix any problems.

Medicaid and Inmates

Matthew Elwell, director of the Luna County Detention Center, spoke of how Medicaid impacts a person upon release from a facility. Medicaid is terminated 60 days after incarceration, he said, and upon release, that person must reapply. A person leaves a facility with a minimal amount of medication, then decompensates and often re-offends. Medicaid needs to be put in place prior to release, Mr. Elwell said. Jails are eager to put inmates safely back into the community and integrated into care. Jails are beginning to get training in applying for presumptive eligibility, he said, but entities doing this must complete the entire Medicaid application. Most

prison inmates qualify for Medicaid, but inmates in jail may come from households that do not qualify.

Julie Weinberg, director of the Medical Assistance Division (MAD) of the Human Services Department (HSD), described Medicaid rules as relating to incarcerated individuals (see handout) and told members that the HSD has spent the last 18 months developing a process to allow for coverage of inpatient stays greater than 24 hours for incarcerated individuals. The process required numerous enhancements and changes to the YES-NM portal functionality, as well as to the Medicaid Management Information System (MMIS). The presumptive eligibility category is short term, is based on a shortened application and is good until full Medicaid eligibility is awarded or denied.

Harris Silver, M.D., is a consultant, health care and drug policy analyst and faculty member in the Department of Family and Community Medicine at UNM. With reform mandated by the ACA, approximately 90 percent to 95 percent of inmates are newly eligible for Medicaid, Dr. Silver said (see handout). Lack of access to health care and untreated substance abuse or mental disorders during and after incarceration are risk factors for poor outcomes. Federal Medicaid allows inmates to keep their coverage but will not pay for medical services during incarceration unless the inmate is hospitalized for more than 24 hours. Suspension allows for inmates to retain Medicaid and be discharged with full benefits. Inmates not on Medicaid can be signed up while incarcerated and then put in suspension status until discharge, Dr. Silver said.

Current Medicaid policies in New Mexico call for termination of Medicaid after 30 days in jail or prison despite the HSD's own 60-day policy, do not provide a category for suspension and do not allow applications from inmates before discharge. Prison employees are being trained to sign up inmates after discharge using presumptive eligibility, but those inmates will not be able to qualify for food stamps and temporary assistance at discharge. Dr. Silver described considerable savings that could be derived from treatment of substance abuse and mental health issues, since Medicaid pays 97 percent of the costs versus the state's three percent.

Committee members were provided with a copy of a letter Dr. Silver received from Cindy Mann, director of the Center for Medicaid and CHIP Services, stating in part that incarceration does not preclude an individual from being determined to be Medicaid-eligible. Inmates are permitted to file an application for Medicaid during the time of their incarceration. The letter goes on the state that the Centers for Medicare and Medicaid Services (CMS) has a long-standing policy that permits states to establish a process under which a Medicaid-eligible inmate is placed in a suspended eligibility status. "In fact, we have informed states that there is no legal basis for terminating the Medicaid eligibility of inmates...solely on the basis of their status as inmates. The suspension provides for a continuity of care...". Dr. Silver concluded that collection of information needed for a presumptive eligibility determination and a completed Medicaid application should occur at jail intake and that there is no good reason why the MAD cannot accept applications from incarcerated individuals and create a suspension category of Medicaid eligibility.

A section of Ms. Weinberg's presentation, titled Barriers to Eligibility, states that applications cannot be submitted until the individual has been released from prison or jail. A committee member confronted Ms. Weinberg with the discrepancy in this statement, and she admitted that it was indeed false. Establishing a suspended category in the state's new MMIS is administratively burdensome, Ms. Weinberg explained. The MAD's information technology contractor has been working on it, but it has been low priority, she said. A member expressed outrage that the state cannot change its computer program in order to save hundreds of thousands of dollars in reimbursements and to improve the lives of many New Mexicans. Asked how soon this could be fixed, Ms. Weinberg stated that a month from now, the MAD should have good presumptive eligibility information, which is a workaround to suspension. Illinois has a grant to offer assistance on the entire inmate eligibility issue, another member informed the committee. Perhaps Illinois should be invited to advise New Mexico, the member suggested. Several members discussed the possibility of asking the LFC to look into the cost to the state and how many dollars have actually been lost from lapses or delays in Medicaid coverage for eligible persons post-release.

Public Comment

Doris Husted, policy director of The ARC of New Mexico, does volunteer work with persons who have been newly released from incarceration. When she asks about Medicaid, some have no idea what she is talking about. She urged that the NMCD and HSD collaborate on a fact sheet or provide other education to persons about to be released. They need to know the next steps, she said.

Denise Lang, Otero County Behavioral Health Council and Local Collaborative, said her husband was a Vietnam veteran, became addicted and got educated, but he committed suicide in 1998. Her son, who had a scholarship at the New Mexico Institute of Mining and Technology, started using drugs after his father's death and ended up in jail. He cleaned up and went to rehab, but he is now serving his second term in prison. The only Otero County facility offering mental health services closed after 40 years. She asked for better oversight by New Mexico agencies, which should start treating addiction like the public health issue it is.

Kathy Sutherland is director of Inside Out, which provides peer support in Española and Taos for substance abuse. She urged legislators to pass a law so that nurse practitioners can prescribe suboxone for treating the enormous problem of opiate addiction. Instead of incarceration, use a jail diversion program instead, she said. If a probation officer suggests that someone go to prison because they cannot stay clean, then you will have more grandparents raising kids. Addicts will relapse; it is part of addiction.

Dr. Silver said there are only 10 pharmacies that are currently prescribing Narcan. Española and state police will carry Narcan in squad cars. The federal Food and Drug Administration requires a prescription.

Alan Carreago spoke as a private citizen. He has been clean since 1985 and worked for many years in addiction treatment programs. He now works with Molina Healthcare, Inc. When he was strung out on heroin in 1985 and tried to gain admission to UNM Hospital, he could not because he was not suicidal. It is a public health issue and a public safety issue that New Mexico does not have the capacity it needs, he said. Turquoise Lodge wait time can be several weeks to several months.

Adjournment

There being no further business, the third meeting of the LHHS for the 2014 interim was adjourned at 5:40 p.m.

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

September 10-12, 2014
Barbara Hubbard Room, New Mexico State University, Las Cruces
Elephant Butte Lake Event Center, Elephant Butte

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Wednesday, September 10, 2014, at 9:15 a.m. in the Barbara Hubbard Room in the Pan American Center 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 (9/10)
Rep. Terry H. McMillan (9/10)
Sen. Mark Moores (9/11)
Sen. Benny Shendo, Jr. (9/10, 9/11)

Absent
Sen. Gay G. Kernan

Advisory Members
Sen. Sue Wilson Beffort (9/11)
Sen. Craig W. Brandt (9/10)
Sen. Jacob R. Candelaria (9/11, 9/12)
Rep. Nathan "Nate" Cote
Sen. Linda M. Lopez (9/10)
Sen. Cisco McSorley
Rep. Vickie Perea
Sen. Sander Rue (9/11)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson
Rep. Phillip M. Archuleta
Rep. Miguel P. Garcia
Rep. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff
Sen. Bill B. O'Neill
Rep. Paul A. Pacheco
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. William P. Soules

(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 (9/10)
Nancy Ellis, LCS
Carolyn Peck, LCS (9/11, 9/12)

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written material are in the meeting file.

<u>Wednesday, September 10</u> — Barbara Hubbard Room, New Mexico State University, Las Cruces

Welcome and Introductions

Representative Madalena welcomed legislators and guests and asked staff members to introduce themselves. He then introduced Garrey E. Carruthers, Ph.D., president of NMSU and a former governor of New Mexico.

Burrell College of Osteopathic Medicine at NMSU

President Carruthers described plans for NMSU to partner with Burrell College of Osteopathic Medicine and said that the following three agreements have already been negotiated: (1) the college will pay $260,000 to $270,000 annually in rent to Arrowhead Center, Inc., business park; (2) the college will purchase various services from NMSU, including student fees and services; and (3) an initial contribution of $150,000 to $500,000 has been made for scholarships. Once pre-accreditation is obtained, there will be 125 to 150 medical students enrolled in the school annually, with an initial investment of $28 million. This project will use a local architect and contractor, and, by the fall of 2016, it will have 70 to 80 full-time employees, President Carruthers said.

There are two other land grant universities that have partnered with privately owned osteopathic colleges and several more that are considering it, he said. New Mexico has a critical shortage of primary care physicians, and osteopathic schools tend to graduate up to 60 percent of students who specialize in primary care. Dan Burrell, the Santa Fe entrepreneur whose name the college will bear, will have to put $35 million in escrow until the first class graduates, with a total start-up investment of $85 million. President Carruthers introduced George Mychaskiw, D.O., dean of the Burrell College of Osteopathic Medicine.

Dr. Mychaskiw said the idea for the school began with a vision to increase health care access in New Mexico and the borderplex (Las Cruces, El Paso), one of the most underserved areas in the nation. He gave a brief overview of the history of osteopathic medicine in America, with its emphasis on treating the whole body and the interrelated importance of nutrition and healthy living. He described 42 osteopathic colleges that are spread throughout the United States, with specialties in all fields of medicine. Dr. Mychaskiw said that the new college hopes to create as many as 300 new residency training programs and will collaborate with community health care organizations and smaller hospitals that do not currently have residency slots to achieve this goal. President Carruthers noted that the early college high school is located

adjacent to Burrell College, and the medical high school is located nearby; both will be able to feed into and interact with the new medical school at NMSU.

Upon questioning, President Carruthers, Dr. Mychaskiw and committee members discussed the following topics.

Firewall between public and private funding. Committee members expressed concern about the potential of public dollars being used on the project, but President Carruthers assured them that NMSU would not be an investor, nor would its foundation, in the new college. While there has been some staff time involved, there have not been any out-of-pocket costs, he said. Eventually, there will be the possibility of faculty exchange, with Burrell paying NMSU faculty to teach some courses.

A cut in funding for NMSU. A member heard that NMSU will get less from the general fund this year, and President Carruthers confirmed that this is true because of declining enrollment. Most schools in the state are experiencing this decline, he said. During the economic downturn, there was a spike in enrollment. Now, high school graduation rates are declining or flat, and private schools, advertising heavily, are encroaching on public colleges and universities. President Carruthers was critical of the funding formula being used by the state; he said it sends the wrong message about the importance of a college education, and it needs to be revisited. Higher education is a high fixed-cost industry, he said. NMSU needs to be more efficient with its resources during the summer, he said, and lottery scholarship students should be able to use their funds for summer courses.

Cost of tuition at Burrell College. Dr. Mychaskiw said tuition will be $48,500 per year, and because the college will be a proprietary taxpaying structure, no Title IV funding will be available for the first two years, so students will have to get private loans and service-related scholarships and grants. There also will be a college foundation that can provide scholarships. Dr. Mychaskiw said that many different models for a private college were reviewed, but even with the Title IV limitation, the private investor model offers the best likelihood of success. This college will be held to the same accreditation standards as other nonprofit schools, and default rates on student loans in medical school are low, between one and two percent, and the graduation rate is nearly 100 percent.

Ambitious numbers for new residency slots. A member said that legislators were warned by the National Conference of State Legislatures (NCSL) that there is a growing crisis of too few residency slots for medical school graduates. Another member cited lower figures for matching osteopath graduates to residency slots than for regular medical school graduates. Dr. Mychaskiw asserted that 98 percent of osteopathic graduates are matched for residencies and that there is no difference in employability once the residency is completed. New residency slots will be created at hospitals in Texas and New Mexico and at federally qualified health centers, he said, adding that he is confident in these numbers. Students will come from all over the country, Dr. Mychaskiw said. The demand is huge (three to four applicants for every student slot), and

southern New Mexico offers an advantage with NMSU. A feasibility study was done, he said, and showed excellent potential at this location for this 30-year project.

Child Trauma and Well-Being Core Group

Susan Robison, director of state relations and public policy for the Casey Family Programs, described the foundation's "2020: Building Communities of Hope" initiative, a shared vision at local, state, tribal and national levels to improve the safety and success of children and families and to reduce the need for foster care (see handout). Casey Family Programs provide nonpartisan, comprehensive information on child welfare and education, which is based on data and best practices.

It takes all three branches of government working together with a shared vision to improve outcomes for the most vulnerable children, Ms. Robison said. Recognizing this, the Casey Family Programs joined with the NCSL, the National Governors Association, the National Council of Juvenile and Family Court Judges and the National Center for State Courts to provide support for state teams composed of all three branches to examine issues and practices and develop state-specific plans for improving outcomes for children and families (see handout). Named the Three Branch Institute (3BI), its goal is to provide measurable improvements in the lives of children involved in the child welfare system. New Mexico was one of seven states chosen in 2013 to participate in a new, 18-month-long 3BI initiative with the specific goal of improving the social, emotional and physical well-being of children in foster care. The governor of each state appointed executive branch team members and the core team leader. The legislative leadership nominated two legislative participants, and each team also included judicial representation. State teams have participated in two national conventions, the first held in Philadelphia in July 2013 and another in Milwaukee in July 2014. Success requires active, sustained participation and commitment from all three branches, Ms. Robison said, and 3BI participants often become ambassadors for 3BI with their peers.

Sidonie Squier, secretary, Human Services Department (HSD), and Yolanda Berumen-Deines, secretary, Children, Youth and Families Department (CYFD), are co-chairs of New Mexico's 3BI team. The two legislators chosen for the project are Senator Beffort and Representative Don L. Tripp. Mr. Hely is also a participant. The 3BI team meets regularly, with the next meeting scheduled on September 24 at 3:30 p.m. on the fifth floor of the Public Employees Retirement Association building in Santa Fe, and all are invited.

Nina Williams-Mbengue, director of the Children and Families Program of the NCSL, said her organization has been working closely with Casey Family Programs and 3BI. State legislators can be instrumental in encouraging collaboration among stakeholders, she said, working with courts, child welfare administrators and others (see handout). In recent years, state lawmakers have crafted policies around child well-being in many areas, including screening and assessment, health and mental health, social and emotional needs and prevention and early intervention. Ms. Williams-Mbengue's handout provided specific examples from different states, and she urged legislators to visit the NCSL's child welfare web page.

Annamarie Luna, deputy program director, Protective Services Division, CYFD, said her division is in its fourth year of the Child Trauma Academy, which utilizes a neurosequential model of therapeutics. Ms. Luna said that the division wants to make sure that each child in foster care receives this assessment, and it is now completing the first training of 20 accessors working within the core service agencies (CSAs). It is important to make sure that each child in foster care is given the trauma-informed assessment, she said, in order to get the child the services the child needs and to reduce the inappropriate use of psychotropic medications in this population. New Mexico's participation in 3BI has provided an opportunity to work with legislators and with the Administrative Office of the Courts, Ms. Luna said.

Daphne Rood-Hopkins, director of the Office of Community Outreach, CYFD, said that CSAs focus on the most vulnerable children, who have complex behavioral issues, and adults with severe mental health issues to provide certain services. CSA providers must qualify and be able to provide timely services, and they must understand the brain map that is central to trauma-informed treatment, Ms. Rood-Hopkins said. They also attend advanced clinical seminars to make certain they are well-trained to implement these strategies.

Veronica Öhrn-Lännerholm, clinical services manager of the Behavioral Health Services Division, HSD, has direct connections with the CSAs and also has oversight of managed care organizations (MCOs). The division is committed to exploring ways to work collaboratively to create long-term sustainability, she said. Connecting stakeholders and divisions was identified by the New Mexico 3BI team as a goal, and achieving it might involve changing definitions and billing codes and assessing the impact of Centennial Care and requirements of the federal Patient Protection and Affordable Care Act (ACA).

Beth A. Collard, a child welfare and juvenile justice attorney, Administrative Office of the Courts, is administrator of the court fee fund of the New Mexico Court Improvement Project. Ms. Collard said she sees the 3BI initiative as a lens, and she emphasized the importance of getting information about available services to the judges and attorneys who work with foster children. Ms. Collard said she is especially concerned about the impacts of psychotropic medications being given to children.

Upon questioning, panel presenters and committee members discussed the following topics.

Composition of New Mexico's 3BI team. A member said it was the first time he had heard about 3BI, and he noted that it seemed odd that no one from this committee is involved. Another member questioned the co-chairs both being from the executive branch and noted that the legislators appointed are from the same political party. The behavioral health system is in serious disarray, the member said, and services are not available for children in custody. Asked about 3BI collaboration with NMSU's child safety department, Ms. Luna said there was a representative in the beginning, and the team is planning to include the university in a larger initiative in the near future.

CSAs and the role of OptumHealth. The restriction on CSAs does not make sense, commented one committee member who does not understand why a respected provider like La Familia cannot be reimbursed for case management services to children. Getting a child in foster care screened and assessed sounds good, the member continued, but why perform this great assessment and then provide identical services to everyone? Ms. Öhrn-Lännerholm said the possibility of expanding CSAs is on the HSD's radar. The challenge is in delivering services, she said. The second-year 3BI plan has been altered, since not every child in foster care can be screened because capacity is lacking. The member asserted that the HSD's decision to shut down 15 behavioral health care agencies in 2013 was an enormous disservice to the children of this state. A member's question about the role of OptumHealth in managing approximately $50 million in general funds for non-Medicaid behavioral health was answered by Ms. Rood-Hopkins, who said she has direct oversight of those funds. OptumHealth does not approve her division's expenditures, it just pays the bills. Ms. Rood-Hopkins also stated that she directly manages the budgets for juvenile justice and infant mental health funds.

Concerns about overmedication. Several committee members asked about children in foster care who are receiving psychotropic medications. Reducing the use of medication in children who are in foster care is an important goal of the 3BI initiative, panel members told the committee, and there are new federal requirements for states to develop protocols for the use and oversight of these medications.

Ms. Robison and Ms. Williams-Mbengue told members they would be pleased to bring in national experts in a "Roots of Empathy" pilot to testify before this committee.

Lunch Presentation of Human Dance and Recreation: High Impact on Health and Human Development

Committee members and staff were bused to Renfrow Hall for a lunch presentation by students and faculty about NMSU's ballroom dancing program, which is one of three degree programs in the country. A group of students offered testimony about the benefits of the NMSU movement program and described plans by well over half of its graduates to continue their education in graduate programs, such as medical school and physical and occupational therapy. A dancing program open to the community on Tuesday evenings attracts an average of 90 people. Ballroom dancing has been shown to help reduce problems of dementia in the elderly, and programs implementing kinesthetic learning in elementary schools have shown tremendous promise, members were told.

Southwest Region National Child Protection Training Center

Shelly A. Bucher, director of the Southwest Region National Child Protection Training Center at NMSU, told committee members that child abuse and neglect has become a national crisis, citing statistics indicating that two out of every three children are exposed to violence in the United States (see handout). New Mexico ranks sixth in the nation in child deaths and forty-ninth in child well-being, Ms. Bucher said, citing multiple recent news reports of child abuse and death. The mission of the National Child Protection Training Center is to end child abuse,

neglect and other forms of child maltreatment through education, training, awareness, prevention, advocacy and the pursuit of justice.

A recent two-day training sponsored by the center and co-sponsored by the New Mexico Administrative Office of the District Attorneys attracted 107 participants who learned from experts the most effective techniques for investigation and prosecution of child abuse cases. Another training in May, ChildFirst, focused on interviewing and preparing for court testimony children who have experienced sexual abuse. A September training, Crime Scene to Trial, taught best practices for investigating child maltreatment, whether physical or sexual, from documenting the crime scene to interviewing witnesses and suspects. In October, another training will be offered in partnership with the Children's Law Center in the investigation and litigation of civil child abuse cases.

Esther Devall, Ph.D., department head and professor in the Family and Consumer Science Department at NMSU, said that severe childhood trauma changes the brain and can affect development and health throughout life. There has not been enough hands-on training for professionals, Dr. Devall said, and the center's programs aim to remedy this. New Mexico can and must do more to address the dismal statistics for its vulnerable children, she said. Ms. Bucher is requesting $250,000 from the general fund to hire a full-time director for the center, pay for presenter travel and training scholarships and expand coverage into west Texas and Arizona.

Citizen Review Board

As state contractor for the New Mexico Child Abuse and Neglect Citizen Review Board, Ms. Bucher presented a spreadsheet of highlighted proposed changes to the Citizen Substitute Care Review Act, which provides a permanent system for independent and objective monitoring of children placed in the custody of the CYFD (see handouts). In a report to the judge, a local review board will indicate whether it agrees with the CYFD's course of action in a particular case. Among others, the changes would set new time lines for submission of information from the CYFD to local review boards and require the CYFD to notify clients of their right to request that a case be selected for local board review. Upon questioning by committee members, Ms. Bucher said local citizen review boards have had difficulty getting information from the department and often get complaints directly from the public, guardians, parents and hospital workers. By law, every CYFD investigation is supposed to come to the board for review. A committee member expressed frustration that a shortage of staff at the CYFD may be affecting this, yet the department, along with many others, continues to come to the legislature with a flat budget. Ms. Bucher said she has been working together with the CYFD on these changes.

Minutes Approved

A quorum for this meeting was achieved at 3:06 p.m. with the arrival of Senator Shendo. A motion was made and seconded to approve the minutes of the July and August meetings of the LHHS and was approved unanimously.

Healthy Kids, Healthy Communities Update

Patty Morris, Ph.D., is director of Healthy Kids, Healthy Communities, a Department of Health (DOH) program that helps provide start-up funding for selected communities throughout the state to build a broad-based local coalition to increase opportunities for physical activities and healthy eating. Initiated in 2012, the program now includes nine counties, four tribes and 21 public school districts, and it involves 24 percent of the New Mexico public elementary school population, Dr. Morris said (see handout).

Increased physical activity is encouraged by opening school yards during non-school hours, creating new signage to encourage the use of active play spaces and maps of plans and connectivity, promoting mileage clubs and designing road "diets" to accommodate bikes and pedestrian traffic. Increased opportunities for healthy eating include providing salad bars and pre-made salads for students, utilizing locally grown produce in cafeterias, sponsoring fruit and vegetable tastings at schools and using community and school gardens as outdoor classrooms. In rural areas, encouraging the establishment of a farmers' market, food-buying clubs and healthy corner stores creates healthier options, Dr. Morris said. There has been a decrease in obesity of third grade New Mexico students from 22.6 percent to 19.9 percent between 2010 and 2013. While rates for Hispanic obesity have remained flat, there has been a decrease of nearly seven percent among Native Americans and a five percent decrease among whites, and these disparities are being studied.

Dawn Sanchez, southwest region health promotion manager at the DOH, described the success of Healthy Kids Las Cruces, which has become a model for other communities (see handout). Initially, five community leaders were identified in health care, food delivery, education, community planning and parks and recreation. Outcomes of their meetings included coordinated efforts to establish safe routes to schools, many new miles of bike routes, the publication of trail maps, the establishment of open school yards and the crafting of a joint use agreement for sharing of community athletic facilities. Outcomes to increase healthy eating included fresh fruit and vegetable tastings for more than 12,000 students, implementation of a federal snack program providing fresh fruits and vegetables in 14 elementary schools, school garden programs and multiple community garden partnerships. Setting priorities, goals and objectives through a comprehensive work plan, the coalition plans to expand into Main Street downtown businesses and to enhance community health care through a partnership with the Paso del Norte Health Foundation.

Best Practices for Addressing Childhood Obesity

Carol W. Turner, Ph.D., food and nutrition specialist at the NMSU Cooperative Extension Service, gave committee members a brief history of the unique partnership among federal, state and county governments that was constitutionally mandated in New Mexico in 1915 (see handout). Dr. Turner then described two programs offered by the Cooperative Extension Service that help address childhood obesity in New Mexico.

The first of these is Ideas for Cooking and Nutrition classes that reached nearly 21,000 children in 199 schools in 18 counties during the 2013-14 school year, Dr. Turner said. Initiated in 1970, the classes engage children in trying new foods and in building nutrition and physical activity skills. The second program is Fit Families, which is a seven-week course of hands-on cooking and activities that involve the whole family learning together and adopting a healthier lifestyle. Many families do not know how to cook food that is quick and healthy, Dr. Turner said. The Cooperative Extension Service has nutrition partnerships with Farm to Table, La Semilla and Healthy Kids New Mexico and works with policy changes involving federal rules, state funding, New Mexico schools and municipal efforts to create healthy food zones.

Patricia C. Keane, M.S., is a principal investigator for the Prevention Research Center (PRC) in the School of Medicine at the University of New Mexico (UNM). The PRC's mission is to provide science-based health promotion and disease prevention research (see handout) and, through collaboration, training, dissemination and evaluation activities, to improve health and quality of life for all New Mexicans. Nutrition, physical activity and obesity prevention are major focuses of research for the PRC, Ms. Keane said. In New Mexico, Native Americans (36.3 percent) and Hispanics (30.8 percent) are at increased risk for being overweight and obese compared with non-Hispanic whites (20.8 percent), and this disparity is evident in kindergarten. Prevention strategies focus on improved nutrition and increased physical activity, but changes to policy and environment are important as well. Ms. Keane's presentation included suggested strategies and a listing of multiple resources. She also described the Child Health Initiative for Lifelong Eating and Exercise (CHILE Plus) for preschool-age children and their families and the Supplemental Nutrition Assistance Program Education (SNAP-Ed), which encourages healthy food choices by those receiving SNAP benefits, among other projects. Starting in preschool is so important, Ms. Keane said. It takes time and resources to involve children in the process.

La Clinica de Familia (LCDF)

Suzan Martinez de Gonzales, chief executive officer (CEO) of LCDF, said her clinic is the largest safety net provider in the city of Las Cruces and southern Dona Ana County and is located in a county where 24 percent of the population has lived in poverty for at least three decades (see handout). LCDF has accepted the city's conveyance of the old hospital building for renovation into a teaching community health care center providing medical, dental and behavioral health services. Ms. Martinez de Gonzales said that LCDF is very busy, currently seeing up to 22,000 visits annually with a staff of 317, and there are not enough exam rooms. The new facility will allow the clinic to increase primary care for 13,000 additional clients and will require additional staff of 144. As a teaching center providing integrated community health services, LCDF hopes to alleviate the high cost of emergency room care. As a federally qualified health center, LCDF is asking the LHHS for support in obtaining state funding of $1.2 million for information technology (IT) needs, Ms. Martinez de Gonzales said, including new cable throughout the renovated building and a new wireless network.

A committee member asked if LCDF had been approached by Burrell College of Osteopathic Medicine. Ms. Martinez de Gonzales replied in the affirmative, but she stated that

plans to become a teaching center were already in place. Several members congratulated LCDF for its many years of nonprofit work in the community. A member asked if LCDF had considered the state's Anti-Donation Clause of the Constitution of New Mexico; better to look into this now instead of being surprised later if there is a problem, the member cautioned. Another member suggested that LCDF might approach the Office of the Governor about having its IT request included in the budget as statewide impact funds.

Public Comment

Erin Marshall, volunteer New Mexico campaign manager for Compassion & Choices, gave an update to the committee on the *Morris* case. The judge ruled that terminally ill, mentally competent residents have a constitutional right to request prescription medication to shorten their suffering. Ms. Marshall provided information (see handout) about this decision and about the attorney general's intent to appeal the ruling. If this decision is affirmed on appeal, aid in dying will be permitted in New Mexico, Ms. Marshall said. Compassion & Choices will wait to see what happens to the appeal and will not be urging any legislation during the upcoming session.

George Brown, a 58-year-old Vietnam veteran, said there has been a breakdown in health care for veterans in the state. Mr. Brown said he spent most of his life as a trucker, but now he is in very poor health, on oxygen full time and living in a trailer on borrowed money. Mr. Brown said he has never asked for help before, but he finally got some medication for anxiety from the Veterans Health Administration after numerous calls. He asserted that veterans are not being very well served in New Mexico. A committee member said Mr. Brown resides in his district, that he has been directed to Centennial Care and that he may qualify for Medicaid.

Ms. Keane, speaking of behalf of herself, noted that this is Hunger Action Month, and she is concerned about food insecurity and challenges with New Mexico's SNAP applications and new work requirements. At a recent public hearing, representatives of the HSD were less than respectful to those who opposed the changes, Ms. Keane said. Health impacts of hunger include infants at greater developmental risk, pregnant women at risk for lower birth weight and higher rates of hospitalization toward the end of the month when benefits run out. Hungry children have higher rates of depression and anxiety and are less able to learn.

A member suggested that a letter be sent from this committee to Secretary Squier asking for an investigation into the behavior of HSD employees at that public hearing. The member said he seeks to get at the heart of the manner in which the HSD is conducting itself. A motion was made, seconded and passed for staff to determine if there is an applicable code of conduct for state employees and to draft a letter to Secretary Squier asking her to investigate the incident.

Recess

The meeting recessed at 5:45 p.m.

<u>Thursday, September 11</u> — Elephant Butte Lake Event Center, Elephant Butte

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:16 a.m., welcomed legislators and guests and asked staff members to introduce themselves.

Sole Community Provider Hospitals Funding

Jeff Dye, president and CEO of the New Mexico Hospital Association, reminded the committee that there is no longer any such thing as the "sole community provider program". It is now the Safety Net Care Pool (SNCP) program. Mr. Dye's association represents 44 member hospitals, and he said all are dealing with a major transition; health care reform is happening day-in and day-out, and the new world order is less reimbursement and more scrutiny, he said. Hospitals' Medicare/Medicaid cost report, which generally has grown by three to five percent annually, shows a .08 percent increase for 2013, basically flat, which is a sign of expenses being reined in, Mr. Dye said. Hospitals took a reduction in reimbursements four years ago before the Medicaid expansion, and now with less income, they are being forced to reduce or spin off high-cost services such as obstetrics and home care. While the ACA will mean many more patients are insured, it will take time for full coverage, and the need for uncompensated care has not gone away, Mr. Dye asserted. He provided a spreadsheet summary of SNCP payments to hospitals by county (see handout).

Steve Kopelman, executive director of the New Mexico Association of Counties (NMAC), provided a packet of information to members that included the organization's priority resolution regarding Senate Public Affairs Committee Substitute for Senate Bills 268 & 314 and Senate Finance Committee Substitute for Senate Bill 368 (SB 268), passed in the last legislative session as a compromise on the counties' gross receipts tax (GRT) contribution to fund the new SNCP program (see handout). Governor Susana Martinez line-item vetoed the three-year limitation on county funding in SB 268, which Mr. Kopelman stated has left counties with unlimited long-term liability for what is essentially a state program, the priority resolution concludes, and the NMAC resolves to work collaboratively with the Office of the Governor and legislative leadership to help craft solutions. The sole community provider program was voluntary, Mr. Kopelman noted, with counties working directly with their local hospitals, but when the Medicaid waiver was renegotiated by the HSD and the SNCP was created, it was no longer a county program. SB 268 was an emergency measure, he said, and it already has had dire effects on some counties, forcing them to cut almost all of their indigent care programs and lay off many local providers, leaving counties with the unhappy prospect of having to raise taxes. The NMAC handout also includes a detailed description of the impact of SB 268 on San Juan County, where the indigent health care program includes ambulance, substance abuse treatment, home heath care and hospice services that are now in the negative by more than $800,000.

Brent Earnest, deputy secretary, HSD, said the HSD has worked through changes in the Medicaid waiver to establish the new program and there were not a lot of options (see handout). There is always fear of the unknown, he said, and as payments start to flow in from the new

SNCP, there will be a settling with fewer uncompensated claims coming through. Some counties say the new structure is better, Mr. Earnest said, and counties do have other sources of income. San Juan County has a revenue problem, he said, and this needs to be kept in mind during the discussion. Mr. Earnest said there is a $12 million shortfall in state funding necessary to make the anticipated hospital payments, and while the HSD found a one-year fix for fiscal year 2015, a recurring gap in hospital payments will remain.

Upon questioning, Mr. Earnest and committee members discussed the following topics.

State's reluctance to use general funds to pay this obligation. A member said he has read Medicaid regulations and the ACA, and nowhere in these documents are counties mentioned. The member asserted that a new tax burden has been shifted by this administration from the state to the counties. Mr. Earnest disagreed, pointing out that Medicaid regulations do talk about participation from local entities; it is not uncommon in other states for local entities to put up matches. Counties have contributed $56 million to Medicaid in the past, and this program asks them to contribute only half that amount, Mr. Earnest said. Mr. Kopelman countered that this assertion is deceiving, since hospitals contributed much of the previous match. Before, the payment was voluntary; now, the obligation to put money up is mandatory. There is a recurring shortfall of approximately $12 million, Mr. Earnest said, and it is the governor's position that additional funding has to come from local governments.

Continuing discussions toward solutions. Mr. Earnest said he is willing to continue working with counties. A committee member expressed disappointment that meetings stalled; the bill that was passed was a stop-gap measure, with the understanding that discussions would continue over the interim. Mr. Kopelman noted that the NMAC has set up policy committees, but counties have different needs and are not unified. Jails are costing counties $230 million, he pointed out, and those expenses have become a huge drain on budgets. The counties were not at the table when the new Medicaid waiver was being worked out, Mr. Kopelman noted. The bill that was passed by the legislature required that the HSD make a good-faith effort to fill the gap, and he is disappointed that the HSD has not asked for an increase in its budget. Another member urged Mr. Earnest and Mr. Kopelman to establish a timetable to resume discussions and to report back to this committee.

Mr. Kopelman was asked by a committee member why the NMAC did not sue the state following the governor's veto of the sunset provision in SB 268. NMAC members wanted to see if a voluntary resolution could be found, Mr. Kopelman explained. The state has the plan it likes, the member insisted — no sweat off its back — and counties can raise taxes or cut services.

Counties that cannot meet payments. Members asked for clarification about Mr. Earnest's statement that San Juan County had remitted zero dollars for its GRT increment under the new SNCP. Lisa Gomez, San Juan County indigent program administrator, explained that under the previous sole community provider program, the county had met all of its payments. Now, without any hospital participation with the county, it is impossible to meet the new one-sixteenth GRT

obligation; the county is short $800,000. The board of county commissioners already has reduced payments to indigent programs and providers by 50 percent, she said, and it changed requirements to reduce the numbers of those eligible for services. Over the past five years, San Juan County has cut its budget by $51 million, reduced its work force by eight percent and now is considering tax increases, Ms. Gomez said. Nearly one-third of New Mexico counties are in a similar position.

Public Comment

Rebecca Dow, founder and director of AppleTree Educational Center, thanked committee members for bringing FOCUS and the need for a preschool cost study to the table for discussion, and she told them that advocates from the New Mexico Child Care and Education Association will be coming to them for legislation during the upcoming session.

Wendy Evanston, nurse, developmental therapist and advocate, thanked committee members for continuing to support home visiting. The Little Things Matter Program has been a blessing to the community since funding was cut for maternal child care. The program coming through the CYFD raises red flags for people who might need these services, she said, so more marketing is needed to increase awareness. Millions of dollars are being spent on prisons, and this is preventable, she said. Community programs like this help to rebuild the family support that used to be there.

Jenny Sheppard, a health educator, also voiced support for Little Things Matter as an important service that helps families bridge the gaps. In rural areas, people have to travel many miles for health services, Ms. Sheppard said, and more community health workers are needed to provide local community health care. She has had to change jobs many times, as her position gets eliminated when grant funding runs out, and she is asking for sustained funding for community health workers.

Jamie Michael, who works in the Dona Ana County Health and Human Services Department, said she wants to reinforce previous comments about decreasing county revenue and increasing expenses. Her county serves 47 of the state's 50 colonias, and there are undocumented lawful persons who are not covered by Medicaid but still need services and substance abuse treatment, as well as persons who make a little too much income to qualify for Medicaid but still cannot afford health insurance.

Mary Lamb, indigent claims specialist for Lea County, said undocumented persons do need care, and nearly 60 percent of their claims are for undocumented persons. Ms. Lamb would like to know from Mr. Earnest what the consequences are for counties that do not pay their GRT contribution or pass an ordinance to redirect these funds as set forth in SB 268.

Scott Annala, indigent health care administrator for Lincoln County and chair of the NMAC Healthcare Policy Committee, said nearly half of New Mexico counties are in a similar negative position as San Juan County, and they will be forced to raise taxes.

Jason Espinoza said that the SNCP, if not properly funded, is a looming economic crisis. Many hospitals will close, with employee layoffs from high-paying jobs. Communication between the counties and the state must remain open, he said, adding that everyone owns this problem, and everyone needs to work together toward solutions.

Proposed Rule Changes to SNAP Work Requirements

Mr. Earnest provided a presentation on SNAP requirements that the state will begin implementing in phases, by county, starting on November 1, 2014. New federal work requirements were signed into law by President Bill Clinton in 1996, but a temporary waiver was implemented in 2009 with the American Recovery and Reinvestment Act (see handout). New Mexico's reinstatement of requirements will include additional assistance for individuals to help them build skills and find work, Mr. Earnest said.

There are currently 454,997 individuals on SNAP in New Mexico, and of these, 60,430 are adults with children over the age of six and 26,969 are adult recipients without children, Mr. Earnest said. In October 2013, New Mexico reimplemented mandatory education and training requirements for childless adults, and beginning in October 2014, it will also start to reimplement employment and training requirements for adults with children over the age of six, thus removing the state's 2009 waiver. Allowable work activities for childless adults include community service, job training and work of 20 hours a week or more. For adults with school-age children, allowable activities include individual or group job search/employer contact, community service and job training. There are numerous exemptions from the work requirements, Mr. Earnest said, providing a list of these for both groups of individuals. He also provided a list of counties and Indian tribes, pueblos and nations that are exempt because of high unemployment rates. Some reimbursement is available for dependent care and transportation.

Ed Bolen, J.D., is a senior policy analyst at the Center on Budget and Policy Priorities, an independent, nonpartisan, nonprofit institute located in Washington, D.C. The center conducts research and analysis on a range of federal and state policy issues affecting low- and moderate-income families. Mr. Bolen described the potential impact of the state's proposed changes to SNAP (see handout), and he urged a more measured approach so that work and job training programs do not increase food insecurity by assigning individuals to activities they are not able to complete. Mr. Bolen urged the HSD to request a temporary 12-month waiver for the entire state for 2015 to prevent an increase in hardship on vulnerable New Mexicans. Under federal law, SNAP imposes a very harsh time limit on unemployed childless adults: these individuals can only receive SNAP benefits for three months out of every three years unless they are working or participating in job training. New Mexico lags behind most of the U.S. in creating jobs lost during the recession, which is more evidence for supporting a request for a temporary waiver, Mr. Bolen asserted. The waivers were designed by Congress to provide a safety valve in states with high unemployment, he said, adding that he is deeply concerned that unemployed poor individuals who are willing to work but unable to find a job will lose their SNAP benefits under this rule. Mr. Bolen urged the legislature to closely monitor outcomes of the SNAP employment and training program.

Kathy Komoll, director of the New Mexico Association of Food Banks, told committee members that the food bank industry is one of the most collaborative and adaptive to challenges, with rural outreach, mobile pantries, food rescue and on-the-job training. Every week, more than 40,000 New Mexicans seek food assistance (see handouts), she said, and over 40 percent of people served by New Mexico food banks are children under the age of 18, while 21 percent are seniors and 16 percent are grandparents raising grandchildren. Overall, 89 percent of households seeking food assistance report an annual income of less than $20,000 per year ($386 per week), she said. New Mexico is ranked number one in childhood hunger. Food banks are already operating at capacity and are having to turn people away. The system cannot serve every person who drops out of SNAP, Ms. Komoll said; food banks simply cannot fill that gap.

Ruth Hoffman, director, Lutheran Advocacy Ministry, reminded members that the U.S. Department of Agriculture directs SNAP and asked what problem is being solved by changes to the state program. The question being asked should be, how do we address hunger in New Mexico?, Ms. Hoffman said. The HSD has had a backlog of applications, has experienced difficulty with its IT system and now is adding complex reporting requirements with no case management to evaluate the work program. Where are the jobs?, she asked. Where is the job training? Where is the affordable child care? What is community service and how will it be administered? Ms. Hoffman said her organization has advocated for people living in poverty for over 30 years, and she also is speaking on behalf of the New Mexico Conference of Churches. She expressed doubt that the HSD or its contractor, SL Start, has the capacity to manage the thousands of participants who must now be added to the work program caseload, and she fears that participants will simply be pushed off SNAP when they are unable to comply with a poorly planned and administered program.

Sovereign Hager, staff attorney with the New Mexico Center on Law and Poverty, expressed frustration that it has been very difficult to get information about changes to SNAP that were announced in August but were not made publicly available. The HSD has experienced serious difficulty with its IT program and the influx of new Medicaid consumers, Ms. Hager said, and already had demonstrated problems with inadequate performance data reporting and a high rate of improper denials and terminations in SNAP. The new state requirements are not mandated by federal law, she asserted, and will require monthly tracking of tens of thousands of New Mexicans. There is no description of community service in the state's regulations, and the cost of dependent care can only be reimbursed; it is not paid up front. When people lose benefits, the state loses money as well, with an estimated $15 million less that will be coming into New Mexico's economy. There has been a 24 percent decline in SNAP participation as a result of job requirements for childless adults, Ms. Hager said, and no evidence that more are working, just that they lost their benefits. She urged committee members to require the governor to report on results from the job search requirement that has been in place for the last year.

Upon questioning, panel participants and committee members discussed the following topics.

Why a rush for New Mexico to do this now? Mr. Earnest said that a year from now, New Mexico will be facing the same issues. By starting now, new requirements can be phased in by county, and there is an opportunity to engage people, he said. A member countered that doing this early may allow for administrative phase-in, but there is no phase-in of jobs. Ms. Hager reported that more than 20,000 individuals have been referred to lose benefits, but there are no follow-up data from the HSD as to how many actually lost benefits and why. There has been a big drop in SNAP enrollment during this period, she noted. Ms. Hoffman expressed doubt that the HSD has the capacity to engage SNAP participants. Last year, the state did engage single childless adults, and it referred 20,000 of them, she said.

Measures of engagement. A committee member asked for metrics on the HSD goal of engagement. In his presentation, Mr. Earnest used data from the U.S. Bureau of Labor Statistics, the member noted, and those numbers do not work for rural New Mexico. If Mr. Earnest can pick his own numbers, they are impossible to compare, and since no one understands it, no one can question it. Another member asked Mr. Bolen if there have been any studies about the efficacy of this type of engagement. There has not been a comprehensive one, Mr. Bolen said, but research has indicated that it has very little impact, and studies have shown that community service rarely leads to a job. There might be value to someone being busy, he agreed, but this should not be confused with obtaining skills to get a job. Subsidized jobs lead to long-term wage gain, Mr. Bolen concluded. The member continued to press Mr. Earnest for specific details about the department's engagement plans. Mr. Earnest said plans for engagement are not new; the HSD has done them in the past. Putting a lot of people into subsidized jobs has worked for several thousand individuals, Mr. Earnest said, but to do this, the HSD would have to talk about the resources that would be needed. Precisely his point, the member said: the HSD does not know what resources are needed to implement its engagement program, and the member wants to see a presentation on this at the next meeting of the LHHS.

Concerns about the HSD contractor, SL Start. A member asked Mr. Earnest if the Legislative Finance Committee (LFC) has done an evaluation of SL Start recently. It has not, Mr. Earnest said, but the HSD has conducted regular reviews of its work on the New Mexico Works Program (Temporary Assistance for Needy Families). The member noted that SL Start's contract was renewed six months ago for $10.1 million and asked if the HSD reviews of the Washington State-based contractor are posted on the sunshine portal. They are not, Mr. Earnest said, but the contract is. Mr. Earnest promised committee members that he would get back to them with more information about SL Start's performance and its expanded role in the SNAP work program.

Lack of tribal consultation. A committee member noted that there has not been consultation with the tribes regarding SNAP benefits for members who are off-reservation or consultation about who is going to be exempt. Ms. Hager said there was a resolution from tribal governments requesting tribal consultation, and a letter was sent to the U.S. Department of Agriculture objecting to the state's SNAP plans moving forward without tribal consultation.

SNAP definition of "disability". A member asked Mr. Earnest how disability is determined by the department and was told that it is done by looking at obvious signs like disability payments and by proof from medical records. Ms. Hager stated that what is not obvious in the regulations is that there may be barriers that may fall under the federal Americans with Disabilities Act (ADA). An ADA compliance plan would be good, she continued, but the HSD does not have one. A complaint has been filed against the HSD and the SL Start contract regarding ADA compliance and the lack of provisions to accommodate persons with disabilities, Ms. Hager reported.

New Mexico Health Insurance Marketplace Status Update

John Franchini, superintendent of insurance, Office of Superintendent of Insurance (OSI), reported that the New Mexico health insurance market appears to be stabilizing, and rates are even more competitive than anticipated. There are 33,740 individuals in the exchange as of August 31, 2014, and another 30,000 to 40,000 will be coming into the exchange with ACA-noncompliant plans. These plans will be grandfathered in and can be enhanced on the exchange, he said. The ombudsman program, funded by a grant, has had more than 1,100 contacts. Also through a grant, an outreach director and two assistants have been added to staff. The OSI is working on a global positioning system (GPS) tool that will allow an instant view of insurers' provider networks; this will be posted on the OSI web site soon.

Superintendent Franchini discussed at length the New Mexico Medical Insurance Pool, which insures the sickest of the sick, and previously was the only avenue for these individuals to be insured. Since implementation of the ACA, the pool of 8,450 has dropped to 5,200 at the end of June, with many individuals qualifying for Medicaid and others now being covered under a spouse's policy. The pool is very expensive for the state and needs to be further depopulated, Superintendent Franchini said. An actuarial study is under way to explore raising the rates. Nonetheless, the pool should not be eliminated, he said; it could become a temporary place for people to have coverage between enrollments. New Mexico is now fifth highest in the rate of uninsured, Superintendent Franchini said. The state's 2014 return on investment for health care puts it more near the middle, at thirty-second. There have been $4 billion worth of health insurance premiums written in the state, he said, and while this amount is small compared to other states, New Mexico's system needs to be nurtured to make it better.

Aging in Sierra County

Majorie "Majie" Powey, M.S., R.N., Sierra Joint Office on Aging, provided members with Sierra County statistics: a population estimate in 2013 of 11,572, with 39 percent who are 60 years and older and eligible for services under the federal Older Americans Act. Sierra County has increasing numbers of seniors who have low incomes and need services (see handout). Ms. Powey described a series of programs funded by federal, state and/or local contributions that provide meals, transportation and homemaker services for seniors in what is a very rural county. In recent years, funding has been reduced for most of these critical programs at the same time demand has increased, Ms. Powey said, and it is her understanding that senior programs are once again on the chopping block. She is appearing before the committee today to ask for help. A member made a motion, seconded and approved, that the committee send a letter to the LFC asking for

supplemental state funding to the Older Americans Act for meals. Another member also wants the letter to inquire about the possibility for seniors to purchase food stamps.

Recess

The meeting recessed at 5:13 p.m.

Friday, September 12 — Elephant Butte Lake Event Center, Elephant Butte

Representative Madalena reconvened the meeting at 9:13 a.m., welcomed legislators and guests and asked staff members to introduce themselves.

New Mexico Health Insurance Exchange (NMHIX) Update

Jason Sandel, vice chair of the board of directors, NMHIX, introduced Amy Dowd, the new CEO hired by the board at the end of August. Ms. Dowd, formerly director of Idaho's insurance exchange, said she feels the future of the NMHIX is bright. Her immediate focus will be working with the board for success of the open enrollment period starting November 15. Idaho is different than New Mexico in that there was no expansion of Medicaid, Ms. Dowd said, but similar in that it also is a very rural state and has a half-dozen federally recognized tribes that contract with the exchange. The Idaho exchange had to be creative and work very hard to reach rural populations, she said; its initial enrollment was 78,000.

Mr. Sandel's presentation (see handout) included a chart of the uninsured rates for New Mexico: 21.6 percent just prior to the ACA, 14.5 percent currently and 9.6 percent projected for the spring of 2015. The outreach campaign for the NMHIX definitely "missed the mark", Mr. Sandel admitted, referring to disappointingly low numbers of businesses and individuals who signed up last year. A mass media approach was chosen instead of person-to-person contact, but now a new request for proposals has gone out for additional outreach contractors and is due on September 20. Mr. Sandel was pleased to announce that Native American outreach has expanded to the Navajo Nation, a long-sought goal, and an additional 85,000 Medicaid enrollees are expected by the year's end. The board voted to stay with the federal platform through the next enrollment period to allow thorough testing of the state's IT system interfaces. The board now is focused on determining strategies for sustainability once grant funding runs out.

Upon questioning, Mr. Sandel, Ms. Dowd and committee members discussed the following topics.

Marketing strategies. A member suggested small contracts with state universities to do field research on how to achieve the best outreach. Another member suggested utilizing schools, which are often the center of any community. As a point of clarification, a member asked if there is a difference between an enrollment partner and an outreach contractor. In New Mexico, outreach contractors have not been involved in enrollment; this was directed by the interim CEO of the NMHIX, but it may be changing, Mr. Sandel said. In Idaho, there was no separation between outreach and enrollment, Ms. Dowd said. The original NMHIX marketing vendor was based in

Wisconsin, and, upon questioning, Ms. Dowd said she felt certain that there are companies in New Mexico that could have provided this service. A committee member said he voted against legislation creating the NMHIX because he objected to its exemption from the Procurement Code. The member asked why a Wisconsin company would have more expertise than a New Mexico company and urged the NMHIX to hire talented local companies.

High cost of doing business. A member noted that more than $42 million had been spent to sign up 34,000 enrollees, and the cost per individual seemed extremely high. Ms. Dowd agreed, and she said her focus will be on using money wisely to get more enrollees. In earlier discussions with the NMHIX, it was suggested that a $20 million annual operating budget was needed to sustain it. Asked about the budget in Idaho, Ms. Dowd said it was about half that figure. The current financial report presented by Mr. Sandel shows nearly $40 million of the $42.4 million in total NMHIX expenditures in a "contractors" category, and a member asked for a breakout of that category, as this would be very helpful to the committee. Many decisions about the direction of the NMHIX had already been made by the time the board was constituted, Mr. Sandel explained, and now different decisions have been made for new directions; Ms. Dowd is the face of that change.

Health Coverage Provider Network Adequacy

Claire McAndrew is private insurance program director of Families USA, a national nonprofit, nonpartisan organization focused on achieving high-quality and affordable health care for all. Ms. McAndrew said she has spent much of the past year researching issues of access to providers once a consumer has enrolled in coverage, and she has found that an insurance card does not guarantee access to care. Advocates and consumers have been raising concerns about provider network adequacy for decades, Ms. McAndrew said, as they find directories out of date as providers have moved away or their phones have been disconnected or they are not taking new patients (see handouts). In-network specialists may be even harder to find, she said. Marketplace competition has brought insurance prices down, and the ACA forbids discrimination for preexisting conditions, so network design has become an important tool for insurers to control costs. This can be good if the network is carefully shaped, but adequacy is not always the result. New Mexico does have protections in statute, but it has issues with monitoring and enforcement, Ms. McAndrew said. Look to agency capacity to make certain a comprehensive investigation can be mounted, she advised, and monitoring compliance is the only way to know. The legislature could require or recommend satisfaction or secret shopper surveys. If a plan provider has been notified and does not correct deficiencies, more actions and penalties can be pursued and service areas can be restricted until problems are worked out.

Paige Duhamel, a staff attorney at the Southwest Women's Law Center, told committee members that access to health care is key to her nonprofit center's mission. Ms. Duhamel said her organization has been hearing about a lot of issues with adequacy for maternity and breast and cervical cancer care, as well as a lack of access to specialty care (see handout), and she agreed with Ms. McAndrew that New Mexico needs better monitoring of provider networks. There are problems with continuity of care when providers at federally qualified health centers, the Indian Health Service and Tribal 638 programs are not part of the network. There is little transparency of

MCO provider network oversight, Ms. Duhamel added. Other issues include consumer confusion about different provider networks for different plans from the same insurance carrier and increasing requirements for prior authorizations before care is delivered. Ms. Duhamel provided a list of potential updates to New Mexico's network regulations and described ongoing meetings with the Stakeholders Advisory Group and the OSI, which has been working with UNM to map provider networks. In addition, advocates have requested that Julie Weinberg, director of the Medical Assistance Division, HSD, present on MCO network adequacy regulation at the next Medicaid Advisory Council meeting. Ms. Duhamel was pleased to report that the OSI has been receptive to hearing more about putting additional regulations into place, and she is very excited about new OSI staff on board.

During questioning by committee members, Sharon Huerta, Centennial Care CEO at BlueCross BlueShield of New Mexico (BCBSNM), spoke from the audience to defend access and availability of her organization's provider networks. Ms. Huerta, invited by the chair to join presenters at the table, said she welcomes the opportunity to meet with advocacy groups. With regard to behavioral health, Ms. Huerta said she personally has been visiting with new providers. Oversight of her organization is tremendous, Ms. Huerta said, with hundreds of reports required on quality improvement, consumer satisfaction, finances and anti-fraud efforts, in addition to state reporting required in its contract. All claims from Native American 638 programs are honored, Ms. Huerta said, and those claims are paid while staff is still working through care coordination. The organization's four tribal liaisons have reported that Native Americans are pleased with care coordination, and, hopefully, BCBSNM can continue to have a positive impact on the Native American community.

A member speculated that if the state moves to better standards, perhaps the OSI ombudsman could monitor this. Ellen Pinnes, a lawyer and health policy consultant, spoke from the audience to clarify that the OSI ombudsman's role is to provide individual case resolution. The state is short on standards for specialty care, Ms. Pinnes said, and this a big area of concern for many people. The member, questioning whether there is a need for legislative action, made a motion for the committee to send a letter to the OSI inquiring as to what extent additional legislation is needed in regard to the issues discussed. The motion was seconded and passed unanimously.

Adjournment

There being no more business before the committee, the fourth meeting of the LHHS for the 2014 interim adjourned at 12:25 p.m.

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

October 20, 2014
Santa Claran Hotel
Espanola

October 21-22, 2014
State Capitol, Room 307
Santa Fe

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Monday, October 20, 2014, at 9:17 a.m. on the seventh floor of the Santa Claran Hotel in Espanola.

Present
Rep. James Roger Madalena, Chair
Sen. Gerald Ortiz y Pino, Vice Chair
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos (10/20, 10/21)
Sen. Gay G. Kernan
Sen. Mark Moores (10/22)
Sen. Benny Shendo, Jr.

Absent
Rep. Terry H. McMillan

Advisory Members
Sen. Sue Wilson Beffort (10/21, 10/22)
Sen. Craig W. Brandt (10/21, 10/22)
Sen. Jacob R. Candelaria (10/21)
Rep. Nathan "Nate" Cote
Sen. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill (10/21, 10/22)
Sen. Mary Kay Papen (10/21, 10/22)
Sen. Nancy Rodriguez
Sen. Sander Rue (10/22)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson
Rep. Phillip M. Archuleta
Rep. Miguel P. Garcia
Sen. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Rep. Vickie Perea
Sen. William P. Soules

Guest Legislator
Rep. Nick L. Salazar

(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
Carolyn Peck, LCS
Nancy Ellis, LCS

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written material are in the meeting file.

Monday, October 20 — Santa Claran Hotel

Welcome and Introductions
Representative Madalena welcomed those assembled and asked committee members and he staff to introduce themselves. He then introduced J. Michael Chavarria, governor of the Pueblo of Santa Clara. Governor Chavarria offered a traditional prayer and followed with introductions of his staff and tribal department heads who were in the audience.

Health and Human Services in the Pueblo of Santa Clara
Governor Chavarria said the Pueblo of Santa Clara still faces the imminent threat of flooding stemming from the 2011 Las Conchas fire, and he described ongoing emergency stabilization projects at the pueblo (see handouts). There have been four related presidential disaster declarations, he said, with two awards resting with the state and two in which the Pueblo of Santa Clara is the direct grantee, all with total damage awards of more than $100 million. Governor Chavarria also described a national disaster resilience competition through the U.S. Department of Housing and Urban Development, in partnership with The Rockefeller Foundation, for which the pueblo is eligible and plans to apply by the March 2015 deadline. Winning proposals will receive $1 billion for implementation of long-term recovery, restoration of infrastructure and housing and economic revitalization that demonstrate how communities can plan for a more resilient future. The Pueblo of Santa Clara is part of a national disaster recovery framework and collaborates with federal, state and tribal agencies and organizations, including the U.S. Army Corps of Engineers, the federal Bureau of Reclamation, the federal Bureau of Indian Affairs, the U.S. Forest Service, the Valles Caldera National Preserve and private foundations.

The Pueblo of Santa Clara is the site of a regional senior citizens and adult daycare center, with support coming from the state and from the eight northern pueblos. The programs are housed in a 10,800-square-foot facility in Espanola, and Governor Chavarria invited committee members to stop by for a tour of the center. Adults with special needs and seniors are provided with meaningful activities that stimulate both the mind and the body, he said. A long-

range goal of the program is to implement third-party billing and eventually to become self-sufficient.

Governor Chavarria described water and wastewater projects at the pueblo, which has secured grant funding from federal, state and tribal sources to replace aging infrastructure and to help provide adequate fire protection by the end of 2015. Santa Clara Pueblo Behavioral Health offers many services in mental health and substance abuse counseling, treatment and prevention, he continued, and plans are under way to assess efforts and expand services. The pueblo also is a recipient of a systems-of-care grant, now in its final year, from the Children, Youth and Families Department (CYFD). Third-party billing for behavioral health, community health representatives (CHRs), transportation for CHRs and senior center and adult daycare services remains problematic, Governor Chavarria said, and guidance from the CYFD has not been robust. He described services of the Pueblo of Santa Clara for children and adults and the need for adequate funding as the tribal community continues to grow.

Governor Chavarria described plans for a proposed 84,346-square-foot regional health facility in Espanola that will replace the pueblo's current health clinic and will be a joint venture with the Indian Health Service (IHS) and six neighboring tribes and communities. A 20-acre site has been identified for the $40.5 million project that will include primary care, behavioral health, dental, vision and other specialty care services. The Pueblo of Santa Clara would own the facility, but the IHS would provide staffing, and services could be expanded to include consumers other than tribal members. He informed the committee that the Pueblo of Santa Clara intends to apply for designation of the health clinic as a facility operating as a tribal "638 facility", meaning a facility operating under tribal control pursuant to the federal Indian Self-Determination and Education Assistance Act. As a 638 facility, Governor Chavarria said, third-party billing will become crucial. A feasibility study will be part of the Phase II application for the proposed new facility.

Referring back to the presentation on federal funds for damage from flooding, a committee member asked Governor Chavarria about delays by the state in forwarding those funds to the tribe. It is a problem, the governor stated, because much of the money does not arrive until a year or more later. The Pueblo of Santa Clara just received a presidential waiver to increase the federal match from 75 percent to 90 percent for one of the projects, he added. The chair invited Governor Chavarria and his staff to attend the next two days of the LHHS meeting in Santa Fe.

Pueblo of Jemez Experiences with Medicaid Centennial Care

Maria K. Clark, director of the Pueblo of Jemez Health and Human Services Department, described the accredited ambulatory health care center operated by the Pueblo of Jemez (see handout). In 2012, the pueblo decided to expand upon its federal mission and opened its doors to non-Indian residents in surrounding communities, she said, and now a small IHS program has been transformed into a full-service outpatient health care facility. As part of its Centennial Care (CC) plan, the state's Human Services Department (HSD) proposed a new mandate to require

Native Americans to enroll in Medicaid managed care plans, despite the fact that federal law prohibits such a mandate, Ms. Clark explained. The HSD's request to the Centers for Medicare and Medicaid Services (CMS) for a waiver from this prohibition was widely opposed by tribal leaders, who cited concerns about access to services, timely payments and culturally competent care. In 2013, the CMS rejected the state's plan to make Medicaid managed care mandatory for Native Americans, although individuals who require long-term care are still required to be enrolled with a managed care organization (MCO). Tribal members and many others continue to support passage of a state law to prevent mandatory enrollment of any Native American into a managed care plan and preserving fee-for-service (FFS) Medicaid as the default option, Ms. Clark said. Despite the CMS denial, the HSD auto-enrolled thousands of Native Americans into its MCOs, and efforts to opt out have been very difficult. On average, it has been taking three to four months to process an opt-out request, and currently, nearly 30 percent of patients at the Jemez health care center are waiting to be enrolled in FFS Medicaid, according to Ms. Clark. These are perhaps as many as 7,000 Native Americans waiting to opt out. While MCOs receive, on average, $3,284 per member per month, there is currently no reimbursement to tribal health centers for care coordination under FFS Medicaid. The state could reap considerable savings by allowing American Indian health facilities to be reimbursed for case management, Ms. Clark asserted. Other reimbursement issues include double payment of claims from previous MCOs (Loveland and Amerigroup), some of which still have not been resolved. Care coordination for tribal long-term-care recipients is nearly nonexistent, according to a recent survey that revealed that none of those interviewed knew who their assigned care coordinator was or what level of care they had been assigned by their MCOs. Ms. Clark said she and her staff remain eager to work with the HSD toward resolution of enrollment and reimbursement issues.

On questioning, Ms. Clark and Lisa Maves, a medical social worker with the Pueblo of Jemez Health and Human Services Department, discussed with committee members the following topics.

Identification of Native Americans. Julie Weinberg, director of the Medical Assistance Division of the HSD and administrator of CC, was recognized from the audience, and she denied that there was any attempt by her division to auto-enroll Native Americans. The system relies on self-identification, Ms. Weinberg said, and workers taking applications were overwhelmed and probably forgot instructions about identification. Most of the auto-enrollment cases have been resolved, she asserted. Ms. Maves countered that auto-enrollment issues are as recent as two weeks ago, and those disenrolling must wait until the following month for it to take effect. Many of the auto-enrolled did not receive notice of the 90-day opt-out window, and there was no FFS option indicated on state plans, Ms. Maves said. A discussion commenced about the role of Xerox, which manages the CC call center, and about incorrect information given out to consumers who call asking to disenroll. Ms. Weinberg said the state's ASPEN system determines eligibility and contains demographic information. If the enrollee's information does not indicate "Native American", that person will be auto-enrolled in an MCO. A bureau in her division can change the race code, and she said she will try to correct Xerox's misinformation.

Compensation to tribes for care coordination. Ms. Weinberg reiterated that there are no plans to reimburse for care coordination in any FFS environment. Asked by a member if this is a federal rule, Ms. Weinberg said she did not think that there is anything in CMS regulations that would prohibit such payment.

Explanation of federal Office of Management and Budget (OMB) reimbursement for FFS. The IHS and tribes get the OMB rate from the state, which is $330, inclusive of a physician visit, lab work, etc., Ms. Clark said. If a Native American is seen at a nontribal facility, the match is 70 percent. Ms. Weinberg said the reimbursement rate is 100 percent for adults in the Medicaid expansion. Any services delivered at a tribal facility are reimbursed 100 percent. MCOs pay this and pass along the invoice to the state, which then pays the MCO 100 percent of the tribal invoice.

Need for legislation. A committee member noted that in light of the CMS denial to the HSD, the choice of a Native American should be promoted rather than corrected. There should be systems in place to promote this choice without being administratively burdensome, the member stated. This issue keeps coming up with no resolution, and perhaps legislation is needed. Health care is a huge industry, the member continued, and tribes are trying to develop their own services. In a small community, people are used to going down the street for care and information; having a company located far away is burdensome to both the individual and the community.

Psychiatric Medication Oversight for Children in Foster Care

Krystal Goolsby, president of Leaders Uniting Voices Youth Advocates of New Mexico and a graduate of the state's foster care program, told committee members that her advocacy group discussed medication at a meeting last week. Young children who come into the foster care system are already traumatized and are naturally more "hyper" in their behaviors, Ms. Goolsby explained. Children are given medication, and if one does not work, another is prescribed. One member of her group was on 16 different medications by the time she was old enough to understand; now she is on only three. Another group participant said his medications make him "feel like a zombie". Although the age of consent in the system is 14, Ms. Goolsby said, any youth in foster care should have a relationship with the prescribing therapist and a voice in the choice of medications. Describing her time in a residential treatment center, Ms. Goolsby said she was never asked how medications affected her, and anyone refusing medication was classified as noncompliant. Most of the young people hate taking their medications, she said. Now, Ms. Goolsby said, she sees that many of her friends need help, but because of their experiences, they refuse to take medications that could help them.

Thomas I. Mackie, Ph.D., assistant professor at Tufts Medical Center in Boston, thanked Ms. Goolsby for sharing her story. Dr. Mackie has been investigating the use of psychotropic medications in children for the past six years. The use of these medications can alter the mental health of a child, Dr. Mackie said, and research lags behind prescribing trends (see handout). There has been an exponential increase in the use of these medications prescribed for emotional

and behavioral disorders in children, and particularly in preschoolers, Dr. Mackie said. These trends, and the lack of research to support current practice, have important implications for work with traumatized children. Adolescents represent 25 percent of the Medicaid child population and 60 percent of total behavioral health expenditures. The use of psychotropic medications in Medicaid-enrolled children grew 62 percent in five years (2002 to 2007). In New Mexico, the concurrent use of three or more classes of psychotropic medication in children grew by nearly 35 percent during the same five-year period. Multiple studies have shown that provider shortages, lack of access to effective non-pharmacological treatments and gaps in coordination and continuity of medical and mental health care may play a role in these patterns of psychotropic medication use in foster children, Dr. Mackie said. Federal laws passed since 2008 now require more oversight and coordination, including screening, monitoring, use of more professional expertise, informed consent and sharing of information and decision-making. Dr. Mackie described varying state responses to these changes, and he urged legislators to review those listed on page 26 of his handout, especially noting the Ohio Minds Matter web site as a good example. Acquiring more mental health expertise for the state is critical, Dr. Mackie said, especially for those with child psychiatry expertise.

Jared Rounsville, director of the Protective Services Division, CYFD, described a newly formed council that includes Dr. George Davis, who is a child psychiatrist, and consumers. The council works with CYFD staff around the use of psychotropic medications in New Mexico. It has become clear that using these medications to mask trauma in children is not the most effective treatment, Mr. Rounsville said, and the CYFD has a deep and compassionate desire to change this. The CYFD is also training foster parents on this topic, using Dr. Bruce Berry's trauma academy and his neurosequential model of brain development.

On questioning, Ms. Goolsby, Dr. Mackie and Mr. Rounsville discussed with committee members the following topics.

Challenges with lack of providers. Mr. Rounsville admitted that finding and recruiting educated staff is a challenge, especially in rural areas. He said there are approximately 50 child psychiatrists in the state, but not all of them are practicing, or they are practicing part time, and most are in the Albuquerque area or at the University of New Mexico (UNM). Others who are prescribing psychotropic medications for children include psychiatrists who treat adults, pediatricians, nurse practitioners and physician assistants.

Lack of data. There are about 2,200 children in foster care in New Mexico, Mr. Rounsville said, and the CYFD does not know how many are on psychotropic medications. A member asked about babies being placed on psychotropic medications in foster care, and Dr. Davis responded that there are very few babies on these medications, but there has been a rise in medications for children under age five. The CYFD is working with the MCOs to find out how many Medicaid-recipient children are on these medications. Daphne Rood-Hopkins, director, Community Outreach and Behavioral Health, CYFD, spoke from the audience to assure committee members that the data have been requested and that the HSD has been very responsive

and will provide those numbers soon. There was a data dump by OptumHealth when it left the state last year, she said, but the CYFD is not getting a report on a regular basis. A member suggested that what is needed is a central registry like the one the state created for opiate prescriptions, and she would request and sponsor such a bill for pharmacists. A registry would work for everyone, the member asserted, and would not be politically sensitive. She also noted that, with the majority of behavioral health providers shut down by the HSD in 2013, there are no data available for how many consumers were on psychotropic medications at that time and where they are now. The member told Mr. Rounsville that she wants the information from the OptumHealth data dump to be provided to the committee. Another member asked Mr. Rounsville for data from the CYFD's Juvenile Justice Division, as well.

Who makes the decisions? Mr. Rounsville said it is the intention of the CYFD to intervene on behalf of children in foster care in a much more aggressive way to reduce the use of medication and provide trauma-informed therapy. Dr. Mackie pointed out that there are many good resources available about alternatives to medication. Another member noted that if there is nothing in MCO contracts requiring MCOs to follow the steps of treatment laid out by the CYFD, medication will always be the cheaper choice for them.

2014 Senate Joint Memorial 14 Report: Grandparents Raising Grandchildren

This memorial tasked the CYFD to work with the HSD and the Public Education Department to study issues affecting grandparents raising grandchildren, including custody and guardianship, financial resources, availability of legal services, food and housing assistance, medical care, transportation and community-based support organizations (see handout).

Mr. Rounsville provided a history of legislative efforts to assist kinship caregivers and a history of agencies that can assist in identifying legal issues that need to be addressed, including enrollment in public education. Since October 2006, the Aging and Long-Term Services Department has contracted with Pegasus Legal Services for Children, in conjunction with Law Access New Mexico, for this purpose, and it has provided legal assistance to 3,325 families, averaging 536 families a year and providing outreach and education to more than 7,256 individuals annually. Mr. Rounsville said that the CYFD provides training to relatives about resources and services and always attempts to identify relatives that are caregivers for children who otherwise would be placed in foster homes.

Today, there are 54,638 grandparents in New Mexico who are serving as heads of household for 52,098 grandchildren, according to the most recent American Community Survey of the U.S. Census Bureau, with a slight trend toward multigenerational households that can offer greater financial stability. Access to public benefits vary but are higher in multigenerational households than in those with grandparents raising grandchildren. Thus, the greater need for assistance is with this latter group, Mr. Rounsville pointed out. Other trends that emerged from this survey include an increasing number of grandparents over the age of 60 who are raising grandchildren, more children between the ages of 12 and 17 who are being raised by grandparents for more years and an increasing number of grandchildren under the age of two

being raised by grandparents. There is disparity among ethnic groups: 57.4 percent of these families are Hispanic; 24.4 percent are Native American; and 14.8 percent are white. Finally, he said, while the number of grandparents with disabilities has declined, the number of grandparents who are still employed is on the rise.

Financial resources include the HSD's Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program and other emergency food and energy assistance and the CYFD's child care subsidy programs. Community resources include Las Cumbres Community Services, Engaging Latino Communities for Education (ENLACE) New Mexico, the Adelante Development Center, Inc., and AARP New Mexico. Promising practices can be found at the Edgewood Center for Children and Families in San Francisco, which supports an extensive online one-stop shop for caregivers and public policymakers; Kinship Services Network at The Children's Home, Inc., in Tampa; and subsidized guardianship programs that support kinship caregivers in Florida, Louisiana and Missouri.

Grandparents Raising Grandchildren

Elizabeth McGrath, an attorney and the executive director of Pegasus Legal Services for Children, described the difficulty of access to legal services for many grandparents. Her organization provides advocacy services in uncontested cases, but her organization has a long wait list, and she emphasized the need for additional funding from the state. A big problem is that access to information about a case often comes too late to affect the outcome. Ms. McGrath said that many children do not have a voice in the disposition of their own cases, and she would be willing to work with committee members on a remedy for this issue.

Rex Davidson, executive director of Las Cumbres Community Services, spoke of the sacrifices that many grandparents make, and he urged school systems, many of which are not well-versed in children's rights to education, to do a better job. Erwin Rivera, community resource/family specialist for ENLACE, pointed to audience members who are grandparents raising grandchildren and asked them to tell some of their stories. It is very difficult for a grandparent to negotiate a complex educational system without help, Mr. Rivera said. ENLACE, which also needs increased funding and support, could be a model used around the country. Testimony from grandparents raising grandchildren included one grandparent who said that food insecurity remains a big issue for her, as does housing and clothing. A grandfather who took in two young granddaughters said he had the support of CYFD training and Las Cumbres Community Services, but he does not qualify for financial services because he has a job. Now, 11 years later, his granddaughters' father and mother are doing better.

Mental and Behavioral Health Programs and Services Available to Native Americans

Wayne W. Lindstrom, Ph.D., director of the Behavioral Health Services Division (BHSD) of the HSD and chief executive officer (CEO) of the Interagency Behavioral Health Purchasing Collaborative, described the vision and responsibilities of the collaborative, the role of the Behavioral Health Planning Council (BHPC) and local collaboratives, and the statewide managed care plan implemented with CC in January (see handout). He then introduced Barbara

Alvarez, BHSD tribal liaison, who detailed non-Medicaid provider programs for Native Americans totaling more than $1.5 million (see spreadsheet). The funds and grants cover a wide range of services, including treatment of domestic violence, traditional Native American counseling, substance abuse, pregnant women with substance abuse, detoxification, treatment of veterans using western and traditional interventions, access to housing, prevention of homelessness, education for healthier lifestyle choices, a framework to help reduce underage drinking and a small grant to The Life Link to provide ad hoc invoicing based on cost reimbursement on behalf of the Native American subcommittee of the BHPC. Dr. Lindstrom told members that he plans to have data on what kind of services are being delivered to Native Americans through CC the next time he appears before the LHHS.

Arturo Gonzales, Ph.D., is executive director of the Sangre de Cristo Community Health Partnership and implementation director of Clinical and Partner Site Implementation and Sustainability of the New Mexico Screening, Brief Intervention and Referral to Treatment (SBIRT) program. SBIRT is an evidence-based practice used to identify, reduce and prevent problematic use, abuse and dependence on alcohol and illicit drugs. It is currently used in primary care settings at partner sites, including the First Nations Community Healthsource in Albuquerque, the Pueblo of Jemez medical clinic, the Taos IHS medical center, the Acoma-Canoncito-Laguna Hospital, the IHS unit in Santa Fe and the trauma center at the UNM Health Sciences Center. Citing the significant success and cost savings of SBIRT's impact in New Mexico since 2003, Dr. Gonzales urged members to help implement the program statewide as part of the New Mexico behavioral health plan and to enable sustainability by ensuring activation of the Healthcare Common Procedure Coding System and Medicaid codes for billing.

Bret Smoker, M.D., chief medical officer of the IHS hospital and clinics in Santa Fe, reported on Native American health disparities: Native Americans experience twice the national average of substance abuse and twice the national average of suicides. SBIRT has been very well-accepted and is valued in the IHS hospital and clinics, including by clinical staff, Dr. Smoker said. It is a very effective intervention and normalizes these issues by integrating the screening into primary care. Leslie Dye, CEO of the Santa Fe IHS unit, said she, too, is very excited about the SBIRT program, adding that nearly everyone has been touched by these issues. Keahi Kimo Souza, behavioral health director at the Pueblo of Jemez Health and Human Services Department, said he is committed to SBIRT helping to address many health challenges, but funding is a big issue. Help still is needed with billing, but the Pueblo of Jemez is honored to be chosen as an implementation site. SBIRT's model of using a behavioral health therapist and peer support worker in the initial stages of brief treatment provides a warm hand-off when further professional help is warranted.

On questioning, Drs. Lindstrom, Gonzales and Smoker and committee members discussed efforts to expand SBIRT statewide. A member questioned the cost shift that can occur when billing codes are added. Dr. Lindstrom said that if this service is added, and if it has to have federal approval, there can be an actuarial cost, and MCOs would be looking for a greater capitation rate. This kind of service is a short-term increase in costs, he added, but long-term

reduction of costs is not part of the Medicaid budget. Another member thanked Dr. Gonzales for his efforts and for coordinating, and doing training for, a single system to help sites provide a service that is especially crucial for rural areas. Dr. Gonzales said today's appeal to the committee was his "last hurrah". In hearings, the HSD testified against the program, he noted. The IHS believes in this program, and UNM believes in it, he said. Dr. Lindstrom, when questioned by committee members, said the BHSD is highly supportive of SBIRT.

Recess

The committee recessed at 5:48 p.m.

Tuesday, October 21 — State Capitol, Room 307

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 9:22 a.m., noting that Representative Madalena would be unavoidably late. He welcomed legislators and guests and asked staff members to introduce themselves.

CC Long-Term Care; Home- and Community-Based Services (HCBS); Community Benefit; Self-Directed Services; Independent Consumer Supports System; Care Coordination; Alternative Benefit Package

Ms. Weinberg told members that CC's innovative Medicaid model has put New Mexico in the spotlight, and other states are watching closely for outcomes. Currently, New Mexico has approximately 729,000 individuals enrolled in Medicaid, which includes Medicare premium-only programs. There are 575,000 people enrolled in CC, with 171,000 of those from the state's Medicaid expansion (see handout). Long-term services and supports in CC include nursing home care and HCBS through the community benefit, which can be agency-based or self-directed. To be eligible for the community benefit, an individual either must be Medicaid-eligible, either financially or due to disability, or not otherwise eligible for Medicaid but eligible for institutional-care Medicaid. The first group is now entitled to full HCBS; individuals in the second group must have a waiver slot to obtain services. There are now more than 14,000 individuals with expanded access to HCBS, Ms. Weinberg said, and the CMS has authorized 4,289 waiver slots in New Mexico, 2,945 of which are currently filled. It is anticipated that another 800 slots will be filled by the end of fiscal year (FY) 2015. There are approximately 15,000 individuals on the wait list, Ms. Weinberg said, but some do not qualify and many others do not respond when contacted. Some people put themselves on the registry because they think they might eventually need it, she said. Priority is first-come, first served, except for nursing home residents who wish to return to the community.

Care coordination is at the heart of CC, according to Ms. Weinberg, and follows a health risk assessment (HRA) conducted on every member by the MCOs to address needs and goals. Currently, the MCOs report that about 50 percent of their members have been assessed; a member cannot be forced to undergo an HRA. Expansion adults are under CC's alternative benefit plan (ABP), which includes a wide array of physical, behavioral and dental health

services and may require nominal co-payments for certain services, depending on income. It does not include long-term supports and services, and a medically frail individual can choose to become ABP-exempt to access these. Others with conditions such as pregnancy, serious mental illness, chronic substance use disorder, a terminal illness or other serious illness may also opt out of the ABP due to its limits on the extent and duration of various therapies.

William Orr, M.D., told members that UnitedHealthcare Community Plan of New Mexico has intensive coordination of care so that individuals can be transitioned across physical and behavioral health systems of care. With regionally based blended teams, services now can be integrated. Needs assessments are done in the member's home, with a focus on education and data-sharing, Dr. Orr said.

Molina Healthcare of New Mexico uses a person-centered, integrated-care approach, according to Cathy Geary, director of health care services and a nurse with many years of experience with the medically frail. Care coordinators are advocates who help people navigate a complex health care system. Ms. Geary said she has been involved in many Medicaid rollouts, and CC is the most complex she has seen. Maintaining an interdisciplinary team of providers for physical and mental health is very important to the plan, Ms. Geary said. The HRA is done in a member's home, and community health workers and peer-support specialists are on board as part of the community connection. Molina operates in 14 states, and Medicaid is its only business.

Charles Milligan, an attorney and senior vice president for enterprise government programs, Presbyterian Health Plan, Inc., spoke of the company's need to be nimble with care coordination plans that can change as members' needs change. The Presbyterian model includes a hub of services and nonmedical supports. Mr. Milligan described four dimensions of integration: (1) between physical and behavioral health needs; (2) between Medicaid and Medicare (for members who are dual-eligible); (3) between home-based and institutional care; and (4) between acute care and community-based services and supports. Home visits to members are critical to the planning process, he said.

Sharon Huerta, CEO of Blue Cross Blue Shield New Mexico (BCBSNM), told members that her company exceeds its contractual requirements for CC. Multiple contacts are usually required to conduct an HRA in a member's home, and the company uses promatoras and community health workers on the ground in the community. While the majority of members fall into the lowest level of need for care coordination, BCBSNM makes a robust effort to assess, and assist in, members' evolving needs.

User Advocacy Panel

Jim Jackson, executive director of Disability Rights New Mexico (DRNM), said that CC holds promise for the elderly and disabled, with expanded long-term-care services and a diverse menu that should provide for everyone's needs if program elements are in place, functioning and working together. However, DRNM's experience is quite different from what has been presented, he said, and many barriers remain (see handout). Mr. Jackson maintained that nearly

10 percent fewer persons are being served now than this time last year under the previous Coordination of Long-Term Services (CoLTS) program. He questioned why waiver slots have not been filled, and he pointed out that the state gives preference to individuals in a nursing home who want to access HCBS, creating an incentive to go into a nursing home to bypass the nearly 16,000 people on the wait list. This issue is not new to CC, but it is a continuation of a state policy, he said, not a federal requirement.

Claire Dickson, a staff attorney with the nonprofit Senior Citizens' Law Office in Albuquerque, said that care coordination, a lynchpin of CC, should be robust; it is the right time and the right place, and it is written into contracts with the MCOs. While care coordination should help consumers with the complicated navigation of CC, this is not necessarily happening, she said. Ms. Dickson offered three cases of different consumers who were unable to access a care coordinator or whose cases were simply dropped from any assistance. These cases and others at the office have made Ms. Dickson concerned about the level of knowledge of care coordinators.

Sandy Skaar, owner and director of Self-Directed Choices, LLC, a support broker agency for the self-direction community benefit option under CC, described many MCO members who have not had their initial assessments; members who were on the Mi Via self-directed home- and community-based waiver services program under the CoLTS "c" program for brain injury services program prior to the implementation of CC who now are having their budgets cut; and numerous problems with care plan approvals and appeals (see handout). Ms. Skaar also expressed concern about an apparent lack of expertise among care coordinators and frequent turnover among personnel. The goal of community reintegration has helped many New Mexicans leave nursing homes and live safely in their communities. Now, budget cuts might force them to return to nursing homes, and Ms. Skaar asked if this is what is wanted for fellow New Mexicans.

Ellen Pinnes, a lawyer and consultant to the Disability Coalition, discussed details of the ABP for new Medicaid enrollees. Under the federal Patient Protection and Affordable Care Act (ACA), states could align their "expansion" adults under traditional Medicaid or under the ABP. Most states have chosen the former; New Mexico chose the latter (see handout). Ms. Pinnes described some differences between traditional Medicaid and the ABP in New Mexico, including different benefits, co-payments and the fact that the ABP does not include long-term services. According to federal regulation, persons who are medically frail or who have serious mental disorders, complex medical conditions, disabilities or chronic substance use disorders are exempt from the ABP. Ms. Pinnes said she could not find a definition of these individuals in CC or in the state's Medicaid program manual. According to the HSD, as of July 31, approximately 160,000 newly eligible adults had enrolled in Medicaid, and only 270 of these had been determined to be ABP-exempt. She said she cannot understand why this number is so low. All expansion adults are automatically enrolled in the ABP, and exempt individuals must opt out. This is contrary to federal requirements, Ms. Pinnes said, asserting that the HSD's approach to

this issue creates barriers to long-term services for newly eligible seniors and people with disabilities.

Guy Surdi, a disability specialist and member of the Governor's Commission on Disability, presented brochures from the New Mexico Independent Consumer Support System with phone numbers, resources and links (see handouts) and supplied members with a copy of the CMS "Special Terms and Conditions", which describes the federal requirement for independent consumer supports to assist enrollees in understanding the coverage model and in the resolution of problems regarding services, coverage, access and rights (see handout). The system should provide consumers with comprehensive information regarding their benefits and help identify the appropriate services needed, but New Mexico's system is not very consumer-friendly, Mr. Surdi said, and does not provide any understanding of benefits. He has heard many complaints from consumers about how difficult and frustrating it is to contact CC. Progress on this system has been slow, Mr. Surdi said, and with minimal resources, there are no plans for local counselors and no contacts for independent living centers. His recommendation is to initiate robust outreach using local organizations to provide assistance.

On questioning, panel presenters and committee members discussed the following topics.

Ratio of care coordinators to members. The ratio of care is uniform throughout the state, Ms. Weinberg said. The ratios are: one to 750 for Level 1; one to 75 for Level 2; and one to 50 for Level 3. These ratios are set out in the MCO contract. A panelist noted that one of the challenges is that care coordinators are required to be employees, and this accelerates the cannibalizing of providers. Ms. Huerta said that the care coordinator ratio for those in nursing homes is one to 125; it is one to 140 for self-directed members.

Care coordinator safety. Care coordinators are required to travel, given the rural nature of the state, one member noted, but she has heard complaints that some are afraid to enter members' homes, perhaps due to a member's behavioral health issue. All care coordinators receive safety training, representatives of the MCOs explained, and none is required to enter an unsafe situation. They can travel in pairs, with a supervisor or another coordinator, and can request an exception from the HSD. Care coordinators are required to have a bachelor's degree and at least two years of experience in social services, Ms. Weinberg added. They are also specially trained by the MCOs. She admitted that there may be a breakdown in training on eligibility, and she has made note of that as well as of possible issues with computer systems.

Behavioral health services that are excluded from the ABP. Ms. Weinberg said she does not know what those services are or how many newly eligible consumers have access to behavioral health services, but all necessary services are available to new enrollees through either the ABP or the state plan. If they need those services, they are ABP-exempt, she said. The MCOs are required by contract to deliver those services while they process the exemption. Ms. Pinnes stated that there are three services excluded from the ABP: (1) peer support; (2) respite support; and (3) family support. Another member noted that MCOs are turning down

reimbursement-of-care coordination or services that are not provided by a core service agency, of which there are only a few. Ms. Weinberg asked members to call her if they hear about someone who should be getting services but is not. A panelist urged a more robust independent consumer support system and more help for people trying to navigate. The resolution of "call Julie" is not robust enough, he said.

Long-Term Services Consumer Panel

Dorothy Danfelser said she has a stepson with brain injury and has had continuing problems with care coordination and an insufficient level of services. Her stepson is 36, had an accident at age 22 and has anger-management issues. She has received $2,800 in co-payments for medication, and she appreciates this program. Her stepson can live at home and lead a somewhat normal life, but care coordination is complicated.

Doris Dennison said she was on Mi Via and was very happy, but she is now in CC with Molina and is having problems accessing and coordinating her health care services. She started receiving denials for services, and her medical supplies were cut. Ms. Dennison said her care coordinator has been changed twice, and she still has not received an assessment. Transportation over long distances is a big problem, and mileage reimbursement is now lower. She was not advised that she could, as a Native American, opt out of CC. Ms. Weinberg noted that anyone who needs long-term supports and services must be in CC, including Native Americans.

Deborah Cooper said her husband is a brain injury survivor. Brain Injury Services Fund money will run out soon, and she does not think he will qualify for long-term services. Ms. Cooper said she has worked as a brain injury advocate and resource facilitator and took training at her own expense. Now, under CC, she has had a cut in pay for helping others because community direct support is no longer a supported code. Ms. Cooper is a founding member of New Mexico's Rural Coalition/Coalición Rural, and she has a son who is disabled with behavioral health symptoms. She is responsible for a household of three but cannot afford insurance for herself. One of her clients was not able to get the services he needed and now is in a nursing home.

Ed Keller said he has a severe brain injury. He said a care coordinator "looks good on paper", but he knows a nurse who lives in Las Vegas and has a caseload of more than 100 people. After a three-hour assessment, he was assigned to Level 2, and a budget was supposed to be set up as of August. Now he has been assigned a new care coordinator and was told that because it had been more than 90 days since the last one, he has to have a new assessment. Mr. Keller said he got a laptop computer but could not get an insurance policy for it. Now, if he drops the laptop, he will not be able to get a replacement. His new care coordinator does not seem to know what she can put in his budget, which is to start December 1. "These shifting sands are intense", he said. "These are people's lives."

Ms. Weinberg was asked by a committee member if the amount of funding available for Mi Via clients was reduced under CC. She responded that funding did not get reduced, but the

benefit cannot exceed the average cost of a nursing home ($56,500). Those already in the program who had higher budgets were grandfathered in, she said. If a consumer's needs change, then the budget might change. MCOs that want to reduce budgets have to get approval from the Quality Bureau of the HSD, Ms. Weinberg said. Only 10 requests have occurred, she said, and just two have been granted. Mr. Keller said he was told the previous week that his entire budget was up for review regardless of what it was last year. Ms. Weinberg said she does not understand why he would have been told this. The committee member urged Ms. Weinberg to help the consumers who appeared before the committee today, and she agreed to do so.

Program of All-Inclusive Care for the Elderly (PACE)

Beverly Dahan, vice president of government and legislative affairs for New Mexico PACE, said the program provides comprehensive health services for individuals age 55 and over who are sufficiently frail to be categorized as nursing-home eligible by their state's Medicaid program. There are currently 106 PACE programs in 31 states (see handout). InnovAge (formerly Total Community Care) is the only PACE provider in New Mexico, Ms. Dahan said, and serves nearly 400 participants in Bernalillo, Sandoval and Valencia counties.

Irene San Roman, M.D., medical director of InnovAge Greater New Mexico PACE, said the program's comprehensive approach to care for the elderly offers an alternative to nursing home care. Clients are able to receive the support and services they need to allow them to stay at home, maintaining their dignity and independence. InnovAge provides a multitude of professional and social services, primary and specialty care physicians and adult daycare and health center services, and it is reimbursed on a fixed per-member, per-month rate by both Medicare and Medicaid. There are no co-payments, premiums, deductibles or service limits, Dr. San Roman said. Citing several different cases, Dr. San Roman said that the program saves money in the last six months of life, and it also supports families by allowing them to continue to work.

A committee member asked if the program is new. It was set up by the federal Balanced Budget Act of 1997, Ms. Dahan said, and was operated for many years in Santa Fe by St. Joseph's Hospital. New Mexico is now capped at 400 and has a wait list. The state does put up matching dollars for the program. InnovAge has approximately 2,400 clients in Denver and Pueblo, but it is a very challenging program to try to put in rural areas. Another member asked about the savings to the state. Ms. Dahan said studies have shown that it saves 20 percent in the last three years of life and 60 percent in the last six months of life. A member whose great-grandmother spent her last two years of life in the PACE program said it gave her grandmother dignity.

Nursing Home Reimbursement Rates

Linda Sechovec, executive director of the New Mexico Health Care Association (NMHCA), provided background on her organization's $3.5 million request for FY 2015, $2 million of which was approved — a 3.65 percent rate increase for nursing facilities (see handout). The new rates were effective July 1 but were not loaded by MCOs until late

September. Most of the claims back to July 1 have been approved for payment, but some are still pending, she said. This appropriation has been critically important because of the negative impacts that came with the implementation of CC, she said, including the state's decision to change level-of-care criteria, resulting in a projected decrease of $30 million in Medicaid payments. There also have been problems with MCO nonpayment of claims, delayed level-of-care determinations, backlogs in eligibility determinations and payment delays. Ms. Sechovec said that the change in criteria to restrict patients who qualify for "high" nursing facility services was made with minimal input from providers and no consideration of the financial impact to the industry. In October, her organization created a model to project that impact: $30 million annually in losses to New Mexico facilities. This change in the criteria has threatened facility solvency statewide, Ms. Sechovec asserted, causing a reduction in staffing and services and halting capital improvement programs to upgrade facilities and equipment. Facility margins of operation are now in the negative.

A committee member asked Ms. Sechovec how her members stay afloat. Most of her members are being supported by national entities, she explained, but corporate executives have been calling, asking what is going on in New Mexico. New rates must be negotiated, she said; it is critical that all entities move forward together and find a solution. Her calculations show more than $16 million is needed from the state.

Long-Term Services Provider Panel

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers (ADDCP), told committee members that she is urging that $15 million be appropriated, $5 million each to the Family Infant Toddler Program, the developmental disability (DD) state general fund and the DD Medicaid waiver program. The situation is dire, she warned. Several large providers have dropped supported employment, and Goodwill Industries no longer will provide DD waiver services. LEADERS Industries in Lea County, which has been in business for over 40 years, is closing down altogether, Ms. Hatanaka said. With the oil and gas boom in the southeastern part of the state, LEADERS cannot find staff to compete with energy industry salaries. Provider agencies are currently working under "survival mode" conditions due to rate cuts and the lack of predictable annual rate increases (see handout). Her members assert that developmental delay and disability service systems in the state are unsustainable due to increasing unfunded mandates and the absence of any rate increases. The ADDCP is asking the legislature and the Department of Health (DOH) to: (1) recognize that current provider rates do not cover costs of services, mandates and expectations; (2) reduce unfunded mandates through revisions to regulations and service standards; (3) provide for annual cost-of-living increases; and (4) reimburse at rates that actually meet the costs of operations and compliance required to sustain the service systems.

Bobby LeDoux, director of Citizens for the Developmentally Disabled in Raton, a member organization of the ADDCP, told committee members that between 2009 and 2014, his organization lost a total of 24 percent of its annual revenue, with a five percent additional loss anticipated by the end of the year. There used to be an expectation that there would be "light at

the end of the tunnel", he said, but such a belief is no longer possible; it just gets worse and worse. Mr. LeDoux is highly critical of the continuing costs of the *Jackson* lawsuit in a community like Raton, which "has lost everything" in the economic downturn.

Mike Kivitz, president and CEO of Adelante Development Center, Inc., in Albuquerque, provided members with a fact sheet highlighting financial issues for his nonprofit organization (see handout). He pointed out that rates lost 17 percent purchasing power versus the Consumer Price Index between 1999 and 2010. A five percent rate reduction in 2011, combined with an eight percent reduction in the annual resource allotment for each consumer, has resulted in an $18 million reduction in waiver spending systemwide. In May 2013, further reductions in rates were implemented, he said. During the last 14 years, standards, regulations and other directives have exploded, Mr. Kivitz said, resulting in a DD provider system that is not sustainable. Providing waiver services is a dying business, he said. Adelante has had to shut some services; it has closed one location and is looking to get out of supported employment altogether. Mr. Kivitz said he wants to make an economic development plea for jobs in New Mexico: 75 percent of his budget goes for salaries and benefits for staff.

Panel presenters and committee members discussed the need for a new rate study. This is a disastrous situation, a member stated, adding that in a panel presentation on this topic at the Disabilities Concerns Subcommittee, she was appalled that, with 10 of 15 behavioral health providers shut down, no one had any information on what happened to the shuttered agencies' clients, what amounts of funding had been withheld from them, where those funds are being held now and if they are earning interest. Hopefully, the LHHS can get OptumHealth to provide the committee with some answers, the member concluded. Another member asked if a Legislative Finance Committee (LFC) analyst could present recommendations on rate increases at the next meeting of this committee. The chair assured the member there would be follow-up. Ms. Hatanaka reminded committee members that the $500,000 raise for DD waiver providers scheduled for July 1 still has not been implemented by the HSD.

Public Comment

Rebecca Shuman, operations manager and self-directed community benefit (SDCB) support broker at AAA Participant Direction in Albuquerque, provided committee members with a detailed presentation (see handout) of how members transitioning from Mi Via are having their services reduced and how new members are having services denied. Overall, CC's SDCB members are experiencing an alarming rate of long-term care service reductions (12 percent) and denials (20 percent), Ms. Shuman asserted. The MCOs have been using agency-based reimbursement rates rather than self-directed rates, and the computer program required for use by consumers blocks requests for service or requires a reduction in hours. Because the request does not go through, no letter of denial is sent by the MCO, and the self-directed client is unable to appeal the decision or apply for a Medicaid fair hearing. Ms. Shuman urged that MCOs be blocked from using agency-based rates for self-directed consumers, that Xerox make changes to its online program so that no request for service from a self-directed client is blocked, that self-directed clients be allowed to appeal any decision with or without a notice of action letter and

that hearings be provided to all self-directed members, whether they have exhausted the MCO appeal process or not. Ms. Shuman maintains that many traditional health care professionals working at MCOs do not understand the purpose and benefits of self-direction.

Ken Collins, formerly from Oregon where he was a semiprofessional baseball player, identified himself as brain-injured from a snowmobile accident and said he has been a presenter the last four years at the statewide disabilities conference. Mr. Collins provided written materials related to his comments (see handouts). Although his brain injury occurred more than 30 years ago, Mr. Collins reported that the use of biofeedback, neuroplasticity and mindfulness therapies have provided him with dramatic improvement over the last three years. After listening to the day's committee testimony, it is his opinion that the MCOs are creating stress, not solving it.

John Noel, director of staff development at A Better Way of Living in Albuquerque, said his agency may be closing its employment services. Mr. Noel said that he has seen a drastic reduction of funding and an increase in regulation for supported employment. Having a job provides an individual with a hand up, not a handout, and he urged the state to practice what it preaches.

Recess

The meeting recessed at 5:11 p.m.

<u>Wednesday, October 22</u> — State Capitol, Room 307

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:06 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

Update: Medicaid Credible Allegations of Fraud

Knicole Emanuel, an attorney with Williams Mullen in Raleigh, North Carolina, and a specialist in Medicare/Medicaid compliance litigation, spoke in favor of Senator Papen's proposed legislation amending the Medicaid Provider Act. The search for fraud has become overzealous, Ms. Emanuel asserted (see handout). The ACA requirement that the state Medicaid agency "must" suspend payments to a provider with a "credible allegation of fraud" (CAF) is a very low standard for such drastic consequences, basically putting that provider out of business, Ms. Emanuel said. The impact is especially difficult in rural areas when staff members become unemployed and the entire community is adversely affected. The investigative process for a CAF must not infringe on the legal rights of providers, and it must afford due process, she said. Federal law relies on the states to provide due process, but this was not done in New Mexico.

Ms. Emanuel said Senator Papen's bill requires a CAF to be "verified", meaning the totality of facts and circumstances must be considered. Prior to determining the existence of a CAF, the state must use auditors who are licensed and credentialed, provide written notice of tentative findings, explain specific allegations and allow correction of clerical errors. Senator

Papen's bill includes additional remedies for providers: judicial review and injunctive relief with recovery of attorney and witness fees if the judge finds that a department has acted arbitrarily or capriciously, she said. Senator Papen's bill also allows for the return of suspended payments within seven days upon the posting of a bond by the provider pending final determination of overpayment or a determination by the attorney general that no further action is required. Ms. Emanuel cited examples from her own clients of fraud being alleged over simple mistakes in home health care, billing for a code that required prior authorization, a determination of "medical necessity" made by an unauthorized individual and inadvertent mistakes of gender or other typing errors. Typos do not equal fraud, Ms. Emanuel emphasized; fraud is an intentional act.

James Kerlin, CEO of The Counseling Center, Inc., for the past 20 years, said his company had been contracting with state agencies for most of its nearly half-century history and never had anything but satisfaction with its clinical billing systems, in-house audits and audits by the state entity, with scores that never went below 94. He asked members to try to imagine his shock upon discovering that the HSD had asserted a CAF against his company and stopped all Medicaid payments. His company was denied any information and was told that the CAF was now a criminal investigation. Mr. Kerlin said that if his organization could have seen what was being looked at by the HSD, it could find the problem and resolve it. The Public Consulting Group (PCG) audit was different than most, Mr. Kerlin said; PCG came in and left without any follow-up. The Counseling Center operated from June 24 until August 8 on reserve funds; on August 7, it was told that a transition to La Frontera would occur at midnight the next day. La Frontera hired all but four of its staff, and initially there was very little effect on the clients; but to be forced out of business was a tremendous shock and a professional insult, Mr. Kerlin said, and Alamogordo lost an important unifying element of the community. Mr. Kerlin urged committee members to support Senator Papen's bill mandating the due process that his company was not allowed. Bill Domiller, board president of The Counseling Center, spoke from the audience to add that the agency was shut down with no communication to the board of directors. The lack of due process is criminal, Mr. Domiller asserted.

Mark Johnson is CEO of Easter Seals/El Mirador, a Santa Fe-based nonprofit organization for children with behavioral health needs and adults with intellectual disabilities. His company was one of 15 New Mexico agencies accused of fraud by the HSD, and there was never any disclosure or due process. The PCG audit stated that it did not find evidence of any CAFs, and face-to-face meetings could have resolved these matters, Mr. Johnson said. The outcome was that the HSD spent $24 million to replace providers, and Easter Seals lost $4.5 million and had to lay off 40 employees. New Mexico's attorney general cleared his company of fraud accusations in May 2014, but the case was immediately re-referred by the HSD, Mr. Johnson said. His company is still owed $700,000 for Medicaid services that were delivered.

Senator Papen prefaced a discussion of her bill with the fact that the Internal Revenue Service always tells a targeted individual or company what it is looking for. Her bill gives providers the right to know what they are being accused of, she said, and while it might not make a difference to the 15 agencies, it will make a difference in the future. There are 729,000 New

Mexicans enrolled in Medicaid, and the state's dealings need to be collaborative, Senator Papen said. The HSD suspensions did not improve mental health services in the state and ran counter to the creation of more jobs. Significant numbers of workers have been laid off, further disrupting the economies of many communities. To keep providers and attract new ones to the state, Senator Papen said, there must be greater transparency and guarantees of due process. She asked committee members to endorse her bill.

Ms. Mathis, who assisted Senator Papen in drafting her bill, described problems with the lack of precise or objective definitions of "credible", "verification" and "fraud" under current law. She then detailed the changes being proposed in Senator Papen's bill to sections of the Medicaid Provider Act and the Medicaid Fraud Act (see handout).

Upon questioning, presenters and committee members discussed the following topics.

Who can make a CAF? A member asked if legislation could be drafted to make the attorney general the entity responsible for making a CAF. Ms. Mathis said it was her understanding that under federal law, it is the department secretary who makes that determination. Ms. Emanuel concurred, adding that the state agency can contract with another entity, such as PCG, to conduct a preliminary investigation. In New Mexico, PCG found no evidence of fraud, she noted, but this finding was thrown out by the HSD. The member recalled that HSD attorney Larry Heyeck insisted that once a CAF is made, the secretary's hands are tied and she is required to suspend payments; this is mandated by the ACA. Ms. Mathis said that federal law does require payments to be suspended after a referral, but it also allows the suspension to be lifted, or partially lifted, for good cause; it is her understanding that all of the 15 agencies requested, but did not receive, a good-cause exception. The member said he is still puzzled at how two of the 15 agencies were able to buy their way out. Ms. Mathis explained that the HSD and the attorney general are empowered by law to settle on behalf of the state.

Questions about power. A member thanked Senator Papen for her bill and expressed outrage at what happened to the 15 behavioral health providers. He said he is stunned by the lack of legislative power to do anything. In his home community, one of those agencies, Hogares, delivered great services for more than 40 years, and he does not know why it has not filed suit against the state. Ms. Emanuel reminded committee members that most of the providers are now bankrupt, and it is costly to pursue a lawsuit. She said that the legislature does have power; in her state of North Carolina, the legislature passed a law giving itself more power and now reviews state agency action before it is taken.

Coding errors. A member whose husband is a physician and reviews medical codes every day said she appreciates this opportunity to pull out human error from the definition of fraud. This bill is a great first start, the member stated, and she hopes it will get some traction. The member also asked Ms. Mathis if Subsection D of Section 6 of the bill, regarding payment of fines for receiving a certain value of benefit, is for a single service or is an aggregate amount. Ms. Mathis said she would look into this.

Continuing questions about HSD data and the role of OptumHealth. A member noted that, recently, the HSD has claimed "more services are being given than previously". No claims data for the last six months of 2013 have been provided, Ms. Mathis noted, despite repeated requests from Senator Papen and the committee. A member was incredulous that $27 million was spent in the transition to Arizona providers over that six-month period, yet there are no data. Another member clarified that the $27 million was not for services; it was to facilitate the transition. OptumHealth was paid $40 million to oversee the behavioral health system but has suffered no consequences for overlooking the alleged systematic fraud, the member continued. Ms. Emanuel said there are copies of the OptumHealth provider audits that show providers to be 95 percent compliant and doing a great job. Of the entities hired and paid by the taxpayers, none found fraud except the secretary of human services, she said. Another member pointed out that federal law mandates transparency, yet no one knows how much money is still in the hands of OptumHealth, whose contract was extended by the HSD in January without going out to bid.

What constitutes real fraud? Ms. Emanuel said that in her opinion, most audits are designed to uncover misbillings and miscodings, not necessarily systematic fraud. She has seen numerous cases of fraud, such as double-billing, billing services for recipients who are deceased and billing for services that were not rendered, among others. She does not think New Mexico providers were accused of these activities.

The committee chair thanked the panel participants and stated that, lacking a quorum, the committee could not vote to endorse Senator Papen's bill at this time.

Public Comment

Martha Cook, a social worker and member of the National Alliance on Mental Illness (NAMI), said she has seen providers trying to accommodate all of the changes in care systems from Value Options to OptumHealth, and now CC, and it is devastating to acknowledge that the state has been punitive. She thanked Senator Papen for bringing this bill forward.

Deborah Walker, executive director of the New Mexico Nurses Association, described recent intensive training from the federal Centers for Disease Control and Prevention (CDC) for a comprehensive response to Ebola and said that providers at any access point should be able to screen for the disease. Her organization is happy to be a resource for legislators and constituents.

Ms. Pinnes, speaking as a private citizen, urged legislators to look into establishing a process to manage agency contracts over $200,000. The state has an important role to play in protecting due process, and she strongly supports Senator Papen's bill. Recently, OptumHealth has been alleged to have engaged in fraudulent practices, and Ms. Pinnes wondered why the HSD has dealt with it differently than the 15 providers.

Jim Ogle, president of NAMI in New Mexico, said he found out in an email that Valencia County no longer has any behavioral health providers, and people now need transportation to Albuquerque to access services. This will put more pressure on the larger providers and will

cause more problems. Over the years, Mr. Ogle said, he has seen a decrease in the population at the Metropolitan Detention Center in Bernalillo County, but now more mentally ill individuals are being incarcerated at higher rates. He thanked Senator Papen for her bill, saying due process is important and it was denied to the 15 providers.

Written comments submitted by Charles Marquez, lobbyist for the NMHCA, were distributed by a committee member, reviewed the reimbursement rate crisis for the state's nursing homes and decried the lack of input from the member community regarding the HSD's decision. Mr. Marquez stated that the HSD eventually realized in July 2014 that its changes had, in fact, reduced reimbursement to levels well below estimates, and in August, discussions were begun to address needed changes, but the NMHCA has not heard anything more. One member company has nine facilities operating in the red, and another has six facilities in the red, according to Mr. Marquez, placing the industry at high risk for staff reductions and possible closures statewide. The nursing home industry is requesting that the LHHS bring the facts of this crisis to the attention of the LFC for action.

Basic Health Plan (BHP) Update

Mr. Hely described the health insurance program for low-income individuals who do not qualify for Medicaid, including adults with incomes that are 138 percent to 200 percent of the federal poverty level and legal resident immigrants who are excluded from Medicaid for a five-year waiting period (see handout). Financing for a BHP will come from the federal government (95 percent of what it would have spent on tax credits and insurance subsidies), state matching funds and enrollee premiums. At least two plans have to be offered and put into place by January 1, 2016. The risk pool is kept separate from individual and group pools and must have an actuarial assessment, Mr. Hely said. The state must devise a blueprint with public and tribal consultation and establish a trust fund. The BHP will utilize a managed care model.

On questioning, Mr. Hely and committee members discussed differences between the BHP and high-risk pool. The BHP should be more affordable because there are no income restraints, Mr. Hely said. Federal law does not require statutory change, but it does require a blueprint. A member stated that if taxpayer dollars are being spent, statutory change is needed instead of regulations. The member asked Mr. Hely to prepare a memorial for a task force, naming the member as chair, for the December LHHS meeting. Because federal funds cannot be used for administration, costs to the state need to be minimized. BHP plans are called standard health plans, and premiums cannot exceed the cost of the second lowest silver plan on the New Mexico Health Insurance Exchange (NMHIX).

Medicaid Pediatric Dental Pilot Proposal

Walter Bolic, CEO of Delta Dental of New Mexico, and Michael Wallace, director of government and corporate relations for the company, described dental utilization trends as they relate to Medicaid growth nationally and in New Mexico (see handout). The nonprofit Delta Dental of New Mexico has more than 350,000 commercial and retired members, Mr. Wallace said, and a problem has emerged for individuals who are below 400 percent of the federal poverty

level who are trying to access benefits but cannot find a provider. He then introduced Rick Lantz, manager of government relations for Delta Dental of Michigan, Ohio and Indiana, who described his company's partnerships with the Michigan Department of Community Health (MDCH).

Delta Dental of Michigan, part of a nationwide system, is the largest administrator of dental benefits in Michigan, providing coverage to more than 3.3 million members, Mr. Lantz said. Its partnerships with the state include Healthy Kids Dental (HKD) (Medicaid) with 540,000 members, MIChild (State Children's Health Insurance Program) with 32,000 members and Healthy Michigan Plan (Medicaid expansion program) with 236,000 enrollees. The MDCH identified barriers to dentist participation in Medicaid — insufficient reimbursement, administrative hassles and broken appointments — that have resulted in poor access to dental care for enrollees.

HKD was established as a pilot program in 22 counties between Delta Dental and the MDCH in 2000, serving Medicaid-enrolled children under the age of 21. Seven expansions over three administrations later, children in 80 of Michigan's 83 counties are now being served by the program, Mr. Lantz said. Enrollment is automatic, and enrollees can receive care from any dentist in the HKD network with no patient co-payments or annual maximums. Delta operates two main networks of dentists in Michigan: premier (93 percent participation) and the discounted preferred provider organization (PPO) (30 percent participation). The HKD program utilizes the premier network but pays according to the PPO fee schedule, using the same claims administration and payment system as for its commercial customers, with 97 percent of claims processed within 10 days, Mr. Lantz said. With multiple positive outcomes for enrollees, verified by independent evaluation, the cost is $118 million per year for 540,000 enrollees $40.6 million in state funds and $77.4 million in federal funds.

Delta Dental of New Mexico has contacted state Medicaid officials about a possible pilot program, Mr. Wallace said, and there was interest but also concern about a potential increase in the administrative burden. Delta Dental is the largest insurer in the state, Mr. Wallace said, and would be able to deliver, overnight, access to dentists.

NMHIX Update

Amy Dowd, CEO of the NMHIX, gave a presentation to committee members on the agency's plans for the upcoming enrollment period, starting November 15 (see handout). The estimated number of uninsured people eligible for tax credits is between 161,000 and 172,000 — over half of the total uninsured people in New Mexico, Ms. Dowd said. Changes have been made to enrollment assistance, including titles, training and sources of funding. All enrollment counselors are required to take the CMS navigator training course, which includes a detailed review of conflict-of-interest and privacy and security standards. The NMHIX has again put out to bid contracts for enrollment entities, with 17 organizations submitting proposals, 13 of which were accepted. The marketing and communications request for proposals (RFP) brought 18 applicants (12 of these in-state), four of whom were chosen, and four groups were selected from the outreach and education RFP, Ms. Dowd said. The Native American outreach now includes

subcontracts with all 22 tribes, nations and pueblos in New Mexico, Ms. Dowd said, with a goal of outreach, education and enrollment to 9,200 Native Americans.

Roxane Spruce-Bly, interim CEO of Native American Professional Parent Resources, Inc. (NAPPR), described plans to complete at least 90,000 encounters as a partner with the state's Native American communities in developing community-based outreach, education and enrollment programs (see handout). The goal is to enroll at least 2,250 individuals in qualified health plans through the NMHIX. There is an opportunity through the ACA to transform Native American health care, Ms. Spruce-Bly said; the benefit cannot be overstated. NAPPR will be working on the Navajo Nation at at least 18 sites where people can go for assistance and to access enrollment counselors. There is also a very strong partnership with NAPPR in IHS facilities, she said, where messaging can be tailored for Native Americans and veterans; the latter group is a target of widespread outreach efforts. Monica Marthell, interim director of health care education and outreach at NAPPR, said she is often asked questions, and is able to answer them, in her native language. NAPPR is planning further involvement with the NMHIX, acting as the Native American service center, by providing a walk-up storefront offering all functions associated with the center and extended service hours.

Ms. Dowd said she has been very impressed with the talent and expertise available within the state and is pleased to report that from January 1 through August 31, $14.3 million, or 34 percent, of NMHIX expenditures has gone to New Mexico vendors.

New Mexico's Readiness to Confront a Public Health Crisis

Michael Landen, M.D., state epidemiologist, DOH, provided committee members with a detailed presentation on the state's public health preparedness plans, including response to the Ebola virus (see handout). Obesity, chronic disease and substance abuse continue to cause far more damage to New Mexicans than infectious diseases, Dr. Landen said. Detailing differences between pandemic influenza and Ebola, he concluded that the risk of importation of Ebola into New Mexico is extremely low. The DOH investigates more than 10,000 cases of communicable diseases each year, and it is one of 10 states chosen for federal Emerging Infections Program funding; a centralized health department in a state with a small population allows for very timely investigations and interventions.

The Homeland Security and Emergency Management Department coordinates the state's response to all emergencies, Dr. Landen said, and the DOH's Scientific Laboratory Division is the state's response network lab. The DOH's health alert network and access to the CDC's EpiX system assures rapid communication to hospitals, providers and local emergency managers statewide. A network of medical volunteers, regional health care coalitions and the "HAvBED" — "hospital available beds for emergencies and disasters" — electronic tracking system of hospital bed availability further enhance the state's ability to confront a disease outbreak, natural disaster or terrorism event. The DOH receives approximately $8.5 million annually in federal preparedness funding; nearly $3 million in additional federal funding for infectious/communicable

disease surveillance; and $400,000 in state general funds for surveillance, investigation and disease control.

New Mexico's Ebola preparedness plan is directed by the governor and will be posted on the DOH web site the week of October 27, according to Dr. Landen. It will be revised as the international and national response to the outbreak progresses. He detailed steps for evaluation and early recognition of a suspected case, lab testing, contact tracing and new personal protective equipment guidance. The DOH has an Ebola health care team that consults with hospitals, clinics and emergency services on implementation of the guidelines. Quarantine or isolation can be voluntary or court-ordered, he said, and can occur in a variety of settings. New Mexico does have the statutory tools in place to confront a crisis, but Dr. Landen said that Section 24-1-15 NMSA 1978 should be updated to clarify legal definitions of "quarantine" and "isolation" so they are consistent with public health definitions. LCS staff is working on a bill incorporating these changes. In conclusion, Dr. Landen said, pandemic influenza or other viruses transmitted through the air are the greater infectious disease threats to New Mexicans. The risk of Ebola is extremely low, he said, but the state is well-prepared to respond that remote possibility.

Anita Statman, deputy secretary of homeland security and emergency management, provided members with a fact sheet about local and federal coordinated responses to any event of the Ebola virus in New Mexico, including securing temporary housing for isolation and protecting a citizen's civil rights and liberties.

A committee member thanked Dr. Landen for his thorough presentation and suggested that the DOH put out a press release to let people know that they can go to the web site. Another member commented on the public hysteria around airplanes and Ebola. Dr. Landen emphasized that the Ebola virus is not airborne, and the risk of contact from an armrest on an airplane is extremely low. Good protocols for contact-tracing are already in place, he said, and every hospital in the state should be able to evaluate a suspected case and use the tiered system of referral. He also noted there is a Level 1 trauma center at UNM in Albuquerque. Gabrielle Sanchez-Sandoval, general counsel for the DOH, responded to a member's question about enforcement of isolation if a person does not agree to be confined. The DOH experienced this with a tuberculosis outbreak, Ms. Sanchez-Sandoval said, and requested an emergency hearing after hours to obtain a court order. Law enforcement would be involved, she said. Dr. Landen announced that on Friday, October 24, the Indian Affairs Department will host a conference call with tribal leaders and representatives from the CDC, the DOH and the IHS regarding response to the Ebola virus, and he invited interested committee members to participate.

Adjournment

There being no further business, the fifth meeting of the LHHS for the 2014 interim was adjourned at 5:50 p.m.

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

November 24-25, 2014
Room 307, State Capitol
Santa Fe

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Gerald Ortiz y Pino, vice chair, on Monday, November 24, 2014, at 9:27 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
Sen. Mark Moores
Sen. Benny Shendo, Jr.

Absent
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan

Advisory Members
Sen. Craig W. Brandt (11/25)
Sen. Jacob R. Candelaria (11/24)
Rep. Miguel P. Garcia
Sen. Linda M. Lopez
Sen. Cisco McSorley
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Rep. Vickie Perea
Sen. Nancy Rodriguez (11/24)
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta
Sen. Sue Wilson Beffort
Rep. Nathan "Nate" Cote
Sen. Daniel A. Ivey-Soto
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Sen. Sander Rue
Sen. William P. Soules

Guest Legislators
Rep. Thomas A. Anderson
Rep. Patricia A. Lundstrom (11/25)
Rep. Bill McCamley (11/25)
Sen. Michael Padilla (11/24)

(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

Guests
The guest list is in the meeting file.

Handouts
Handouts and other written material are in the meeting file.

Monday, November 24

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

Senate Joint Memorial (SJM) 3 (2014): Children, Youth and Families Department (CYFD) Reporting
Jared Rounsville, director of the Protective Services Division (PSD) of the CYFD, told committee members his division had not yet been able to assemble a written report answering all of the many queries contained in SJM 3, which was sponsored by Senator Padilla (see handout). He offered to answer the questions posed in the memorial.

Senator Padilla informed the committee that he had grown up in the state's foster care system. He described a series of town hall meetings that he organized last year regarding CYFD investigations and foster care services that resulted in nine hours of public testimony. He said that CYFD staff had not attended any of those meetings. Noting that the department had been experiencing difficulties related to staff retention, high vacancy rates and high caseloads, Senator Padilla sponsored SJM 3, which requests that a report be delivered to the LHHS by today's date. The memorial sought information about the average number of foster children per home, placement stability data, how homes are identified and selected, standards for home certification, data for children making the transition from foster care, data on CYFD social worker caseloads and salaries, data on cases opened and the sources of the reports, education and training of caseworkers in the PSD and the identification of obstacles for the PSD to meet its mission and goals.

Mr. Rounsville said that there is a limit of six children per foster household, including the foster child; occasionally this limit is exceeded temporarily in an emergency when CYFD caseworkers are trying to keep siblings together. In a survey of 1,000 foster homes, the average number of children per household was 2.2, he said. His division does not track placement stability data, but it does report performance measures quarterly to the Legislative Finance

Committee (LFC). This is an area in which New Mexico has consistently struggled, Mr. Rounsville said, with current numbers showing that approximately 76 percent of foster children have experienced no greater than two placements in a 12-month period. The CYFD would like this percentage to be higher, he said. Certifying a foster home involves statewide recruitment and extensive background checks, he said, and the last update of the regulations occurred in October 2009. There are approximately 4,000 children in foster care during a calendar year, but, currently, there are no data available that track behavioral health concerns, Mr. Rounsville said. Many children have been exposed to extensive trauma and may not be properly diagnosed. Data on children who "age out" of foster care, estimated to be about 80 individuals annually, soon will be tracked through New Mexico's participation in a federal youth-in-transition database, he said. New Mexico has limited transitional living programs available in Albuquerque, Hobbs and Taos, and some federal funds are available for education and job training. However, he said, there are not enough resources to meet needs. Services need to be further developed, he said.

Asked about the total number of cases opened by the PSD each year, Mr. Rounsville said that it varies by season, with a dropoff during summer. The overall trend is upward, Mr. Rounsville said. There were spikes in activity after several recent high-profile cases in the news media. Most of those new case reports were not an overreaction to the media, he asserted, but were actually reports on families that needed help. The CYFD will be requesting funding to hire additional full-time staff to handle the PSD caseload, which increased from an average of 16.9 in October 2012 to 23 by June 30, 2014. The average hourly wage for an entry-level caseworker, as of September 2014, was $16.85, with a three percent increase in that rate starting in January 2015 and another three percent increase scheduled in July. Four weeks of specialized training is required for each new hire. Regarding the source of most reports to the PSD, anonymous tips from relatives and neighbors form the largest category, followed by reports from law enforcement, educators and social workers. Mr. Rounsville said that the CYFD will be proposing legislation to amend the mandatory reporting clause in state law to clarify that all adults have a responsibility to report suspected child abuse and neglect. With an increasing caseload for investigators, the PSD needs more resources to follow up, and it will be asking for statutory changes that allow the PSD to petition the court in order to give incentives to force families to undergo treatment, he said.

On questioning of Mr. Rounsville by Senator Padilla and committee members, the following topics were discussed.

The importance of placement with relatives. Foster care placement with relatives is the first choice of the CYFD, Mr. Rounsville said, and relatives need to be identified as soon as possible. After an extensive background check, relatives can immediately be licensed, followed by an expedited process of approval, which otherwise would take 90 to 120 days.

Different types of foster care. In addition to regular foster care, there is specialized foster care for children with greater needs; respite foster care, which gives foster parents a rest over a weekend; and treatment foster care by families recruited and licensed by private behavioral

health agencies. Managed care organizations (MCOs) pay treatment foster care providers through Medicaid. There are never enough foster care families, Mr. Rounsville said, and when a family decides to adopt a foster child, which is obviously a very good outcome, the ranks of available homes are correspondingly reduced.

Steps being taken to retain staff. Child protective caseworkers are underpaid across the entire country, Mr. Rounsville asserted. New Mexico salaries are in line with surrounding states, but the biggest challenge now is that MCOs are hiring caseworkers at nearly double the salary they are currently earning. The department has a plan for expedited hiring, and there is a "strike team", with members from the CYFD, the State Personnel Office and the Department of Finance and Administration. Mr. Rounsville urged strong legislative support for CYFD budget requests.

Time line for a final report. A committee member asked when the committee could expect the final report requested in SJM 3. Mr. Rounsville said it would be ready within a couple of weeks. When asked if the CYFD will make the report available to the public, Mr. Rounsville said that this information will be presented at public meetings this coming year. Senator Padilla indicated his willingness to help the CYFD in any way needed.

J. Paul Taylor Task Force Report

Claudia Medina, director of community health initiatives in the Office of Community Health at the University of New Mexico Health Sciences Center (UNMHSC) and chair of the task force, appeared along with Stewart L. Duban, M.D., a pediatrician who teaches at UNMHSC and a task force member, to present the executive summary and task force recommendations (see handout) for a statewide system of supporting at-risk families and preventing child abuse and neglect. Acknowledging the work of more than 55 members of the task force, which was established in 2012 and continued its work in 2013, the presenters described the task force's focus, which involves an emphasis on early screening of children in a primary care setting and on connecting that child's family to needed services. Dr. Duban said that recommendations are about screening and identification and building on existing structures, not about starting yet another organization. New Mexico has 175,000 children under five years old; 29 percent live in poverty, and 30 percent to 40 percent are at risk, he said. The task force recommends maximizing dollars that already exist in state and federal funding streams. Data are needed, as is the coordination of care using community health workers (CHWs) and creating a path for CHWs to be reimbursed for their services. Wraparound services in local communities should include treatment services, home visiting and education on parenting skills and positive discipline techniques to provide a safe and nurturing home, he said.

What is needed by the task force now is a mandate or a blessing, Ms. Medina noted, not just a nod to continue "chatting". Bold leadership is required from the Children's Cabinet, the LFC and the LHHS to accomplish enactment of these recommendations, she said. A path to reimbursement for CHWs is crucial, she said, and there must be an effort to get Medicaid and other stakeholders to the table. Since 2008, early intervention services have been drastically reduced in New Mexico, and now those services are virtually nonexistent. Dr. Duban described

a task force recommendation that a diagnosis of severe emotional disturbance no longer be required for at-risk infants, toddlers and young children to be eligible for needed services. As an alternative, New Mexico should use the federal Substance Abuse and Mental Health Services Administration eligibility criteria, he said. There also needs to be collaboration in data collection among state agencies in order to reduce silos and allow a child to be followed into adulthood across state agencies.

Ms. Medina said a bound version of the task force report and recommendations will be available in December.

Health Care Work Force Working Group Committee Report

Richard S. Larson, M.D., Ph.D., executive vice chancellor and vice chancellor for research at UNMHSC and chair of the New Mexico Health Care Work Force Working Group, provided committee members with the working group's 2014 annual report and gave a presentation on work force shortages and possible solutions (see handout). Since House Bill (HB) 19 (2012) became law, licensure boards in New Mexico are required to develop surveys of their members, and resulting data are directed to UNMHSC for stewardship and storage, Dr. Larson said. In addition, the working group was established with statewide membership, and it is tasked with evaluating needs and making recommendations. In 2013, a statewide advisory committee reported on health care work force shortages, especially in rural areas, and urged more funding for expanded training in nursing, dentistry, primary health care and psychiatry. It also urged greater use of telehealth services (Project ECHO) and training of CHWs. Dr. Larson described details of new combined training programs for nurses and physicians, the need to expand state-funded residency positions and the need to identify promising students with rural backgrounds who are interested in primary care. Dr. Larson also encouraged strong support for certification of CHWs, which will begin in 2015 at multiple campuses around the state and will lead to more cost-effective coordination of health care.

Discussing the efficacy of financial incentives for health care professionals, tuition assistance and debt repayment figure prominently in a health care professional's choice of practice location, Dr. Larson said, but the state has lost federal funding for this incentive program and must make up the difference. The working group was not able to determine the effectiveness of the state's personal income tax credit for practitioners providing services in underserved rural areas, but it did develop several suggestions to improve retention of professionals in rural areas: include community leaders in the selection process; explore strategies to help manage workloads; and enhance linkages between rural practitioners and UNMHSC. The New Mexico Health Care Work Force Working Group is one of only a few such bodies in the nation, Dr. Larson said, and it is developing an increasingly detailed picture of the state's health care professionals, their practice priorities and their capacity to serve the unique needs of the state. Permanent funding for this working group is being sought in UNM's proposed budget, Dr. Larson said, and funding will provide an avenue to achieve even greater levels of detail and accuracy. The funding also will enable a detailed analysis of New Mexico's mental and behavioral health needs.

Approval of Minutes

A committee member moved that the minutes from the September 10-12, 2014 LHHS meeting in Elephant Butte and Las Cruces and from the October 20-22, 2014 meeting at the Pueblo of Santa Clara and the State Capitol be approved. The motion was seconded and passed unanimously.

Engaging Market Forces, Competition and Quality to Attract, Retain and Compensate Health Care Providers

Martin Hickey, M.D., chief executive officer (CEO) of New Mexico Health Connections, a nonprofit, physician-led health insurance provider headquartered in Albuquerque, presented a concept that he said could provide more income to primary care and mental health providers and help stem the current maldistributions in those fields (see handouts). Lack of access increases the cost of care and burns out providers, Dr. Hickey asserted. Primary care and behavioral health are at the bottom of the provider pay scale, yet these services can offer the most value and greatest health status improvement. Health care is a piecework industry, Dr. Hickey pointed out, and there is no regulation or true competition; the solution to nearly every challenge is to build more beds and order more tests, he said. The United States pays twice as much as any other country for health care, yet it is thirty-eighth in morbidity and mortality. Nearly one-half of this is unnecessary and wasteful, Dr. Hickey said, paid for by ever-increasing health insurance premiums and tax dollars.

Transparency is the key to controlling costs, Dr. Hickey said, and collecting quality and efficiency data on providers through an all-payer claims database will encourage referrals to the most efficient and effective specialists and hospitals. If providers are given the data, they will self-correct, he asserted, and the marketplace will reward quality, not quantity. With such a database, consumers could go to a health information exchange web site and compare their choices, similar to the way consumers now log on to Orbitz to search airline fares and hotels. Referrals to the most cost- and outcome-effective specialists and hospitals will generate huge savings, Dr. Hickey maintains, which then can be shared with primary care and mental health providers and with consumers in the form of lowered premiums. Dr. Hickey said that other groups around the county actually have put these concepts into practice; they do work and they help to retain physicians and providers. For New Mexico, it could mean that more primary care providers would come to and stay in the state, and it would allow the marketplace, not the taxpayers, to pay for attracting and retaining providers.

On questioning by committee members, Dr. Hickey explained that the legislature can build an all-payer claims database by requiring all insurance companies to enter their claims in the database, which should be housed and maintained by a separate, neutral organization. A committee member made a motion that staff be requested to prepare a letter to the New Mexico Health Insurance Exchange and the Office of Superintendent of Insurance asking if such a database could be established without legislation and seeking additional input on the concept. The motion was seconded and passed on a vote of 3-1. A committee member objected that there

was not a quorum present for this vote, and the chair suggested that the vote be postponed until the next day.

Sexuality and Gender Equality (SAGE) Health Project

Senator Candelaria presented copies of a proposed senate joint memorial requesting the secretary of health to convene a lesbian, gay, bisexual, transgender and queer (LGBT) health disparities task force to analyze health disparities and make recommendations for addressing those disparities. The memorial requests that the task force employ a "health in all policies" model to examine the environmental, socioeconomic, cultural and other social determinants of health. Senator Candelaria lauded the bipartisan and collaborative effort involved in preparing this memorial, especially that of the Department of Health (DOH) and its staff members. Shelley Mann-Lev, director of the SAGE Health Project, said her organization is very enthusiastic about opportunities presented by this memorial.

James Padilla, epidemiologist in the Chronic Disease Prevention and Control Bureau of the DOH, presented an overview of New Mexico LGBT health data (see handout) indicating increased risk and a growing recognition of stigma and discrimination in mental health, violence and substance abuse. Sexual orientation data collection from New Mexico adults began in 2005 as part of a national survey, Mr. Padilla said, and was updated in 2013. That same year, sexual identity measures were included on the Youth Risk and Resiliency Survey conducted in middle and high schools in New Mexico and in 30 other states. Mr. Padilla said that possible contributors to LGBT health inequities could include stress related to discrimination, barriers to accessing health care, including a lack of health insurance and delaying treatment, a lack of cultural competency for LGBT consumers in the health care system and the use of alcohol and tobacco products to help cope with stress.

Robert Sturm, training coordinator for the SAGE Health Project and executive director of the New Mexico Community AIDS Partnership, lauded the collection of data but said that much more is needed. He has heard stories from LGBT community members about going to doctors and being told very hurtful things, and these narratives make it easy to understand the community members' lack of trust in the health care system. Health workers do not have enough training about LGBT issues, Mr. Sturm said, but providers seem eager for training and appear to be supportive of systemic change.

Senator Candelaria asked for endorsement of the memorial by the LHHS. A motion was made for endorsement, seconded and unanimously approved.

Chiropractic Physicians' Scopes of Practice

Adrian Velasquez, D.C., introduced himself to the committee as a representative of a group of chiropractic physicians who wish to register their opposition to the direction of a small group of New Mexico chiropractors who have been actively pursuing prescriptive drug authority. Dr. Velasquez, in practice in Albuquerque for five years, provided extensive background on chiropractic health care, its origins and practice as a noninvasive approach that does not use

drugs or surgery (see handout). He stated that chiropractic doctors use adjustments of the spine to alleviate pain and irritation long enough to allow the body to self-regulate and self-heal. An important component of treatment is the education of patients in the pursuit of healthier lifestyle choices, including better nutrition and exercise, he said, and many patients choose their chiropractor as their primary care doctor. Pharmaceuticals stop pathways in the body and override systems, Dr. Velasquez explained, and they block the body's ability to regulate itself. He cited statistics from the World Health Organization that highlight the American penchant for a "quick fix" of health problems with drugs: the United States represents five percent of the world's population and consumes 75 percent of the pharmaceuticals available worldwide, yet it is ranked thirty-seventh in health outcomes among all nations. New Mexicans do not need more drugs being prescribed by chiropractors, Dr. Velasquez concluded.

Brad Fackrell, D.C., has been in practice in Rio Rancho for 17 years and testified about prescriptive authority for chiropractors as a matter of public safety. Bills to expand this authority have been introduced in the legislature for the past four years, and another bill currently is being prepared for this session, he stated. The group of practitioners pushing for this legislation claims to represent more than 30 percent of the state's chiropractors, but it actually represents only about 20 percent, Dr. Fackrell asserted (see handout). He noted that the issue of adding prescriptive authority to the chiropractic scope of practice in New Mexico has never been brought before the members of the New Mexico Chiropractic Association for a vote, much less even for discussion. He cited a statement from the 2013 Chiropractic Summit, an umbrella group of prominent chiropractic organizations, that passed unanimously and states that "no chiropractic organization in the Summit supports the inclusion of prescriptive drug rights and all chiropractic organizations in the Summit support the drug-free approach to health care". Dr. Fackrell also provided statements from leadership of several chiropractic colleges urging chiropractic to remain drug-free. The clinical training required for chiropractic prescriptive authority in proposed bills is problematic, he said, because programs for this training do not exist. A safer path for an advanced practice chiropractor who wishes to gain prescriptive authority would be for that individual to pursue a degree in the nurse practitioner program at UNM or New Mexico State University (NMSU).

Public Comment

Glenn Walters, deputy secretary of the Higher Education Department, asked for endorsement of upcoming legislation that would expand the purpose of the Nurse Educators Fund to allow registered nurses to use the fund to obtain higher degrees in order to qualify to become nursing educators. Last year, the bill passed the house and went through senate committees, but it did not make it to the senate floor.

Stephen Perlstein, D.C., said he is chair of the New Mexico Chiropractors Association, and he asserted that the presenters speaking against prescriptive authority are with the International Chiropractic Association, which has 11 members.

Cathy Riekeman, D.C., stated that it is not just the International Chiropractors Association members who are against prescriptive authority. Nationally, the trend is against using drugs, and four chiropractic colleges have come out against it. Dr. Riekeman said that if prescriptive authority is granted, it will have to be incorporated into initial education and not just come from a class completed after graduation.

Recess

The meeting recessed at 4:40 p.m.

Tuesday, November 25

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:20 a.m. He welcomed those assembled and asked committee members and staff to introduce themselves.

Falls Task Force Report

Toby Rosenblatt, chief of the Injury and Health Epidemiology Bureau, DOH, and Janet Popp, a physical therapist and member of the New Mexico Adult Falls Prevention Coalition, reported on progress of fall-prevention activities statewide, as required by HB 99 (2014) (see handouts). The DOH has engaged key collaborators, Mr. Rosenblatt reported, and has expanded provider training in fall risk assessment and prevention, as well as in community-based fall-prevention activities. A public awareness campaign about fall risks includes a new web site (www.stopfallsnm.org) and collaboration with the Aging and Disability Resource Center of the Aging and Long-Term Services Department (ALTSD). The DOH is contracting with NMSU's Department of Kinesiology and Dance to implement a falls screening initiative and with the ALTSD to distribute falls-awareness literature to the public. Falls are not an inevitable consequence of aging, Mr. Rosenblatt said, and while New Mexico has reduced its fall-related death rates among older adults during the last decade, New Mexico is still significantly above the national average in fall-related deaths.

Greater efforts in falls education and prevention in rural areas need to be made, Ms. Popp emphasized. If residents cannot age in place, their departure is a great loss to those communities. There has been increased emphasis on teaching tai chi to seniors, a program that has been proven highly effective, she said, but not everyone wants that form of exercise; other evidence-based programs that enhance balance need to be considered. A committee member inquired if any Medicaid MCOs were putting fall prevention into their health plans. Not yet, Ms. Popp said, but she expects that this may become more of a priority as the state's population continues to age. The presenters said that more funding for falls prevention is needed from the legislature. The legislation originally sought an appropriation of $1 million, but just $100,000 was finally approved.

Liver Transplant Facility

Julio C. Sokolich, M.D., a multi-organ transplant and hepatobiliary surgeon, presented a proposal for the establishment of a multi-organ transplant program for New Mexico (see handout). New Mexico, one of 12 states that does not have such a program, has the opportunity to position itself as a leader in liver transplant services, providing excellent results combined with reduced waiting periods, Dr. Sokolich said. There is significant demand, based on the number of potential liver transplant patients and available organs. Over the past three years, 32 organs were diverted from the New Mexico donation service area to other states, he said. UNM and Presbyterian Hospitals provide post-surgery services to liver transplant patients who return from out-of-state surgeries and report that between 70 and 80 percent of these are funded by Medicaid, which pays an average of nearly $400,000 per surgery. Chronic liver disease is the fourth largest cause of mortality in New Mexico, and the rates of the primary causes of liver disease — alcoholism and hepatitis C — are twice the national average. There are currently 165 New Mexico residents on waiting lists in other states for a liver transplant. Dr. Sokolich asserted that professional expertise is already in place in New Mexico that would support the program, and organ donation has increased due to enhanced education programs promoting it.

In 2002, a national model for end-stage liver disease was developed to prioritize the allocation of liver transplants, and this change provides an opportunity to help more New Mexicans, Dr. Sokolich said, pointing to a five-year chart of financial metrics supporting his contention that the state could become a viable regional transplant center.

As an example, Dr. Sokolich cited New Mexico's current situation with kidney failure patients. There are 1,300 patients on kidney dialysis in New Mexico, he pointed out, and, at nearly $100,000 a year for each patient, the state spends more on dialysis care than on transplants.

Dr. Sokolich's presentation included testimony from a resident of Gallup, whose wife underwent a liver resection in another state, who described the financial stress for family members and who asked the committee to support this proposal. William Keifer, chief operating officer of Rehoboth McKinley Christian Health Care Services in Gallup, where more than 400 individuals are currently on dialysis, said his hospital would be willing to partner with an Albuquerque facility to help establish a collaborative effort.

Via telephone, Hani P. Grewal, M.D., a multi-organ transplant surgeon at the Mayo Clinic in Boise, Idaho, spoke to committee members at Dr. Sokolich's behest. Dr. Grewal said that what is needed is an examination of historical efforts to establish a transplant center in New Mexico and why those efforts did not succeed; identification of institutions with transplant infrastructure; adequate funding for resources and infrastructure; and identification of leaders with a passion to take on this task. Transplant patients generate a lot of revenue for a hospital, Dr. Grewal said, but the capital investment is quite intense, and putting resources into place for Medicaid/Medicare certification is a slow process. If any of these elements is missing, Dr. Grewal said, he would not advise taking on the project.

Representative Lundstrom, who sponsored House Memorial 48 (2013), calling for a feasibility study of a liver transplantation institute in New Mexico, said that the study results seemed to create more questions than answers, and she felt a financial matrix was needed. The feasibility study was conducted by the Transplant Management Group, LLC (TMG), and it indicated a very poor prognosis for a free-standing liver transplant institute in New Mexico. The feasibility study recommended the establishment of a national partnership/collaborative relationship with an out-of-state liver transplant program.

Dr. Sokolich said $5 million would be needed to create a program with a broader base. By the second year, the program could be self-sustaining, he said. The funding request would not be for a single facility, but to establish a network of facilities that would be able to offer transplants. The goals of this project would be to serve the community and to distribute care throughout the state, Dr. Sokolich said, and to attract specialists to New Mexico. There are 62 other institutes around the country, he stated, and if a group can be brought together, a liver transplantation institute could happen here.

Supportive Services for Liver Transplant Patients

Brad McGrath, deputy secretary, DOH, was unable to make a presentation to the committee, and, in his place, Winona Stoltzfus, M.D., regional health officer at the DOH, provided copies of the feasibility study conducted by TMG to committee members, as well as copies of a letter to Representative Lundstrom from Secretary of Health Retta Ward expressing her confidence in the results of the study (see handouts). Dr. Stoltzfus described the process that led to the study: UNM put out a request for proposals in response to Representative Lundstrom's memorial. TMG was selected, and all major hospital systems in the Albuquerque area were invited to participate. Of the five different scenarios, a national partnership/collaboration with an out-of-state liver transplant program was recommended, Dr. Stoltzfus said, and the DOH would be glad to lead the way in formalizing the process of establishing such a collaboration to help improve health care for New Mexicans. Dr. Stoltzfus agreed that a financial study would be the best next step. A variety of factors worked against the recommendation for a transplant center in New Mexico, she said, from lack of capability of hospitals to availability of specialists and subspecialists required to perform the complex surgeries. The TMG feasibility study was a collaborative, inclusive process, Dr. Stoltzfus said, and regulatory requirements of the Centers for Medicaid and Medicare Services (CMS) were used in the process.

Mr. Hely clarified for committee members that the CMS requires a "center of excellence" designation in order for the cost of these surgeries to be reimbursed. A new center would have to perform the first 10 transplants without reimbursement to achieve this designation. Dr. Sokolich insisted that a special operating room is not necessary; a transplant surgeon, a transplant nephrology group and an entity that works exclusively with transplants are requirements. He asserted that there are enough annual liver donations available in the state to meet CMS requirements, stating that New Mexico has both the demand and the donors.

A committee member made a motion for staff to draft a letter to all hospital CEOs in the state asking them to come together for further discussion about a possible liver transplant institute. The motion was seconded and approved unanimously.

Legalization of Marijuana

Representative McCamley told members that he will be sponsoring a bill to legalize marijuana in New Mexico during the upcoming legislative session. He provided a brief history of marijuana in the United States, which was legal until the Marijuana Tax Act of 1937 made it illegal throughout the country (see handout). Today, there are 23 states that allow medical marijuana and four states, plus the District of Columbia, that now allow recreational use of the drug, he said. Representative McCamley provided statistics showing that the prohibition of alcohol from 1920 to 1933 actually fueled the rise of organized crime and an increase in homicide rates. Comparing the risks to health from alcohol versus marijuana, statistics indicate that alcohol is far more dangerous than marijuana, he said. In addition, the United States is the only industrialized country to prohibit the cultivation of industrial hemp; nonetheless, the country is an importer of this valuable crop.

New Mexico could save more than $33 million annually in costs associated with law enforcement and corrections if marijuana is legalized, taxed and regulated, Representative McCamley said, and this funding could be used for other purposes. He suggested that legalized marijuana production in New Mexico follow the model used by the State of Oregon; that it be monitored from seed to sale by the Alcohol and Gaming Division of the Regulation and Licensing Department; and that production of industrial hemp be encouraged in New Mexico. His legislation will propose that taxes be distributed to K-12 education (40 percent), addiction services (20 percent), state police (15 percent), local law enforcement (20 percent) and abuse prevention (five percent).

Representative McCamley said that legalization of marijuana has been steadily gaining in popularity among citizens, both nationally and in New Mexico. The governor is opposed to it, but Representative McCamley said that moving forward is a process that he is willing to begin. The more New Mexico can regulate marijuana availability, the better off New Mexico will be, he said, noting that Colorado already has collected more than $30 million in taxes in just six months. Most preconceptions about the dangers of marijuana use are not based on fact, Representative McCamley asserted. A committee member agreed that the proposed legislation will begin an important dialogue. He added that the public "is way ahead of the politics" when it comes to marijuana.

Health in All Policies

Marsha McMurray-Avila, coordinator of the Bernalillo County Health Council, introduced committee members to the Health in All Policies (HiAP) collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas (see handout). Health policies include transportation, land use, education, taxes, agriculture, economic development and criminal justice. There are several

ways to promote health, equity and sustainability, she said. The first of these is by incorporating them into specific policies, programs and processes, and the second is by embedding these attributes into government decision-making processes so that healthy public policy becomes the normal way of doing business. Promoting equity is essential, given the strong ties between inequity and poor health outcomes, she said. The HiAP approach brings together partners from many sectors; breaks down silos; and recognizes the links between health and other policy issues, Ms. McMurray-Avila said, and it could create permanent changes in how agencies relate to each other and how government decisions are made.

Examples of current policy discussions and projects where the HiAP approach could benefit New Mexico include the J. Paul Taylor Task Force, the legalization of marijuana, the statewide long-range transportation plan, Race to the Top and obesity-prevention projects, Ms. McMurray-Avila stated. She offered examples from other cities and states where HiAP has been formalized, including the cities of Chicago and Seattle and the states of California and Rhode Island (see handout). She said that the HiAP work group requests the formation of a HiAP task force, either through a legislative memorial or administratively through the DOH long-range planning process.

Jacque Garcia, a Bernalillo County representative of Place Matters, an initiative of the National Collaborative for Health Equity, designed to build capacity of local leaders, discussed root causes of racial and ethnic health inequities, including racial segregation, water and soil pollution and a glut of fast food restaurants and liquor stores in certain communities. Kristina St. Cyr, a Place Matters representative from Dona Ana County, pointed out how marginal conditions and high rates of poverty and obesity affect residents and how the county's comprehensive plan could help address housing costs, transportation issues and access to education, jobs and healthy food. Jordan Johnson, Place Matters representative for McKinley County, described active measures that are needed to protect communities from uranium mining's legacy of cancer and other diseases due to radioactive waste in the Rio Puerco.

Ms. McMurray-Avila said she is concerned about sustainability of the HiAP effort. County health councils are able to see what pieces are missing and advocate for what is needed.

Behavioral Health Boarding Homes Task Force Report

Jim Jackson, executive director of Disability Rights New Mexico (DRNM), and Miguel Chavez, DRNM senior advocate, presented a comprehensive investigation by their organization into the deaths of Alex Montoya and Cochise Bayhan from carbon monoxide poisoning in Las Vegas, New Mexico, on October 24, 2013 (see handout). Mr. Jackson also provided committee members with copies of a letter from K. Lynn Gallagher, deputy secretary of health, regarding the status of an interagency review of boarding homes, copies of the boarding home tenant resource list and a December 2010 report on licensure in behavioral health care prepared by the House Joint Memorial 34 Committee. The DOH is not authorized to regulate every boarding house in the state, Ms. Gallagher asserted, just those providing covered health services. If no health care services are provided, these homes are governed by landlord-tenant laws and municipal

occupancy rules. The 2010 report recommended that, due to budget and DOH resource constraints, no new regulations or processes for boarding and care homes be initiated at that time, but the DOH's Division of Health Improvement would work with operators of these homes to develop some minimum standards. The DOH does regulate boarding homes that provide assistance with at least one or more activities of daily living for two or more unrelated adults, Ms. Gallagher's letter stated, and the DOH's Health Facility Licensing and Certification Bureau now plans to add clarifying language in those rules.

Mr. Jackson outlined details of the report on the "tragic and preventable" deaths of Mr. Montoya and Mr. Bayhan, both discharged from the New Mexico Behavioral Health Institute at Las Vegas to a boarding "home" that was a Weather King portable storage shed not intended for human habitation on the property of a Las Vegas couple. The shed had no plumbing, water or electricity. Electricity was provided by an extension cord connected to the owner's mobile home, where the two men showered and ate their meals. DRNM is a nonprofit New Mexico agency authorized by state and federal law to investigate incidents of abuse and neglect of individuals with mental illness. The boarding home was not licensed and had never been inspected by any state agency or a fire department. Three days before the deaths of the two men, the husband of the boarding home operator installed a propane gas heater, later determined to be the cause of the lethal carbon monoxide.

The DRNM report concluded that the men lived in circumstances for which there was no oversight, ultimately causing their deaths, Mr. Chavez said. There is no systematic oversight of boarding homes such as the one in which these men resided and died, and while three state agencies do have jurisdiction over boarding homes or places providing personal or custodial care to adults with serious mental issues, none of them provides systemic oversight to these kinds of residences. The report cited a lack of housing options for individuals with serious mental illness and provided a long list of recommendations, including mandatory local fire inspections and business licenses, oversight of such facilities by the DOH as assisted living facilities for adults, access of such residents to the state's long-term care ombudsman and amendment of the Long-Term Care Services Act to include living situations such as boarding homes, among others.

Mr. Jackson concluded that these two deceased individuals were the subjects of neglect and said that the DRNM is appearing before the committee to talk about the system. Several state agencies clearly do have authority to oversee these situations, Mr. Jackson asserted, and DRNM wants to encourage them to exercise their statutory authority. The law is clear, he continued, but until these agencies step up, residents need to know that they can complain. A committee member noted there did not appear to be any representatives from those state agencies in the audience. Another member commented that the DOH report provided to the committee was not current but was written four years ago. Most of these individuals in boarding homes are on social security income and should be Medicaid-eligible, the member said, but Medicaid will not pay for services in a free-standing mental health facility, and a legislative fix is needed. Mr. Jackson agreed, adding that DRNM does not want to see any interruption in Medicaid services and that MCOs should be coordinating care for these individuals.

Adjournment

There being no further business before the committee, the sixth meeting of the LHHS for the 2014 interim was adjourned at 5:10 p.m

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

December 3-5, 2014
Room 307, State Capitol
Santa Fe

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative James Roger Madalena, chair, on Wednesday, December 3, 2014, at 9:30 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
Sen. Benny Shendo, Jr. (12/5)
Rep. Elizabeth "Liz" Thomson*
Sen. Pat Woods (12/4, 12/5)†

*appointed by the speaker of the house as a voting member for this meeting
†appointed by the president pro tempore of the senate as a voting member for this meeting

Absent
Rep. Nora Espinoza
Rep. Doreen Y. Gallegos
Sen. Gay G. Kernan
Rep. Terry H. McMillan
Sen. Mark Moores

Advisory Members
Sen. Sue Wilson Beffort (12/4, 12/5)
Sen. Craig W. Brandt (12/3)
Sen. Jacob R. Candelaria (12/3, 12/5)
Rep. Miguel P. Garcia
Rep. Sandra D. Jeff (12/3, 12/4)
Sen. Linda M. Lopez (12/5)
Sen. Cisco McSorley (12/4, 12/5)
Sen. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez (12/4, 12/5)
Rep. Edward C. Sandoval
Rep. Phillip M. Archuleta
Rep. Nathan "Nate" Cote
Sen. Daniel A. Ivey-Soto
Rep. Paul A. Pacheco
Rep. Vickie Perea
Sen. Sander Rue
Sen. William P. Soules

Guest Legislators
Rep. Gail Chasey (12/4)
Sen. Howie C. Morales (12/4)

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

Minutes Approval

Because the committee will not meet again this year, the minutes for this meeting have not been officially approved by the committee.

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS
Carolyn Peck, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written material are in the meeting file.

Wednesday, December 3

Welcome and Introductions

Representative Madalena welcomed those assembled and asked committee members and staff to introduce themselves.

Report on the Interagency Benefits Advisory Committee

Maria Griego, program evaluator for the Legislative Finance Committee (LFC), provided a report (see handout) on oversight of public employee health benefit plans for the Interagency Benefits Advisory Committee (IBAC). The IBAC was created by the Health Care Purchasing Act and is composed of four self-funded entities that provide health care benefits for public employees in New Mexico: the Public School Insurance Authority, the Risk Management Division (RMD) of the General Services Department, the Retiree Health Care Authority (RHCA) and the Albuquerque Public School District (APS). The act requires member agencies to jointly go through a request for proposals (RFP) for services, but it does not require joint participation in contracted services, Ms. Griego explained.

The LFC evaluation found that IBAC agencies generally have done a poor job of controlling health care costs for public employees. Instead of focusing on cost-saving measures, the agencies have shifted costs on employees and employers through higher premiums, a practice that the report calls unsustainable. Merging the four entities would put the agencies in a better position to negotiate on cost and to implement cost-saving measures. The expansion of Medicaid and additional health coverage options available to public employees on the state's health insurance exchange will provide additional options to public employees. New fees and

regulations arising from the federal Patient Protection and Affordable Care Act (ACA) will have to be taken into consideration in IBAC budgeting and plan design.

Ms. Griego described key recommendations for the legislature, including the creation of a consolidated health care finance entity to administer health benefits on behalf of governmental entities (state and local governments, school districts and institutions of higher education); to coordinate and consolidate purchasing; to oversee quality improvement and fraud and abuse surveillance activities with Medicaid; and to investigate the possibility of warehousing data and claims processing using existing systems in Medicaid. Recommendations for the IBAC include more active participation in provider rate development, contractual reporting mandates for more detailed reporting on cost drivers and uniform reporting on outcome performance measures, and incentives and disincentives relating to changes in provider rates.

Mark Tyndall, co-chair of the IBAC and director of the RHCA, agreed that the desired outcome for everyone is higher-quality results at lower cost and that the claims system in use has not changed much over the past 40 years. Mr. Tyndall noted that the IBAC has been through four procurements and is becoming better with negotiations. The lack of health providers in the state makes negotiations more difficult, he said, and market consolidation of facilities and providers adds to that challenge, as does the high cost of specialty pharmaceuticals. Mr. Tyndall said he believes that fee-for-service is not the right way to go, and that cost-transparency tools would be very valuable. He cautioned that changes should be implemented in a responsible manner so as not to exacerbate the health care provider shortage.

Vera Dallas, director of employee benefits for APS, reiterated Mr. Tyndall's comments, noting the importance for APS of value-based purchasing and bundled payments and of continuing to focus on high-cost drivers. APS has had a progressive on-site wellness program for the past five years and does have data to examine its high-cost claims. Having timely access to physicians continues to be a problem, Ms. Dallas said. APS does support these recommendations. Anthony J. Forte, director of the RMD, said he also concurs with the recommendations in the LFC report. A committee member noted that the recommendations in a 2010 report were the same and asked if any were being implemented. Ms. Griego said there has been considerable conversation among the entities, but changes take time to implement; there have not yet been any quantitative benefits.

The IBAC is supportive of the push for transparency, Mr. Tyndall said, and of proposals that everyone pay the same amount for the same service, but the only way this could work would be if Medicaid pays more than it does. A committee member suggested the possibility of a joint memorial to set up a task force of stakeholders to determine how to implement the consolidated entity.

Managed Health Care Credentialing of Health Care Providers

Mr. Hely provided members with a copy of a proposed bill sponsored by Senator Cliff R. Pirtle to amend and enact sections of the Health Maintenance Organization Law to establish

provider credentialing requirements and define "credentialing" and to repeal a section of the New Mexico Insurance Code (see handouts). Senator Pirtle was unable to attend the day's meeting, and Mr. Hely said he would provide information about the bill to the committee.

The bill seeks to require the superintendent of insurance to provide for a uniform and efficient credentialing process, to establish a universal credentialing application and to require that the application be processed within 45 calendar days of receipt. Notification of missing information must be given within 10 calendar days. The bill limits requirements for re-credentialing to three years. If a carrier does not provide the applicant with a decision in writing within 45 days, the carrier must reimburse covered health care services to the provider in accordance with the provider's contracted reimbursement rate. On behalf of Senator Pirtle, Mr. Hely also provided a sheet with actual time lines for credentialing and contracting by carrier or plan (see handout), indicating that many are taking up to 160 days, and some as long as nine months, for this process.

Laura Hill, director of Independent Practice Association of Southern New Mexico, said she is grateful for the draft of this bill. While the 45-day time line is in current law, very few follow it, she said, and the problem has become much worse in the past few years as health maintenance organizations (HMOs) and other carriers have farmed out the credentialing process to other entities. She described the difficulty of recruiting into practice a physician who, because of a delay of eight months for credentialing, cannot bill for the patient the physician has seen. Verification of documents is very important, Ms. Hill said, but an independent physician cannot survive this length of time without pay.

Cody Dodson, office manager of Rio Pecos Medical Associates, Ltd., also spoke in favor of Senator Pirtle's bill. Rio Pecos had to pay the salaries of the last two physicians it hired for six months while they were unable to see patients; these losses were in the six figures, he said, and a smaller practice could not afford to do this. The issue is about patient care in rural areas, he said, and if the credentialing challenge is not met, businesses will fail.

Advance Care Planning in New Mexico

Mr. Hely began this discussion by providing a short, admittedly "unscientific" survey that he designed online and sent to members of the New Mexico Hospital Association, the New Mexico Nurses Association, the New Mexico Medical Society and the New Mexico Osteopathic Medical Association, asking five questions about health education and advance care planning conversations with patients. He received a total of 138 responses and shared the survey results with committee members.

Nancy Guinn, M.D., medical director of the Home and Transition Service Line for Presbyterian Healthcare Services and a specialist in family and palliative medicine, said that advanced care planning is a conversation that should include family members as well as the patient (see handout). In the best of circumstances, it will be more than a single conversation and will include the designation of a health care power of attorney and instructions on what type of

care the patient may and may not want in the future. Dr. Guinn said she did not receive any training in medical school about advance care planning or end-of-life issues, and even today, when such discussions are required by law in hospitals, there has not been nearly enough provider education. She described a community-based steering committee that has developed an advance directive document for "medical orders for scope of treatment" (MOST) for New Mexicans, and she provided committee members with copies of a double-sided document printed on bright green paper so it will stand out in a folder or patient's file (see handout). It is a document that can translate into medical orders, Dr. Guinn said, and is now being used in Albuquerque, Truth or Consequences and Santa Fe. Education and conversations about the MOST document is being conducted throughout the state.

Ellen Leitzer, Esq., executive director of the Senior Citizens' Law Office, Inc., provides representation and systemic advocacy, education and legal representation to older adults with the greatest economic and/or social needs in Bernalillo, Sandoval, Valencia and Torrance counties. Advance directives for health and finances have been a major focus for her nonprofit organization since 1983, when it drafted the first do-it-yourself statutory durable power of attorney, which was ultimately adopted by the legislature (see handouts). Her organization has held workshops throughout the region and has been able to recruit attorneys for home visits. Since 2009, the organization has prepared forms in both English and Spanish for more than 1,800 seniors, and these documents preserve an individual's autonomy, Ms. Leitzer said.

Stormy Ralstin, managing attorney of the Legal Resources for the Elderly Program (LREP), New Mexico State Bar Foundation, said LREP provides free legal help to individuals who are 55 and over, with no income restrictions and in dual-language format (see handout). LREP has provided legal services for advance directives to more than 1,700 clients since 2010, maintains a legal telephone help line and provides workshops, clinics, public education and systemic advocacy on many issues. It also provides referrals to private attorneys statewide. LREP attorneys handle approximately 4,500 cases a year involving consumer protection, long-term care, probate, social security, foreclosure, deeds, wills, trusts and many other issues. During the next year, LREP plans to create a practice manual and online site for attorneys, Ms. Ralstin said. Advance directives and power-of-attorney documents are critical for seniors, and very few attorneys in rural areas are willing to accept referrals. Feedback indicates that with guidance and training, more attorneys would be willing to take these cases.

On questioning by committee members, Dr. Guinn said she hopes that Medicaid soon will agree to pay for smaller services in a home setting. Her palliative care consultation team sees about 1,000 patients a year, most with an average life span of three months. About 30 percent of them already have advance directives in place, she said. Mr. Hely clarified for committee members that Medicare does not require a physician to have a discussion with patients about advance directives, but it is required in hospitals. The chair expressed concern about outreach of LREP workshops and clinics to Native Americans. Ms. Ralstin assured him the workshops are held at senior centers throughout the state, including on tribal lands.

Human Trafficking Task Force Report

Susan Loubet, executive director of New Mexico Women's Agenda, and Julianna Koob, New Mexico Coalition of Sexual Assault Programs, Inc., presented an update and findings from the Human Trafficking Task Force, which has been meeting monthly for the past year. After much discussion, group participants decided to focus on minors who are at risk for prosecution as prostitutes (see handout) and who should be treated as victims rather than as criminals. Task force members believe it is critical to address the myriad needs of exploited youth in New Mexico because they are at the highest risk of becoming victims of human trafficking. Screening for sexually exploited minors is better than a sweep, the members decided. More training, with sensitivity to lesbian/gay/transgender issues, of law enforcement personnel, service providers and advocates is important. Providing services for victims is crucial. Child victims of prostitution require specialized recovery programs, Ms. Loubet said, and because there can be a lot of "churning" in and out of juvenile detention facilities or jail, programs need to be flexible to allow the victim a new start. The number of victims in New Mexico is highly speculative, the presenters said, partly because of the transitory nature of the crime. More training in law enforcement and community awareness is needed to help identify victims of human trafficking. The group identified current providers: LifeLink in Santa Fe, ENLACE in Albuquerque, Pathways at the University of New Mexico Health Sciences Center (UNMHSC) and Spoken For at Copper Pointe Church in Albuquerque. Future providers include Hope's Home in Moriarty, a grant-funded facility for girls that is a project of Beyond Borders Ministries, and a home for adult women in Tijeras to be opened in February with funding from the Wecks Family Foundation.

The task force examined promising efforts in other states to address human trafficking and found numerous recommendations for more services for victims, including job training and education and increased training for law enforcement. The presenters said the task force is not recommending any new laws, but it asks that the task force be continued for another year, making more of an effort to engage survivors in the process. The presenters asked for two memorials, one to encourage the Federal Bureau of Investigation in New Mexico to share data about sexual exploitation of minors and the other to encourage more education of local law enforcement, with training provided by criminal justice professionals. Finally, they said, task force members are asking for support with funding of more services for victims.

Recommendations of the Behavioral Health Subcommittee (BHS) of the LHHS

Representative Thomson, chair of the BHS, presented members with a list of seven legislative proposals recommended for endorsement, all previously presented to the subcommittee, that were determined to be both evidence-based and cost-effective. The BHS provided projected aggregate budget recommendations for the proposals and separate budgets for each project's recommended expenditures over a five-year period (see handouts). Many project presenters were on hand to answer questions from committee members.

Programs recommended for endorsement by the LHHS, with budgets for a five-year rollout, are as follows:

(1) a $3.5 million appropriation to develop a center of excellence to expand and replicate the FOCUS/Milagro integrated care model for pregnant/postpartum women with substance abuse issues (.198138.1);

(2) a $1,911,240 appropriation to establish and maintain a statewide behavioral health warm line and clearinghouse with a published current list of resources (.198139.1);

(3) a $12 million appropriation to use UNM's Project ECHO telehealth program to expand access to behavioral health and substance abuse disorder treatment through training and support of primary care workers in community clinics and in 20 new sites (.l98l44.1);

(4) a $16,625,000 appropriation to expand access to behavioral health treatment and services through new and existing school-based health centers statewide (.198153.1);

(5) a $395,000 appropriation to increase the numbers of psychiatric mental health nurse practitioners who graduate from New Mexico State University (NMSU) and who remain in practice in New Mexico for at least three years (.198148.1);

(6) a $10,950,000 appropriation to establish supportive housing initiatives, using the Heading Home collective impact model, in Las Cruces, Gallup, Farmington and Santa Fe (.198176.1); and

(7) a $1,024,000 appropriation for in-state transitional living and recovery services for New Mexico adolescents with substance abuse issues (.198177.1).

Mr. Hely referred to .197818.1, a bill to establish parity between behavioral health benefits and other benefits, including but not limited to residential treatment. This bill has not yet been reviewed by the Office of Superintendent of Insurance (OSI), Mr. Hely said. A committee member pointed out that this bill would help to close the "medically necessary" loophole that is often used by insurers to deny coverage for residential treatment.

Public Comment

Ellen Pinnes, an attorney and health policy consultant who is a member of the ethics committee at Christus St. Vincent Regional Medical Center, spoke about advance directives. These come into play when a patient is unable to make his or her own heath care decisions, she said. Advance planning is a process and a conversation that takes place with family and loved ones. Advance directives often are made years in advance and provide guidance toward an individual's wishes. Putting advance directives in place can be a complicated process, Ms. Pinnes said, and this is only part of the broader issues of end-of-life care.

Jim Jackson, executive director of Disability Rights New Mexico, spoke briefly about limited resources and the importance of determining priorities among the day's proposals. Mr. Jackson said he feels they all have merit, but his priority would be for supportive housing, which is one of the state's most challenging issues and consumes a lot of resources in hospitals and jails. He also recommended priority status for school-based mental health services.

Melissa Beery spoke about her grandson, who came to live with her at age four after suffering years of abuse. He is now in Sequoyah Adolescent Treatment Center in Albuquerque, where he has experienced what she described as chaotic treatment and violent outbursts. He is

nearing a six-month deadline for discharge, even through he is not doing better, she said. Her grandson needs therapeutic interventions, with hands-on training for families. What she sees is very little program and a lot of babysitting, she said, noting that New Mexico is spending a lot of money at Sequoyah, but the program is unsuccessful. She asked committee members to help find a better way.

Henry Gardner, Ph.D., a clinical psychologist and a former long-time director of Sequoyah, said he has no direct information about the current operation of the facility other than Ms. Beery's report. It appears that Sequoyah is not taking the hardest core cases, Dr. Gardner said, and its census has been below capacity for two years now. The tough children are being sent out of state at great expense or are being held in correctional facilities.

A committee member said he may sponsor a bill to have the UNMHSC Department of Psychiatry take over the program at Sequoyah. Another member asked if the committee could get a breakdown from the LFC of severance tax bond funding to see where these funds are going.

A committee member expressed disappointment in the lack of attendees at the day's meeting and asked that members be polled to see if there will be a quorum. Another member offered to convey this concern to the speaker and ask for the appointment of additional voting members.

Recess

The meeting recessed at 4:10 p.m.

Thursday, December 4

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:45 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

Poverty in New Mexico

Adelamar N. Alcantara, Ph.D., director of geospatial and population studies at UNM, provided a series of charts and graphs relating to the persistence of poverty in New Mexico (see handout). No matter what happens to the economy, Dr. Alcantara said, New Mexico remains among the top 10 states with a high rate of poverty. Poverty is clustered in the state, and it is "gendered", she said; women have a higher likelihood of being poor. Education has always been seen as a tool of upward mobility, Dr. Alcantara explained, but this is not a very straightforward measurement, especially among Native Americans. Her statistics show that the most highly educated individuals tend to leave the state. The nature of poverty is very complex, Dr. Alcantara said, and measures such as federal income guidelines do not take into account quality of life.

Because the impact of intervention programs funded by the state is not really known, Dr. Alcantara proposed launching a multiyear research project that would link census microdatabases so that individuals could be followed over their lives, and the impact of public assistance offered to them could be assessed. She asked whether intervention programs in education have any impact on poverty and how population dynamics and economic policies shape future poverty patterns. Dr. Alcantara also proposed that projecting the burden of poverty at different geographic levels would be particularly useful for planning and policy development.

On questioning by committee members, Dr. Alcantara described problems with the United States census, with as many as 10 million uncounted individuals nationwide. Her division challenged the census after her staff found 130,000 uncounted households statewide. Using Google maps, her division was able to show census representatives 17,000 homes that the representatives maintained did not exist. Data collection needs to have a longer view, she said, describing continuing frustration with Workforce Solutions Department wage statistics that are deleted after just five years.

Understanding how poverty interacts with other factors is very important to lawmakers, a committee member asserted. Another member recalled the year 2000, when the legislature essentially "bailed out" the gas and oil industry, providing everything it asked for. The member asked if the impact is known on poverty of that policy decision. Dr. Alcantara said the legislature could require greater data collection on many of its projects and funding decisions. Members discussed cultural differences in the definition of poverty, especially among Hispanic and Native American communities. Poverty is a complex issue, the chair noted, adding that poverty attracts tourists to New Mexico. He said he encouraged his own children to become educated so that they can straddle both worlds, and stated he that he is proud of his poverty.

Health Security Act

Senator Morales presented legislation to enact the Health Security Act (.198019.2). He was accompanied by Mary Feldblum, executive director of the Health Security for New Mexicans Campaign. Cost containment will be a primary benefit of the Health Security Act, Senator Morales said, noting that the ACA drafters recognized that states could create their own waivers for innovation. Ms. Feldblum said she has worked for 20 years on this project, which has wide support all across the state and has been endorsed by more than 150 organizations. She described the plan as being like a cooperative, with freedom of choice of doctors, no networks and a comprehensive benefit package. The health plan would be run by a citizens board, would replace the New Mexico Health Insurance Exchange (NMHIX) and would be paid for with existing health care dollars, she said. The role of private insurers would shift from primary to supplementary, much like when Medicare was enacted many years ago. The first year appropriation of $250,000 would go to the LFC to undertake a detailed fiscal analysis, and it is this analysis that Senator Morales believes will garner the support of skeptics.

On questioning of the presenters, a committee member asked about estimates of potential savings for the state. Once the fiscal analysis is conducted, agencies will be able to see the

benefit, Senator Morales said, estimating that savings over the next five to seven years could be in the hundreds of millions, if not billions, of dollars. The plan will provide savings for the state and for local governments and will allow higher reimbursement rates for providers — a big benefit for local communities.

NurseAdvice NM

Connie Fiorenzio, R.N., program director for NurseAdvice NM, described the ninth year of operation for this statewide health advice line, which is staffed 24/7 by 45 registered nurses on a rotating basis (see handout). It is estimated that the 15,000 calls that come into the help line per month save between $3.5 million and $5 million annually in health care costs by preventing unnecessary hospital visits and diverting individuals to more appropriate, less costly services. While no caller is ever turned down, the nonprofit NurseAdvice NM is funded primarily by partnerships with the Department of Health, Indian Health Service units in Santa Fe and Albuquerque, UNMHSC, New Mexico Health Connections, Presbyterian Health Plan and multiple other private practice groups, clinics and hospitals. Ms. Fiorenzio said NurseAdvice NM is experiencing a drop in utilization; one major HMO has informed NurseAdvice NM of its intention to implement its own nurse advice line. Other HMOs use an out-of-state corporate help line. NurseAdvice NM also has an increasing number of calls that come from individuals who do not have health plans that reimburse NurseAdvice NM for its services. These factors threaten the viability of the New Mexico model, Ms. Fiorenzio said.

After further discussion of funding issues, a committee member asked LCS staff to prepare a bill requiring any entity that bills Medicaid to subscribe to the NurseAdvice NM line.

Expansion of First Choice Community Healthcare Services

First Choice Community Healthcare, Inc., is a federally qualified health center with two sites in Valencia County, one site in Santa Fe and a fourth site in Albuquerque's South Valley. It has been providing primary care services since 1972. Employing 75 full-time-equivalent positions, First Choice provided primary health care, behavioral health services, dental services and federal Women, Infants and Children services to approximately 56,000 individuals in 2013, according to Bob DeFelice, its chief executive officer (CEO). Recognizing that individual health is closely linked to community health, First Choice has engaged partners to develop a broad plan at its South Valley Family Health Commons to address multiple factors that determine health, Mr. DeFelice said. These include early childhood education, high school graduation, work force training, jobs, health education and availability of affordable local healthy food (see handouts).

First Choice is planning expansion of its South Valley commons to include a permanent campus for Health Leadership High School, a model early childhood development center, a wellness center, administrative space, a community garden and a farm-to-table restaurant, Mr. DeFelice said. Project plans are now in phase 2, involving the acquisition of seven acres of land. First Choice has applied for $3.2 million in grants for phase 3 and is now asking legislators for $1.2 million in capital outlay funds to complete final planning and design. Michelle Melendez, development director for First Choice, noted the importance of the organization in training

primary care physicians and other providers, 75 percent of whom remain in the state. The economic impact of the expanded South Valley campus is estimated to be a minimum of 100 new jobs and more than $24 million into the economy, she said.

A committee member suggested to Mr. DeFelice that he talk to the governor about including this funding in her package and emphasizing the regional impact of the project. First Choice could come to individual legislators for capital outlay as a fallback position. Another member suggested that Bernalillo County could be a recipient of the funds if the governor would give half, then individual legislators could come up with the other half. A member noted that First Choice has the largest number of providers in the state who can prescribe Suboxone to help treat heroin addiction and dependence on other opiates.

Pregnant Worker Accommodation and Parental Leave

Pamelya Herndon, an attorney and executive director of Southwest Women's Law Center (SWWLC), described legislation creating the Pregnant Worker Accommodation Act (PWAA), (.197761.3). This law ends discrimination on the basis of pregnancy, childbirth or a related condition, requires that employers make reasonable accommodations and provides for a grievance procedure and penalties. The state law is needed because of disparities in federal law. Ms. Herndon said that 56 percent of women in New Mexico who give birth continue to work, and their participation is essential to the economy.

Susan Scott, M.D., who is on the board of directors of the SWWLC, said that, currently, there are as many reports to the federal Equal Employment Opportunity Commission regarding pregnancy discrimination as there are for sexual harassment. Dr. Scott has been a practicing physician for 40 years and a mother for 30 years. She stated that women have always worked through pregnancy, and forced unpaid maternity leave is a huge burden on them that often comes with loss of their health insurance coverage. There are lifelong negative risks and health problems that can occur when babies are born early, Dr. Scott said, noting the potential effects of long periods of standing and physical exertion that should be altered for a pregnant worker.

Representative Chasey, sponsor of the PWAA, clarified for members that it is not a paid leave act. Rather, it ensures that a woman cannot be terminated because of pregnancy or related issues and that insurance coverage will stay in place.

With a quorum established, committee members voted to endorse this legislation and a related memorial, .197678.3, also sponsored by Representative Chasey. This memorial requests UNM's Bureau of Business and Economic Research to convene a work group to make findings and develop recommendations for establishing a publicly managed parenting workers' leave fund.

Recess

The committee recessed at 3:45 p.m.

Friday, December 5

Welcome and Introductions

Representative Madalena reconvened the meeting at 9:10 a.m., welcomed those assembled and asked committee members and staff to introduce themselves.

Health Insurance Exchange Update; Integrated Medicaid and Qualified Health Plan Enrollment

Sean Pearson, acting deputy secretary, Human Services Department (HSD), described a phone call from the Centers for Medicare and Medicaid Services (CMS) approximately one month ago informing him of a required change in the state's previously approved "no wrong door" path to health care coverage. The CMS now wants a "single door" approach that uses federal tax returns and other information stored in a federal data services hub (see handout). The CMS said that state funding would be threatened if these changes are not initiated. Additional development and testing will be required, Mr. Pearson said, and will result in a longer period before rollout of the state's platform. The NMHIX will become more dependent on the HSD's eligibility system, and additional short- and long-term costs will add risk to expanded Medicaid integration, he said. On the plus side, it will present an opportunity to expand the portal to other social services programs across state government and allow for more sharing of information. Responding to a member's question about why the CMS does not like the "no wrong door" policy, Mr. Pearson said that a CMS survey of other states found too many problems with this approach, and the CMS wanted a more unified approach.

Amy Dowd, CEO of the NMHIX, described the kickoff of open enrollment for health insurance on November 15, 2014, which runs through February 15, 2015 (see handout). She provided a list of 14 different organizations that trained more than 300 enrollment counselors statewide and described Native American outreach efforts as well as the appointment of a Native American liaison, Scott Atole. Ms. Dowd also addressed the financial sustainability of the NMHIX, which was built using federal grant funds. BeWellNM, the name of the NMHIX, will need to be fully financially self-sustaining by the time federal grants end on December 31, 2015. To this end, the NMHIX board of directors is putting forth a proposal to adopt a marketwide assessment of specific health insurance issuer premiums based on each issuer's current market share. Issuers subject to the proposed assessment would include those offering major medical plans on and off the exchange and dental issuers offering products on the exchange.

The NMHIX plan offers two options for premiums to be assessed: (1) major medical, Medicaid and dental premiums; or (2) all premiums in item (1) plus vision, life, Medicare supplement, long-term care, disability income, specified disease, accident-only and hospital indemnity policies. Ms. Dowd said that the NMHIX, for which the web site is www.BeWellNM.com, is currently facilitating a collaborative and transparent process to include input on this proposal from a variety of voices across the state. The official public comment period on the NMHIX plan of operations began November 26 and continues through December

19, when public comment on the plan will be heard at an NMHIX board meeting open to the public. That meeting will begin at 8:30 a.m. at the Marriott Courtyard in Santa Fe.

Ms. Dowd also updated committee members on efforts to work in close partnership with the HSD to implement by the fall of 2015 a CMS-compliant and integrated, consumer-friendly individual marketplace technology system that has been fully tested and allows for an easy renewal process. A project steering team with representation from BeWellNM, the HSD, the OSI and insurance carriers will vet key exchange design and policy decisions, and a team of representatives from each of the stakeholders will evaluate vendor proposals. She provided a date of mid-January for presentation of the final design documents.

On questioning, Ms. Dowd and committee members discussed the following topics.

Updated marketing strategy. Ms. Dowd said that review of previous marketing efforts found that presentations were not as effective as face-to-face counseling conducted at local schools, libraries and community events emphasizing free enrollment services. The Healthcare.gov web site seems to be working well this year, she said. The NMHIX has hired an outreach director, Linda Ledeen, who was is in attendance, and is currently seeking to hire a manager of broker relations.

Involvement of the OSI. Health insurers must file their plans with the OSI a year in advance, Ms. Dowd said. The OSI reviews the plans to make sure that they meet minimum essentials and that administrative costs are in line, and it also examines provider network adequacy. The NMHIX essentially blesses what has been approved by the OSI. The NMHIX does not set rates, but it does help to inform consumers regarding rates. Ms. Dowd suggested that the LHHS might want to invite the OSI to give a presentation with the NMHIX during the next interim.

Grant funds remaining after December. The NMHIX can use approved leftover grant money for design and implementation but not for operations, Ms. Dowd said.

What numbers this year would be considered a success? Ms. Dowd said it is too early for speculation, but the updated BeWellNM web site has received more than 12,000 new visitors in dual languages. Re-enrollment is critical, she said, and 50 percent to 80 percent of enrollees are expected to renew. The exchange is continually surveying and polling during this period to adjust outreach efforts and is urging all consumers to update their data. Premiums can change, with some expected to be lower, Ms. Dowd said, but everyone should try to make sure they are in the best position.

Issues with lack of tribal consultation. The chair noted that the HSD has not done a good job with tribal consultation, and it is undiplomatic for the department to go to the CMS with state decisions that were made without tribal consultation. It is good to have meetings on tribal lands, but that does not constitute consultation, he continued. He said that the HSD needs to go before

tribal governments throughout the state — one-on-one, government-to-government. It may be time-consuming for the HSD, but everyone needs to work together.

Citizens Substitute Care Review

Prior to the beginning of testimony, Vicente Vargas, Office of Government Relations at NMSU, informed committee members that because a lawsuit has been filed, neither Shelly Bucher, senior programs operations director for NMSU's Southwest Institute for Family & Child Advocacy, nor Jared Rounsville, director of the Children, Youth and Family Department's (CYFD's) Protective Services Division, will be testifying today.

The Honorable Petra Jimenez Maes, justice of the New Mexico Supreme Court, said she spent many years as a trial judge handling abuse and neglect juvenile cases and has worked extensively with the citizens review board (CRB) in her district. Within the last several years, major problems have arisen with CRB reports submitted to the court; they are not timely, they are late or they do not comply with court rules, she said. Because statute requires these reports to become a permanent part of the record, the summary was helpful, but the recommendations were not. Judges with whom she spoke recently about these reports indicated that CRB volunteers need to become better educated on legal processes. Justice Maes said that she is concerned about the reviews. To be useful, all members of a team should be present. New Mexico statute requires every case to be reviewed, she said, but CRBs are not equipped to handle this. Justice Maes stressed that she believes the CRB concept is a good one; her criticism has to do with the way New Mexico has implemented it. She has examined other states, noting that Colorado and Arizona have panels that meet quarterly to evaluate data. It is time for New Mexico to look at this issue more closely, she concluded.

Dede McCrary, former chair and current member of the State Advisory Committee (SAC), told LHHS members that 80 percent of New Mexico's children in foster care are being deprived of their right to an independent review (see handout). She recommends that the legality of the current contract with NMSU, which was never put out for an RFP, be examined and, hopefully, rescinded. In the 15 years prior to this contract, the cases of all children in foster care were reviewed annually; in 2014, only 245 "selected" cases were reviewed by the current contractor. She described a lack of consensus by members of the SAC, conflicts with the Department of Finance and Administration (DFA), which oversees the SAC, and conflicts of interest for the SAC chair. Now, the CYFD is engaged in selecting the cases to be reviewed, and the report to the court comes from a contractor who was not present at the meeting and not from the CRB. The proposed changes to statute presented at the day's meeting were developed by the SAC chair, a contractor and a representative of the DFA. Ms. McCrary provided numerous recommendations, and she concluded that an impartial assessment of the current foster care review system is highly warranted.

Linda Kennedy, a former employee of a CRB for eight years, said many judges feel the reports are important, but they are frustrated by receiving them late or not at all. The judges told her that they have only a few minutes before each hearing to review a case, and often they do not

read beyond the second page. Ms. Kennedy provided a series of typical excuses as to why CRBs are not reviewing all children in foster care (see handout), and cited three issues that have contributed to the current dysfunction of the system: (1) weak leadership that is unwilling to change; (2) lack of a strong partnership between the CRB and the CYFD; and (3) lack of administrative support for volunteers. All children in state custody need the CRB's vigilant and timely support, she concluded, and whoever holds the contract must have the passion, resolve and ability to get the job done.

Jack Carpenter, a licensed foster parent who has had more than 100 foster children in his home over 26 years, is currently chair of the SAC. He provided a history of the Citizen Substitute Care Review Act and described the review process as a way to report back to the legislature on ways to improve the system and to present to the courts an independent review of children in the care of the state (see handout). Currently, the review boards agree with the CYFD's recommendations 80 percent of the time. The SAC is proposing legislative changes to the statutes in the upcoming session, Mr. Carpenter said, and he provided a spreadsheet with the recommended changes and the rationale for each (see handout). He described recent changes to the makeup of the committee that would strengthen its ability to develop data from local board reviews, seek out research and experience from around the country and better distill information for the courts, the legislature and the CYFD.

A committee member cited a past lawsuit that may have set the troubled course for the SAC, along with the decision to move the contract to the DFA, which does not have appropriate expertise. When the Senate Public Affairs Committee begins meeting in January, the member would like to see an afternoon session devoted to CRBs with all stakeholders present and an attempt to draft legislation to address the issues. Several members said they found Justice Maes' testimony disturbing. Another noted that it would have been better to have heard this testimony earlier in the interim.

Public Comment

Jane Ronca Washburn has served on a CRB for many years. Under the current contractor, the number of cases has declined, and she feels this is because each party is called in separately, increasing the time involved. This change was initiated by the contractor against the wishes of 75 percent of the committee members, she said. Her reports may have been changed or edited by the contractor, and this makes it a report from the contractor, not from the chair of the CRB.

Karen Foote of Las Cruces said the reports that are getting to the judges are written by the contractor, who was not even present at the meeting. The prior contractor reviewed several thousand cases per year and did not need millions of dollars to do this. The current contractor changed the way the process works, Ms. Foote said. Now, the CYFD office in each district picks four cases for review.

Review of 2015 Legislation for Committee Endorsement

One member suggested that the committee prioritize these recommendations, noting that everyone is fighting for the same dollars. It is almost like going to the casino, the chair commented. Another member disagreed with prioritizing, saying this comprehensive list will give members a chance to educate fellow legislators about important issues. He then exhorted them to "go to the casino". Mr. Hely and Ms. Mathis presented each committee member with a large binder containing legislation for review and action.

Adjournment

There being no further business before the committee, the seventh and final meeting of the LHHS for the 2014 interim was adjourned at 5:05 p.m.

BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE MINUTES

MINUTES
of the
FIRST MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

July 24, 2014
Room AD101/102, Northern New Mexico College (NNMC)
Joseph Montoya Building
Española

The first meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Elizabeth "Liz" Thomson, chair, on July 24, 2014 at 9:15 a.m. in the Joseph Montoya Building at NNMC in Española.

Present
Rep. Elizabeth "Liz" Thomson, Chair
Sen. Benny Shendo, Jr., Vice Chair
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
Rep. Edward C. Sandoval

Absent
Sen. Sue Wilson Beffort
Rep. Paul A. Pacheco
Sen. Sander Rue

Guest Legislators
Sen. Linda M. Lopez
Sen. Michael Padilla
Rep. Debbie A. Rodella

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Rebecca Griego, Records Officer, LCS
John Mitchell, Law School Intern, LCS
Nancy Ellis, LCS

Guests
The guest list is in the meeting file.

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

Thursday, July 24

Welcome and Introductions

The chair welcomed subcommittee members, staff and guests and introduced Dennis Tim Salazar, mayor pro tem of the Española City Council. Mr. Salazar welcomed members to Española and apologized that Mayor Alice A. Lucero was unable to attend today. Mr. Salazar said drug and alcohol abuse is a major problem in Rio Arriba County and Española, but with the collaboration of federal and local agencies and treatment specialists, early intervention and after-school activities are being encouraged to promote healthy children. Mr. Salazar stated that he previously worked for Easter Seals El Mirador (ESEM), one of the 15 behavioral health agencies whose Medicaid funding was suspended last year by the Human Services Department (HSD), and that there had been significant negative consequences for children, families and employees in the transition to new agencies. He asked subcommittee members to help in any way possible.

The chair then introduced the president of NNMC, Nancy "Rusty" Barcelo, Ph.D., who described many changes to the college, including graduate degree partnerships with New Mexico State University and soon with New Mexico Highlands University. In 2005, NNMC became a four-year institution, including its sister campus in El Rito. NNMC works with regional high schools in Penasco, Dulce, Chama and Jemez to offer courses with dual credit. She urged legislative support for a residence hall, as some students are being lost to southern Colorado schools that offer residence halls.

Dr. Barcelo introduced Pedro Martinez, Ph.D., vice president for academic affairs at NNMC, who stated that he believes higher education has a responsibility to align its programs with work force development. Dr. Martinez described programs at NNMC that focus on health management and geriatric nursing, and he described plans to create a mobile unit that could go into rural areas and provide basic medical care for seniors.

Report from the State Auditor

State Auditor Hector H. Balderas provided subcommittee members with a letter (see handout) detailing issues identified in the HSD 2013 financial audit that was publicly released by his office on February 27, 2014 (the full audit report can be found at www.osanm.org). As state auditor, it is his duty under state law to provide New Mexicans with an independent opinion of all government agencies' financial affairs, increase transparency, promote accountability and eliminate financial fraud, waste and abuse. His appearance before this subcommittee was at the written request of the chair and vice chair.

The results of the 2013 HSD audit, conducted in collaboration with the independent firm of CliftonLarsenAllen (CLA), which had been selected by the HSD, demonstrate a greater need for state and federal oversight of critical department functions in the expenditure of $2.6 billion in federal Medicaid funds, Mr. Balderas said.

The audit process involved review of a report produced by Public Consulting Group, Inc. (PCG), which was hired by the HSD, that identified an estimated $36 million in overbilling that formed the basis of the HSD's June 2013 referrals to the New Mexico attorney general and suspension of payments to 15 behavioral health service providers for "credible allegations of fraud" (CAFs). The audit process was made significantly more time-consuming and challenging by the HSD's refusal to provide the PCG report until ordered to do so by a district court judge, according to Mr. Balderas. His staff later accidentally discovered that the copy eventually provided by the HSD to his office had been redacted, with language removed that had stated "PCG's Case File Audit did not uncover what it would consider to be credible allegations of fraud, nor significant concerns related to consumer safety". Further legal action by the Office of the State Auditor was required to compel the HSD to deliver an unaltered copy of the report, as ordered by the court. The HSD explained that it had directed PCG to remove the passage because only the HSD may make a determination regarding what constitutes a CAF. Mr. Balderas said he remains troubled by the HSD's alteration of the state record that was the basis for a referral to law enforcement authorities.

Mr. Balderas reviewed significant findings of the 2013 HSD audit, including a lack ofinternal controls by the HSD designed to effectively and timely identify overpayments to providers; a significant deficiency regarding the HSD procedures for investigating CAFs; improperly paid costs to PCG using Medicaid funds; and improper payments totaling $620,383 to five Arizona behavioral health service providers hired by the HSD to replace the 15 suspended New Mexico providers. These audit findings were formally referred to the New Mexico attorney general to assist in ongoing criminal investigations and to the Centers for Medicare and Medicaid Services (CMS) and the Office of Audit Services within the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, Mr. Balderas said. In early March, the CMS informed his office that because of the ongoing criminal investigations, it declined to review the HSD's determinations related to CAFs, he said. The OIG acknowledged "areas of joint concern", and Mr. Balderas remains hopeful that there will be further review by federal authorities of behavioral health services in New Mexico.

In conclusion, Mr. Balderas stated that greater oversight is needed for behavioral health issues in New Mexico, because fragile, at-risk populations suffer the direct impacts of deficiencies in the system. He said he recently wrote to New Mexico's congressional delegation regarding these matters, and he urged subcommittee members to do the same.

Questions/Concerns

A subcommittee member asked Mr. Balderas for a breakdown of federal and state funds used in the HSD's transition to Arizona providers. Mr. Balderas said he did not have this information with him today, but he promised to provide it to subcommittee members. In a welcome development, Mr. Balderas noted, the HSD has chosen the same firm (CLA) for its 2014 audit.

In response to members' concerns about how determinations of fraud are made, Mr. Balderas said there is a great national debate under way about what constitutes Medicaid fraud. The threshold for "allegations" of fraud has been lowered with the federal Patient Protection and Affordable Care Act, and there is considerable confusion and no clear path forward; it is a very difficult way to conduct business when questions about costs can shut a business down. Another member stated that experienced staff is being let go by the new agencies right now, and the member wondered what recourse there might be for consumers. There has been a stunning lack of consequences for the HSD, noted one member; another member commented on the apparent absence of HSD staff at this meeting.

Mr. Balderas emphasized that the state auditor has no authority to sanction a department, only to form an opinion. Corrective action is in the hands of management and the executive, he said, and he urged legislators to continue close oversight. He also urged the passing of an "obstruction of audit" law in New Mexico to ensure public access to information. After subcommittee members thanked Mr. Balderas and his staff for their extensive work, he remarked that PCG was paid more for one project than the state auditor's entire annual budget.

Consequences of Substance Abuse in Rio Arriba County and New Mexico

Michael Landen, M.D., state epidemiologist, Department of Health (DOH), told subcommittee members that he has good news and bad news in the fight against substance abuse in New Mexico. The bad news (see handout): today, and historically, New Mexico has the greatest burden of substance abuse of any state in the country. The death rate from alcohol is more than twice that for drug overdose and continues to rise. The good news is that New Mexico, which is second to West Virginia in drug overdose deaths, has reduced the drug overdose rate by 17 percent over the past two years, due largely to reductions in opioid prescribing. Prescription drug deaths are highest in Rio Arriba County, followed by Mora County.

With alcohol, Dr. Landen said, New Mexico is in a class by itself. The state leads the nation in deaths due to alcohol, but this is a problem that is within the state's power to control, he said. Excessive alcohol use is a public health issue, and Dr. Landen recommends the reduction of alcohol consumption, particularly in high-risk areas, by promoting evidence-based prevention strategies. Such efforts would include increased screenings and interventions and increased local control over alcohol outlet density. Dr. Landen also urged the legislature to look at increased alcohol taxation as an effective way to reduce consumption.

Dr. Landen made recommendations for addressing New Mexico's drug overdose rate as well; he suggests upgrading mandatory prescription monitoring program use by health care providers through licensing boards; enhancing feedback on dangerous prescribing to practitioners and their licensing boards; and assuring that naloxone is available to all at high risk of drug overdose. Dr. Landen also urged that New Mexico assess and address significant gaps in the drug and alcohol treatment infrastructure statewide.

Questions/Concerns

Several subcommittee members asked whether there is a hotline available to report overprescribing by practitioners. Dr. Landen said there is not a hotline, but such public concerns should be reported to the appropriate state licensing board. Another member suggested a public awareness campaign regarding such reporting. Many members also expressed concern about drug disposal, since there apparently is only one incinerator in the state. Because law enforcement is involved in disposing of controlled substances, and a new incinerator must meet federal standards, it is very complicated, Dr. Landen said. The easy availability of leftover medications is a major concern, he agreed.

A member moved to recommend to the LHHS the endorsement of legislation for a local option liquor excise tax, already passed by the senate. The motion was seconded and approved.

University of New Mexico (UNM) Pain Center

The UNM Pain Center is New Mexico's only adult and pediatric interdisciplinary pain management clinic (see handout), providing more than 6,000 patient visits per year, according to Brian Starr, M.D., medical director. Dr. Starr and Daniel Duhigg, D.O., psychiatrist and director of the center's addiction/mental health services, described the focus of the center, which accepts referrals from primary care providers throughout the state regardless of patient ability to pay. The UNM Pain Center educates New Mexico clinicians on screening for addictions, on opioid prescribing and on treating pain in patients who have co-occurring psychiatric illness. The average wait time for an appointment at the center is four to six months. Pain is a public health crisis, Dr. Starr asserted, affecting an estimated 100 million adults in the United States and costing upwards of $365 billion annually in medical treatment and lost productivity (see handout). Education is the key to this issue, he believes, and the center is spearheading that effort in New Mexico.

The UNM Pain Center began a trial in July, in collaboration with the DOH, offering naloxone with every opioid prescription for chronic pain, the first such trial in the country. Naloxone is a drug that has been proven effective in countering opioid overdose, Dr. Starr said, and this trial will study its benefits as a risk-reduction measure addressing New Mexico's high rate of accidental opioid overdose deaths. The UNM Pain Center also collaborates with other key stakeholders, including the Indian Health Service, the U.S. Department of Veterans Affairs and the state boards of nursing, dentistry and pharmacy. While the center employs seven physicians, all are part time and total just 1.3 full-time-equivalents, which is very limiting to the delivery of services, he said, and more funding is needed to move forward. A draft of a senate bill making an appropriation of $1.1 million (see handout) to the UNM Pain Center was discussed.

Panel Discussion: Rio Arriba County School-Based Behavioral Health Issues

Alice Meador, Ph.D., a psychologist with the Española Public School District, provides psychological services for special education students with emotional or behavioral health problems that affect learning. Many of these students have grown up seeing drug addiction and incarceration of family and relatives, Dr. Meador said, and they have huge mental health issues.

Intervention too often happens at a point of crisis, but what these students really need goes beyond symptom management. They need wraparound services, prevention programs, case management and outreach, and programs to help with learning behavioral competence. The special education program only serves students who meet specific eligibility requirements, Dr. Meador said, but there are many other students with needs who do not qualify.

Lloyd Vigil, Ph.D., also a psychologist with the Española Public School District, said that 97 percent of the boys he works with are fatherless. There are advantages to community-based programs, Dr. Vigil said, but the interruption of services that occurred in the transition to new agencies, and the loss of a therapist, is very upsetting to this group of students who, after so many other losses, lack trust. There are four or five homeless students in the district, Dr. Vigil said, and they are monitored by the school; some have graduated with honors.

Christina Baca, director of special education in the Española Public School District, said that families had to reapply to Medicaid with the changeover to Centennial Care and that many parents did not return to the new agencies for behavioral health services. The school district has not yet been able to develop a strong collaborative relationship with the new agencies, panel members agreed, and individual services have been reduced from four hours per day to one hour. Ambros Barros, who works for the district as a parent liaison, was involved previously with a program assisting students coming out of incarceration with their transition back into school. The program focused on prevention for drugs, alcohol and guns, and it was very helpful, he said, but was not continued by the new agency. The disconnect in behavioral health services was very disruptive, Mr. Barros agreed.

Questions/Concerns

Subcommittee members questioned panel members about other disruptions in behavioral and mental health services. Ms. Baca stated that previous agencies had more psychiatrists available to monitor medications, had a higher level of services and had the ability to take clinical services into the home. The district has lost a point person from the agencies to be on site in the schools, she said, and this needs to be restored. Despite challenges, Ms. Baca praised high school programs and the dedication of staff, teachers and students. All students with disabilities have graduated, she said. What is still needed is wraparound services, social workers in the schools and clinical side services that can work with families. This is the piece that the new agencies should be able to provide.

Also included on a district "wish list" would be a treatment center for students with emotional problems/psychotic episodes, early intervention for students with behavioral problems but who are not in special education and services for students with autism, Dr. Vigil added. The schools are eager to collaborate with community partners, and with the justice division, but adequate clinical support is essential.

An unresolved issue is who pays for behavior management services in the schools. Although the transition to the Arizona agencies took place a year ago, panel members were

unaware whether any of the four Medicaid managed care organizations have authorized any of these services. A subcommittee member asked LCS staff to draft a letter to the CMS to determine why this apparently is not being covered.

Rio Arriba County's Pathways and Treatment Model and the State of Behavioral Health in Rio Arriba County

Lauren M. Reichelt, director of the Rio Arriba Health and Human Services Department (RAHHS), provided an overview of the integrated service delivery system that has been built for county residents (see handout). The RAHHS is co-located with the Española Public Health Office and El Centro Family Health primary care clinic in the Rio Arriba Health Commons Clinic, a state-of-the-art facility in Española. Co-location facilitates the integration of primary care and behavioral health services, improves referral processes and builds relationships among providers, Ms. Reichelt said.

El Centro Family Health provides a wide array of health clinics and services for treatment and prevention, all on a sliding-fee scale. The RAHHS provides intensive case management for a variety of specialized populations, including substance abusers, high-risk women who are pregnant, jailed and released inmates, frequent emergency room (ER) users and seniors. A mobile van serves remote communities, often collaborating with other providers for immunizations, medication reconciliation, food distribution, job fairs, health screenings and other services.

The RAHHS is part of a nationwide pilot of the "pathways" model of care coordination, the success of which is judged by specific client health outcomes, Ms. Reichelt said. She described the success of the department's pathways program for pregnant substance abusers, which was touted by the federal Agency for Healthcare Research and Quality in its innovations exchange newsletter (see handout). Other pathways projects were described by David Trujillo, assistant county manager, Rio Arriba County, and include an ER diversion program, which has reduced overall use by 21 percent; a program of vouchers in an affordable housing pathway for homeless persons; and a new pathways program for jail diversion, helping people to get out of jail and keeping them out. Being able to track these individuals in a continuity of care model, including families and children, really does make a difference, Mr. Trujillo asserted.

Ms. Reichelt provided members with copies of an RAHHS presentation, "Steps to a Safer Future for Our Youth" (see handout), which is a detailed response to the June death of an emotionally distressed teenager, Victor Villalpando, shot dead by Española police after the youth, who was holding a cap gun, made multiple calls on himself to 911. Victor, 16, was a gymnast and dancer, was a recent graduate of Moving Arts Española and had been accepted into the New Mexico School for the Arts (see an editorial by Representative Rodella in the handouts). He was born with drugs in his system and had struggled to overcome many challenges in school. Victor was a respected peer mentor and was well-known in the community. The RAHHS presentation on youth safety points to three recent policy changes that impacted the deadly outcome of Victor's confrontation with police: 1) a disintegration of behavioral health services for youth; 2) the elimination of funding for crisis intervention training for law enforcement personnel; and 3) the

proliferation of guns in the community. Subcommittee members were informed of New Mexico's mental health crisis telephone hotline (855-662-7474), staffed 24 hours a day, seven days a week by professional counselors, but it has not been widely publicized, Ms. Reichelt said. Had he known, Victor might have called this number instead of the police. The RAHHS, in collaboration with the Rio Arriba Community Health Council, intends to convene a series of task forces to address these issues, Ms. Reichelt said, as well as the distressingly low profile of the new behavioral health providers in the community.

Questions/Concerns

Responding to a member's question about loss of funding since the County Indigent Hospital Claims Fund tax percentages were changed during the last legislative session, Ms. Reichelt said a number of county programs have been adversely affected, including flights for life, babies born in jail, DWI prevention and inmate health care. A $100,000 appropriation to Rio Arriba County for substance abuse treatment and case management was passed by both houses in the last session, but "Rio Arriba" was line-item vetoed by the governor. A member asked that a letter be sent to the HSD to see if these funds are still available to Rio Arriba County. Another member reminded the subcommittee that a bill about medical care for New Mexico inmates will be discussed at the upcoming joint meeting of the LHHS and the Courts, Corrections and Justice Committee in Albuquerque. Bernalillo County is spending 40 percent of its budget on health care for inmates, the chair pointed out, most of whom are incarcerated because of substance abuse, mental illness or learning disabilities. As a matter of public policy, Ms. Reichelt said, this is atrocious. Ms. Baca concluded the panel discussion with a heartfelt affirmation of Española, saying that the community does not deserve its negative reputation and assuring members that it is a wonderful place to live.

Behavioral Health and Substance Abuse Impact on Public Safety and Law Enforcement in Northern New Mexico

Major Ken Johnson, Santa Fe County Sheriff's Office, said there has been an increase in incidents over the past year dealing with persons with mental issues, especially in the northern parts of the county. This is due to a lack of services, he said, many of which have been recently cut. He was accompanied at the presentation table by Lieutenant Gabe Gonzales, who works as an investigator with the Santa Fe County Sheriff's Office. Both officers expressed frustration with the revolving-door aspect of incarceration and hospitalization for mentally ill persons. They were asked by a member if the sheriff's office had been contacted by either of the two new behavioral health providers in northern New Mexico; they said, to their knowledge, that they had not. Chief Richard Gallegos of the Española Police Department said that he had contact with one of the agencies when several of his officers sought counseling after the Villalpando incident. Police officers are sending people to the hospitals in Española and Santa Fe because many resources are not available or have been cut, Chief Gallegos said.

Public Comment

Mark Johnson, chief executive officer of ESEM, one of the 15 behavioral health agencies accused of fraud by the HSD, spoke to subcommittee members about the devastation of being

forced to turn over a 35-year-old business and lay off 120 employees (see handout) who were serving more than 250 children in northern New Mexico. Mr. Johnson's handout detailed the chronology of the HSD's actions against his organization and the attorney general's determination in January 2014 that there was not sufficient evidence of fraud against ESEM. Nonetheless, in July, the HSD re-referred the organization to the Attorney General's Office. Mr. Johnson thanked subcommittee members for their passion and dedication.

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, said her organization is in solidarity with ESEM. The developmental disabilities provider network members she represents live in fear of the same thing happening to them, she said, and the re-referral of ESEM made her very angry.

Mary Schumaker, foster mother of Victor Villalpando, asked members to look at police training as a mental health issue. It has been 45 days since her son's death, and she said she is still reeling. She then read a poem she wrote about the health of her community.

Satguru Khalsa commented that police dispatchers should have sensitivity training and should have phone numbers for mental health providers. Police officers should be screened for mental health issues, and the treatment system should utilize trauma-informed care.

Roger Montoya, who was an instructor of Victor Villalpando, said that he hopes this tragedy will result in a better community. He and his collaborators are prepared to do it right, he said, but they cannot do it alone.

Valerie Romero thanked subcommittee members for restoring her faith in the system. Ms. Romero said she came here to represent the kids who will be traumatized by changes in treatment. This system has a lot of gaps, she said. Ms. Romero detailed her own troubled past and her successful efforts to overcome it. Today is Ms. Romero's thirty-first birthday, she said, and now she has taken back control of her life.

Adjournment

There being no further business, the meeting adjourned at 4:15 p.m.

MINUTES
of the
SECOND MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

September 17, 2014
J. Cloyd Miller Library
Western New Mexico University
Silver City

The second meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Elizabeth "Liz" Thomson, chair, on September 17, 2014 at 9:15 a.m. in the J. Cloyd Miller Library at Western New Mexico University (WNMU) in Silver City.

Present
Rep. Elizabeth "Liz" Thomson, Chair
Sen. Benny Shendo, Jr., Vice Chair
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Sen. Sander Rue

Guest Legislators
Rep. Rodolpho "Rudy" S. Martinez
Sen. Cisco McSorley

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

Guests
The guest list is in the meeting file.

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

Wednesday, September 17

Call to Order

Representative Thomson welcomed all of those assembled and asked subcommittee members and staff to introduce themselves. The chair then introduced Dr. Joseph Shepard, president of WNMU.

Welcome

Dr. Shepard welcomed the subcommittee to WNMU and thanked behind-the-scenes volunteers who facilitated the meeting, including library staff and volunteer members of the Grant County Prospectors who provided food for the event. Dr. Shepard turned subcommittee members' attention to a nearby glass display case assembled by library staff to educate students about the important work of legislative interim committees. The display includes details about the subcommittee and photos of each of its members. Behavioral health is so important, and, too often, it gets lost in translation, Dr. Shepard said. He assured members that WNMU will always be a partner with the state in helping to meet behavioral health care needs.

Behavior Management Services (BMS) Panel

Julie Weinberg, director, Medical Assistance Division, Human Services Department (HSD), which administers the Centennial Care (CC) program, said that data from CC on behavioral health service utilization will be released soon and that her division desires to put out good, informative numbers. Because Medicaid pays for most BMS, Ms. Weinberg turned the presentation over to Wayne Lindstrom, Ph.D., director of the Behavioral Health Services Division (BHSD), HSD, and chief executive officer of the Interagency Behavioral Health Purchasing Collaborative.

Dr. Lindstrom outlined several aspects of BMS that are provided to children and youths requiring intervention to avoid hospitalization, residential treatment or separation from their families (see handout). These services are part of the Medicaid Early Periodic Screening, Diagnosis, and Treatment Program, and are incorporated into individualized treatment plans based on clinical assessments, Dr. Lindstrom said. BMS include a regimen of positive intervention and reinforcement strategies to help each child function successfully within the home and in the community. During the first six months of CC implementation, BMS increased significantly, Dr. Lindstrom said, while it appears that more intensive behavioral health services to children have lessened. He attributed this decline to probable past overutilization. It is important that the behavioral health system find new and creative ways to encourage family participation in BMS, Dr. Lindstrom said.

Subcommittee members asked why a representative from the Public Education Department (PED) was not present on this panel and were informed by Ms. Mathis that PED representatives had not responded to any of several invitations to participate.

Daphne Rood-Hopkins, director of the Behavioral Health Services Division of the Children, Youth and Families Department (CYFD), said that BMS is one of six services that her division certifies for Medicaid. Ms. Rood-Hopkins provided numerical data to subcommittee members regarding BMS delivered between January 1 and September 17, 2014: seven consumers in fiscal year 2014 were reimbursed through state general funds for non-Medicaid services consisting of an hour a week at the University of New Mexico (UNM); and there are 10 agencies currently licensed to provide BMS through Medicaid serving the following number of clients: Agave Health, Inc., 233; Amanecer Psychological Services, 16; The Community Lighthouse, two; Desert Hills, 48; La Frontera New Mexico, 74; Open Skies Healthcare, 58; Streetwise, Inc., 38; Turquoise Health and Wellness, 35; and Valle del Sol, 120, for a total of 624 clients.

A subcommittee member requested that Ms. Rood-Hopkins document for the subcommittee the total numbers she has reported, and she agreed to provide this information to staff (see handout).

The Honorable Marci E. Beyer, Third Judicial District Court judge, described herself as a member of a group of juvenile court judges that is becoming disillusioned with the system in New Mexico and with New Mexico's continual lack of resources. She agreed to participate on the panel today to help legislators understand the gravity of this crisis. The criminal justice system has become a dumping ground for mental health issues, Judge Beyer said. The current situation with children is that most often, detention or a juvenile correctional facility is the only safe place to house them. Judge Beyer sees about 300 juvenile cases each year, and she described the case of a 16-year-old girl with mental illness and drug addiction who was also the victim in multiple sex cases. Judge Beyer said she had to keep this girl in detention in order to keep her safe because there are so few mental health facilities in New Mexico. Only one agency can assess children — La Frontera New Mexico — and while the assessment is supposed to be done within 24 hours, it actually takes two to three weeks, she said. In other cases cited by Judge Beyer, two male youths waited five to six months in detention, and she finally sent them to an out-of-state facility for treatment. These juveniles are growing up to be housed in the adult system, she said.

Mr. Hely said that when BMS are indicated as a medical necessity along with an individual education plan (IEP), prior authorization with a CYFD-approved provider must be obtained. While Dr. Lindstrom mentioned that BMS utilization increased in the first six months of 2014, Mr. Hely said, it is important to remember that the entire behavioral health system was upended in June 2013. If subcommittee members want data, they need to make comparisons to the data prior to June 2013. The question to be asked is whether there has been a tightening of preauthorizations, and if so, do children have to present with more serious problems before services are authorized. Packets in subcommittee members' folders for today's meeting show turmoil at La Frontera New Mexico, Mr. Hely noted, so the ability to obtain data is compromised. The Legislative Finance Committee could obtain data through subpoena power, Mr. Hely said, adding that information technology systems at the HSD apparently are not

working with the managed care organizations' (MCOs') systems. Mr. Hely urged an action plan by the subcommittee to obtain quality data from the BHSD and the HSD.

On questioning, panel presenters and subcommittee members addressed the following topics.

More questions about data. Subcommittee members were adamant about seeking data prior to June 2013, which apparently are difficult to obtain at this time, and members asked about BMS clients who were being served prior to what one member termed "behavioral healthgate" and whether those clients have been contacted. Ms. Weinberg said her division has asked behavioral health agencies to help identify individuals who were getting BMS prior to the transition, but to date, not many have been located. BMS are not intended to be long-term services, Ms. Weinberg added. Mr. Hely asked if any directives were issued to providers or department heads about overutilization of BMS. Ms. Weinberg said there had not been any directives; the same prior authorization is being used now as was used under OptumHealth (the predecessor to CC).

Relationship between school-delivered BMS and Medicaid BMS. A subcommittee member asked how these services fit together. Ms. Weinberg said that it is complicated. There are Medicaid school-based services programs, and there is a federal match for services delivered in public schools as part of the IEP. Certain, but not all, Medicaid-based services delivered in the school are reimbursed, she said, and for some others but not for BMS, there is administrative reimbursement. The member asked if there were issues between the Medical Assistance Division and the schools regarding payment for BMS, and Ms. Weinberg said that she was not aware of any.

Engaging family participation. A new service under CC is family support, Ms. Rood-Hopkins said, but this has not yet been activated. Training will begin soon, delivered by a national expert, she said. The CYFD also has a family advocacy contract, and the department would like to expand this, but it does not have funds available to do so, she said. A subcommittee member asked whether the CYFD had sought more funding in the budget for this service, and Ms. Rood-Hopkins responded that it had not, due to multiple other priorities for mandatory services such as safe housing and shelter. She said there were other CYFD divisions with larger needs, and she chose not to ask for all that her division needs. Another member suggested that community health councils might be utilized to help generate family engagement.

How is "overutilization" determined? Medicaid requires all medically necessary services for children through age 20 to be delivered, Ms. Weinberg said, and the budget is based on an estimate of that utilization. Judge Beyer questioned the assertion that BMS have been overutilized, stating that she sees just the opposite. The number of agencies that do assessments has been reduced, she noted, and the concept of 90 days as a treatment period is completely unrealistic. These children need six months to a year, and they need step-down services. Instead, it has become a revolving door, she said. It is common sense to provide effective treatment, and

it needs to be done right, Judge Beyer said. A subcommittee member expressed frustration that legislators cannot understand what needs exist when agencies come to them with flat budgets. Legislators need more help, the subcommittee member said; it is either pay now or pay later. Another subcommittee member who has an adult son with autism took exception to the HSD's use of the term "overutilized". Mental illness and autism do not get cured, the subcommittee member pointed out. These are lifetime services, and it is not overutilization to provide continual services. Ms. Weinberg responded that in a review of some BMS cases, clinical notes indicated that too many services were being provided because the behaviors had already been corrected.

More information requested by subcommittee members. A subcommittee member asked about obtaining a copy of the annual surveys of certified CYFD providers, and the member was told these could be provided. The member also asked about CYFD training for BMS. Dr. Lindstrom said this is done through a clinical liaison assigned to each provider. The subcommittee member asked for a list of liaisons and trainings over the last four years. The member also provided a large packet of information to subcommittee members that included a letter from a therapist who formerly worked for La Frontera New Mexico and is highly critical of that organization, along with copies of La Frontera New Mexico survey results showing multiple violations of state standards. There is a lot of information that the subcommittee is requesting, one subcommittee member noted. Citing the tumultuous transition from 15 mental health care providers to the current five providers from Arizona, with two of these five reportedly planning to leave New Mexico, a subcommittee member expressed extreme frustration with how mental illness is treated in New Mexico. It is shameful, the member said. Another member moved that the subcommittee ask the LHHS to send a letter to State Auditor Hector Balderas, asking him to investigate the HSD/CYFD audits of the Arizona companies. The motion was seconded and passed unanimously.

Are Arizona providers cutting services? Dr. Lindstrom admitted that there were significant vacancies among the agencies, and that when there is a shortage of staff, there will be a shortage of services. He also agreed that there is a problem with providers being hired away by MCOs and other organizations offering higher salaries, further depleting the available work force. A subcommittee member asked Judge Beyer if she had observed a crisis in service delivery during the past summer. Judge Beyer confirmed that there were several months when no services were available, and she said that current service availability has not returned to the previous level. The subcommittee member then asserted that denial of services is a constitutional denial of civil rights, and this issue should be taken before the judiciary. An independent body should oversee behavioral health services in the state, the subcommittee member continued. It constitutes corruption in state government when $24 million has been spent on Arizona companies that signed on before the HSD's audit was complete. Something dramatic needs to be done, the subcommittee member concluded.

Another subcommittee member, describing himself as a lawmaker who is relatively new to the legislative process, said he does not understand the powerlessness of the legislature, nor

how legitimate requests to agencies for information can be completely ignored. A mutual working relationship between the legislature and state agencies should exist, he said, agreeing that something dramatic needs to be done.

Reviewing the stack of La Frontera New Mexico surveys, a member detailed a list of deficiencies noted on a single page of an annual quality survey: initial assessment not performed by a licensed clinician; person who was supposed to sign it did not; no treatment update found; plan not signed by clinical supervisor; and progress note documentation not found for an eight-month period. The subcommittee member asked why this is not a credible allegation of fraud, suggesting that perhaps payment to La Frontera New Mexico should be stopped.

Return on Investment for School-Based Health Clinics with Primary Focus on Behavioral Health

Suzanne Gagnon, former board member of the New Mexico Alliance for School-Based Health Care (NMSBHC), nurse practitioner and Robert Wood Johnson Foundation Nursing and Health Policy Fellow at UNM, provided members with a presentation on the value of school-based health care (see handout). New Mexico has 56 Department of Health (DOH)-funded school health clinics, providing a total of 45,000 visits annually. A school-based health center (SBHC) brings a broad range of services into schools that meet specific needs of youths and offers primary and behavioral health care in a convenient setting. Prevention and early intervention help reduce barriers to learning, Ms. Gagnon said, improving school attendance and grades. Nationally, one in five adolescents has a diagnosable mental health disorder. In a study of New Mexico's 56 SBHCs, 20 percent of users receive behavioral health treatment for depressive disorders, family problems or academic difficulties. Ms. Gagnon described a return-on-investment (ROI) tool that is being used to capture the economic value of SBHCs. The ROI analysis shows that more than $6.00 is returned for every $1.00 invested in New Mexico's SBHCs (see handout). The ROI data provide concrete evidence of the value of primary care screening and early intervention offered at SBHCs, Ms. Gagnon concluded.

Adrian Carver, president-elect of the board of directors, NMSBHC, described the negative effects of the 2009 cuts to the DOH's Office of School and Adolescent Health (OSAH) budget, providing a chart of 2015 legislative priorities for his organization (see handout). While New Mexico's SBHCs received increased funding of $500,000 last year, the alliance is urging that pre-recession levels of funding be restored. The NMSBHC is asking for a total of $2.5 million, as well as capital outlay funding from individual legislators for new clinic construction. The increased funding would allow the hours of service to be extended, Mr. Carver said, and $2 million alone will be needed to reopen SBHCs that have closed since 2009. A subcommittee member noted that the alliance is a nonprofit organization, and funding would have to go to the DOH. If funding is not requested by the DOH, it will not get into the budget, the subcommittee member told Mr. Carver. SBHCs are not owned by the schools, Mr. Carver explained. Generally, SBHCs are run by federally qualified health centers or other entities that are separate from the schools because of the federal Health Insurance Portability and Accountability Act privacy concerns.

Yolanda Cordova, director of the OSAH, said new SBHCs need fixed spaces to comply with clinical standards, but the provided space and the equipment and furniture in the space will belong to the school. More funding is needed for operations, Ms. Cordova said, but subcommittee members noted that the DOH budget is flat. Ms. Cordova said that the PED has been supportive of SBHCs but has no money for them, either. Ms. Gagnon said that the alliance continues to look for grant opportunities.

Adult Substance Abuse Continuum

Susie Trujillo, project developer for Gila Regional Medical Center and long-time community health advocate, described Grant County's Community Assessment 2012 that broke the state record for participation with more than 5,000 residents out of a total population of 29,514 participating, and that resulted in a comprehensive community health profile. Ms. Trujillo provided subcommittee members with a thumb drive containing 10 fact sheets about Grant County and its communities; an article about nationwide problems with substance abuse treatment since the advent of the federal Patient Protection and Affordable Care Act; and a copy of the Grant County Substance Abuse Epidemiology Profile 2014 (see handouts). Grant County Commissioner Ron Hall, who has held many other positions in the community, including in law enforcement and serving as a judge, was charged with leading an effort to put together a substance abuse continuum of care plan specifically tailored for Grant County. Members of the work group included representatives of the judiciary, law enforcement, first responders, the detention center, hospitals and local behavioral health providers, among others, and the work group met frequently, sometimes as often as several times a week. The work group came up with a conceptual treatment center to be funded by the county (see handout).

Mike Carrillo, administrator of the Grant County Detention Center and a member of the work group, said it has become clear that change is needed. The detention center currently houses approximately 100 inmates; has a recividism rate of 75 percent; and has many inmates with alcohol, substance abuse and mental health issues. These folks do not belong in jail, Mr. Carrillo said, and generations of families, children and grandparents are being lost. There are no resources to help with post-incarceration transition, and if inmates are not given something to build on, the need to build more jails will result. The current system of detention is not working, he said, but corrections cannot change without the resources to assist that change.

Chris DeBolt, Grant County Community Health Council coordinator, recited statistics from the county health sheet produced by the council; described the council's community resource directory; and described a report on the New Mexico Crisis and Access Line, NMCRISIS (see handout), which answered 6,804 calls between February 2013 and January 2014. Subcommittee members were asked to utilize their respective community health councils and to promote the state's crisis help line.

Jim Helgert, professor of chemical dependency in the College of Professional Studies at WNMU, described multiple related academic offerings at the university, with 35 majors and 15 majors in interdisciplinary studies. The chemical dependency program at WNMU is the only

four-year program in the state, he said, and its graduates can immediately apply for licensure upon graduation. Mr. Helgert's students have completed internships at local provider agencies, and he urged the state to change its Medicaid regulations so that independent providers who do not work for community mental health centers will also be able to bill Medicaid for services. He sees a robust role for WNMU in work force development, providing important mental health/substance abuse practitioners for New Mexico.

A subcommittee member congratulated the presenters for their efforts to emphasize the public health system, not the corrections system, in addressing alcohol and substance abuse problems. South Dakota adopted a similar focus, the member noted, and in the first year, South Dakota saved $42 million. These efforts are a paradigm shift from a prison system to a public health system. In Bernallilo County, one-half of the county budget goes to the detention center, costing $100 per day per person detained, instead of costing $22.00 per day per person housed in a halfway house with behavioral health services. New Mexico is last in the nation in providing alternative services to incarceration, the subcommittee member concluded. Another subcommittee member commented that this effort provides a unique opportunity for Grant County to become a rural model. He asked if the group was considering partnering with Ft. Bayard Medical Center Yucca Lodge as a possible treatment facility. That partnership is under consideration, Ms. Trujillo said, but funding is an issue because Yucca Lodge is heavily dependent on general funds for its operation. The Grant County group will be putting out a request for proposals on this soon, Ms. Trujillo said.

Update on Sequoyah Adolescent Treatment Center

Brad McGrath, chief deputy secretary, DOH, described a major change in the treatment model for Sequoyah Adolescent Treatment Center (SATC) over the past two years (see handout). The facility serves New Mexico males between the ages of 13 and 19 in a secured residential setting who have threatened to harm themselves or others, who have a history of physical aggression, who are suicidal or who have worsening psychiatric symptoms or other mental health conditions. Referrals come from juvenile probation departments, the CYFD and mental health care providers. The former treatment model was based on a corrections philosophy and a punitive culture, using chemical and physical restraints to control behavior, Mr. McGrath said. The current treatment approach involves a team of psychiatrists, psychologists, nurses and teachers who collaborate on a resident-centered care plan, using a crisis prevention intervention model supported by the CYFD and Disability Rights New Mexico (DRNM).

The new approach to treatment incorporates a family-centered Building Bridges initiative and evidence-based treatment in trauma-informed care, Mr. McGrath said. The CYFD has oversight of the facility, with its licensing and certification authority overseeing clinical and environmental care and staff competencies. The SATC is also fully accredited by The Joint Commission, a national independent, nonprofit organization that ensures certain performance standards. There is a governing board, made up of state executives and administrators, and an advisory board, which has been inactive since the transition but will soon be reactivated. The

SATC is an approved school district and provides one-on-one teaching during the required minimum instruction of five hours a day.

Carmela Sandoval, SATC administrator, said the current census is 22, with a projected goal of 30 in 2015. The average length of stay is shorter under the new treatment model, going from 368 days in 2012 to 276 days in 2014, with a treatment priority of reintegrating residents back into their families and communities, she said. The SATC admission process includes a team assessment to ensure that admissions are appropriate for a successful outcome. The presentation also included a description of staff vacancies at the facility (15 percent of 120 full-time employee positions); a breakdown of costs for contracted services; a list of licensed clinical staff; clinical data on the incidence of seclusions, restraints and staff injuries; a list of past and future capital improvements; and total budgets and expenditures since 2012.

Upon questioning, Mr. McGrath, Ms. Sandoval and subcommittee members discussed the following topics.

Long-term follow-up. A subcommittee member noted that the new treatment focus looks a lot like the Missouri Model, where the setting is more like a home than a prison. The member asked what happens to residents once they leave, and the member noted that longitudinal studies are needed to measure success. The subcommittee member also suggested that administrators might want to look to the Casey Foundation for help in making more effective changes.

Concern about selective admissions. The SATC was established as a facility for violent adolescent males, a last resort, and it seems this purpose has been changed, one subcommittee member noted. Mr. McGrath agreed, but pointed out that when the legislature created it, "treatment" was always in the name. The subcommittee member said that he was concerned about "cherry-picking" in admissions and asked what happens to boys who are turned away. If the boys came from jail, then they return to jail if it is determined that the SATC is not an appropriate placement, Mr. McGrath said. The SATC is a treatment center, with a focus on progress. Another subcommittee member said that she was offended by a criterion for rejection: an inability to learn. She is concerned that persons with cognitive disabilities are being put back into the jail system.

Compliments for progress. Jim Jackson, executive director of DRNM, said his organization was involved with some of the SATC investigations over the past several years, and the two organizations have worked well together. Mr. Jackson said that the whole atmosphere and culture of the facility have changed markedly, and he wanted to acknowledge this positive direction.

Subcommittee Business

A motion was made to approve the minutes of the July 24, 2014 meeting. The motion was seconded and approved unanimously.

Ms. Mathis provided members with a bound copy of a Review and Summary of Behavioral Health Findings and Recommendations prepared by Carolyn Ice, LCS research assistant, and Carolyn Peck, LCS student intern. This is a catalogue of key findings from 2001 to 2014, and members will see that these issues have been very well-studied, Ms. Mathis said. The summary is a tool that can be updated annually, Ms. Mathis advised, so it should be kept as an ongoing resource reference.

Public Comment

Henry Gardner, a child psychologist, said he was speaking today as a private citizen. Dr. Gardner said he worked at the SATC, treating the mentally ill for more than 20 years, and those adolescents who are being turned away now are the ones who were meant to be treated, he said. During his tenure, the SATC compiled data, met its budget and had a quality assurance program. The average length of stay was 210 to 220 days, he said. Children should not grow up at the SATC, but they have to stay there long enough to do some good. Dr. Gardner said his main issue with today's presentation is that the population discussed is not the population for which the SATC was built. The original mission of the SATC was to treat children that no one else wanted to help, he said. The SATC should not be competing with private facilities; it should be a last resort.

Victor Strasburger, M.D., said he worked for the SATC for 18 years, until a few months ago. He asserted that there are not 22 patients currently, there are 19, and they are patients, not "boys", as repeatedly referred to by Mr. McGrath. The SATC has had a census as low as 12 to 13 because it routinely turns patients away, he said. There have been three different directors of nursing in the past two years, and all have been good. There exists a management team that does not like disagreement. The medical director is an anesthesiologist. UNM psychiatrists have pulled out of the SATC because they believe that the treatment is substandard. That is why the SATC is contracting out the psychiatric services, Dr. Strasburger said.

Adjournment

There being no more business before the subcommittee, the meeting adjourned at 4:30 p.m.

MINUTES
of the
THIRD MEETING
of the
BEHAVIORAL HEALTH SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

October 8, 2014
Ballroom A, Student Union, University of New Mexico
Albuquerque

The third meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Elizabeth "Liz" Thomson, chair, at 9:25 a.m. in Ballroom A of the Student Union at the University of New Mexico (UNM) in Albuquerque.

Present
Rep. Elizabeth "Liz" Thomson, Chair
Sen. Benny Shendo, Jr., Vice Chair
Sen. Craig W. Brandt
Sen. Howie C. Morales
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent
Sen. Sue Wilson Beffort
Rep. Sandra D. Jeff
Rep. Paul A. Pacheco
Sen. Sander Rue

Guest Legislator
Sen. Linda M. Lopez

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

Guests
The guest list is in the meeting file.

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

Wednesday, October 8

Welcome and Introductions

Representative Thomson welcomed those assembled and asked subcommittee members and staff to introduce themselves. The chair then introduced Richard Larson, M.D., Ph.D., executive vice chancellor and vice chancellor for research, UNM Health Sciences Center (UNMHSC).

Dr. Larson welcomed subcommittee members to the UNM campus and provided a handout highlighting challenges to and opportunities in behavioral health in New Mexico. He cited disparities — New Mexico leads the nation in deaths from drug overdose, and its rate of suicide is nearly twice the national average — and a fragmented behavioral health system with a limited work force at all levels. Intermediate-level programs and services need to be expanded, Dr. Larson said, as does coordination with primary care. A severe shortage of psychiatrists statewide is another problem. The Brain and Behavioral Health Institute (BBHI) at UNMHSC is seeking to address many of these challenges, Dr. Larson said, by providing research teams and programs, community education initiatives and support for interdisciplinary efforts. Goals of the BBHI also include expanding crisis services, including mobile crisis teams, and developing a crisis stabilization center in Bernalillo County.

Mental Health Parity

D. Brian Hufford, a partner at the Zuckerman Spaeder law firm in New York and a long-time health care litigator, described several common issues involving mental health parity: limiting numbers of treatment sessions; adding co-pays that apply only to mental health and addiction services; exclusion of residential care; policies that are inconsistent with standards of care in determining what is medically necessary; and repeated denials of coverage. Parity means that a person with mental illness should receive the same level of coverage as for medically necessary services. There are federal laws, including the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), which require equal coverage for mental and physical health services, but enforcement is lacking at both federal and state levels, he said. In New Mexico, there is no parity for substance abuse treatment, and the law allows plans to turn down coverage, despite the fact that mental illness and substance abuse are often co-occurring. Urging that state law be amended by requiring compliance with appropriate guidelines for treatment, Mr. Hufford suggested that the parity law enacted by Illinois is a good model.

Lisa Reid, life and health director in the Office of Superintendent of Insurance (OSI), said that as a former mental health provider, she is pleased to see an increased focus on mental health parity in New Mexico. Network adequacy is a very big concern right now, she said, and dovetails into parity. The OSI is working with UNM to develop a tool to track and more closely monitor network adequacy issues.

Janice Torrez, vice president of external affairs for BlueCross BlueShield of New Mexico (BCBSNM), described her company's implementation of mental health parity rules and its

expansion of residential coverage for New Mexico members; policies renewing as of January 1, 2015 will reflect recent changes. The company's efforts also include training of employees to comply with the law; a provider advisory group that receives direct input from providers; and customer satisfaction surveys that are conducted regularly. The company uses the Milliman Care Guidelines for both physical and behavioral health decisions, Ms. Torrez said.

Anita Leal, executive director of CHRISTUS Health Plan, told subcommittee members that CHRISTUS will be in the New Mexico Health Insurance Exchange (NMHIX) as of January 1, 2015. Ms. Leal said her company has been challenged in finding mental health providers for its network. CHRISTUS has provided both mental and physical health services for veterans for more than two decades, she said, adding that it, too, follows the Milliman Care Guidelines for standards of care.

Marcello Maviglia, M.D., medical director of Molina Healthcare, said the main focus of Molina Healthcare is to provide the most effective and least restrictive treatment for mental health and substance abuse issues, with appropriate coordination and integration of care. Molina plans do not impose aggregate lifetime or annual dollar limits, Dr. Maviglia said, and the company is working toward complete compliance with mental health parity laws, including inpatient and outpatient care (see handout). Molina also utilizes member advisory boards and customer satisfaction surveys. Care coordination includes peer support specialists, community health workers and transitional coaches to ensure that recovery plans are being met. Molina services can also include traditional healing modalities for Native American and Hispanic populations.

New Mexico Health Connections (NMHC) is a physician-led, nonprofit cooperative, one of only 23 such cooperatives in the country, that will be offering plans on the NMHIX for individuals and businesses in January. Fifty percent of its board of directors are members. According to Matt McFadden, director of behavioral health management, NMHC, each plan includes mental illness and substance abuse coverage, and most outpatient services do not have limits on dollar amounts or the number of sessions. NMHC wants to encourage the use of these services, he said, because if mental health is addressed, then all health issues are addressed. To increase behavioral health service access, the company has reduced the number of services that require prior authorization, and if a member is denied services, a letter of explanation will include forms and instructions on how to appeal the decision.

Liz Locatur, executive director of behavioral health for Presbyterian Health Plan, Inc., said her company has more than 400,000 members in New Mexico, who comprise nearly one out of three insureds. There is close coordination between health plans and the actual service delivery system, Ms. Locatur said, and many opportunities to work directly with members. Presbyterian maintains a robust structure to comply with mental health parity laws and federal Patient Protection and Affordable Care Act (ACA) requirements, including a regulatory department with subject matter expertise led by a board-certified psychiatrist. Feedback from providers and consumers is sought regularly, and frequent adjustments are made as a result.

Harris Silver, M.D., a retired surgeon who is a health care and drug policy analyst and co-coordinator of the Bernalillo County Opioid Abuse Accountability Initiative, described the MHPAEA (see handout). In 2013, final rules were promulgated, and insurance plans that must comply with the law include group plans, with 50 or more employees, that offer mental health and/or substance use disorder benefits, all plans in ACA insurance exchanges and all Medicaid managed care organizations (MCOs). Describing three separate cases of individuals who were denied residential treatment in New Mexico (see handout), Dr. Silver revealed the lack of coverage for residential treatment under the following types of health insurance offered in New Mexico:

- few of the larger employers and almost none of smaller employers;
- almost none of the individual and family policies offered on or off the NMHIX; and
- none of the Medicaid MCOs, except for BCBSNM, which offers limited residential treatment when there are certain physical diseases also present, as a "value-added service".

Despite the fact that New Mexico leads the nation in alcohol-related deaths, is second in drug overdose deaths and third in suicides, the state has only 150 beds at three residential treatment centers, with just 60 of those certified for substance abuse treatment, according to Dr. Silver. He described the national Parity Implementation Coalition composed of professional organizations that are pushing for the inclusion of residential treatment in all health plans. There are numerous studies showing the benefits of residential treatment for substance use and certain mental disorders, Dr. Silver said, and it is central to the American Society of Addiction Medicine (ASAM) evidence-based criteria for treatment. He listed a series of actions by New Mexico's Medicaid MCOs that could be considered violations of the MHPAEA, including denial of residential treatment for substance abuse, eating disorders and other mental disorders; refusal of reimbursement for court-ordered treatment; and a "fail first" policy for mental disorders but not for physical disorders, among others. He also cited the Human Services Department (HSD) funding freeze of 15 behavioral health provider agencies, affecting 87 percent of Medicaid constituents receiving mental health/substance abuse services, as a potential MHPAEA violation, since there was no similar scrutiny of medical and surgical providers. Dr. Silver urged legislators to report violations to federal and state agencies and to convene a task force of providers to determine how medical necessity is defined and what mental health/substance use parity should be in New Mexico.

LCS staff noted that UnitedHealthcare declined the subcommittee's invitation to send a representative to participate in today's panel discussion.

On questioning, panel participants and subcommittee members discussed the following topics.

Why are there so few treatment beds in New Mexico? A member noted that the shortage goes beyond beds; there simply are not enough providers. Mr. Hufford responded that if New

Mexico required health insurance policies to cover residential treatment, an increase in beds would follow. Another factor contributing to the shortage of beds is the low rate of reimbursement to providers, he said. Dr. Silver agreed, adding that residential facilities have closed due to low rates of reimbursement and the extended length of time it takes to get paid. Dr. Maviglia said that these are complex issues that have forced crowding of emergency rooms and jails. Another member asked Dr. Silver if all states struggle with this shortage of beds. Not all, Dr. Silver responded: New York created a treatment system, as did North Carolina. Once states require health insurance policies to cover mental health/substance use, health insurers are incentivized not to send patients out of state, Mr. Hufford pointed out, but appropriate reimbursement rates are critical. The ACA says states cannot discriminate among licensed providers, and this may be worth further investigation as a means of enforcing parity, he added. Litigation against an insurer should be a last resort; it is more important for states to establish a system of oversight and enforcement of parity. He urged that ASAM standards be a part of the discussion in crafting legislation to strengthen New Mexico's parity laws.

Other potential violations of existing law. A member inquired about possible violations of the federal Americans with Disabilities Act of 1990 based on discrimination in the denial of treatment services. Mr. Hufford said this definitely could be a civil rights issue, as could be the disruption of services that occurred in New Mexico in 2013. Dr. Silver pointed out the $12.00 return on investment for every $1.00 spent on substance abuse treatment, which costs New Mexico $2 billion to $3 billion a year. Successful treatment is not all medical, he continued. It includes treating co-occurring and multigenerational issues. Supports are not available in New Mexico, but they are in other states. Another member asserted that until New Mexico gets serious about getting people well, nothing is going to happen; mental health issues go hand-in-hand with substance abuse.

Loophole in the ACA. Dr. Silver described an ACA prohibition on spending Medicaid dollars in facilities with more than 16 beds and the considerable debate surrounding a possible remedy, and he referenced a recent article in *The New York Times* examining the problem (see handout). In California, some facilities have divided up into multiple corporations to get around this prohibition. Parity is not being enforced with New Mexico's Medicaid MCOs, Dr. Silver asserted, but this is not a federal issue; it is a state problem that begins with the HSD. There is nothing in the state's Medicaid waiver about residential treatment.

MCO help with possible New Mexico solutions. One member asked panel participants representing MCOs if their organizations would be willing to work with legislators to craft stronger parity enforcement. Dr. Maviglia emphasized that it would be a mistake to expect residential treatment to solve all of the problems without a better system of care and after-care support, including housing and jobs. Mr. McFadden agreed, saying there is a clear need for residential care, and his organization would not oppose strengthening the law. Ms. Torrez reiterated that BCBSNM does cover residential care and would be glad to work with the subcommittee to help identify other solutions. Ms. Locatur said Presbyterian Health Plan is supportive of a continuum of care, and lack of residential treatment is just one aspect of the

problem. Ms. Leal said CHRISTUS would support exploring better solutions, noting that her company offers many different programs in Texas that are not available through Medicaid in New Mexico.

A member moved that LCS staff begin working on draft legislation to incorporate changes to the state's parity laws suggested by Mr. Hufford and others to give to the LHHS for its consideration. The motion was seconded and passed unanimously.

Minutes Approved

Minutes from the subcommittee's September 17 meeting in Silver City were approved, with instructions to double-check and correct the roster of members listed as attending the meeting. The November 5 meeting of the subcommittee originally scheduled for Gallup made it likely that several members would not be able to attend due to its proximity to the November 4 elections. Members voted and approved moving the meeting to Friday, November 7, in Santa Fe.

Public Comment

Ernesto Baca, legislative coordinator, OSI, said that he needs a sponsor for legislation to update the definition of autism to match the current Diagnostic and Statistical Manual of Mental Disorders.

Evelyn Blanchard, M.S.W., Ph.D., told members she is leading an effort at New Mexico Highlands University's School of Social Work to incorporate a Native American social work institute there, which will be the first in the country. The school of social work's mission upon its 1974 founding pledged to focus on Hispanic and Native American education, Dr. Blanchard told members, and while the effort for Hispanic education has largely been fulfilled, this is not the case for Native Americans. The proposed institute will concentrate on curriculum development, preparation of faculty and participation of New Mexico's Native American populations to ensure that the curriculum is responsive to their needs (see handout). Dr. Blanchard said the school can provide space and material support, and she is seeking endorsement from the Indian Affairs Committee and will be coming to the legislature to seek an appropriation for the program.

Cora Williams said she is a consumer with complicated health issues and does not understand why she cannot deal with all of her concerns in a single visit. She knows her therapist and said she does not want him to be told what kind of medicine she can have or what he can do for her. Ms. Williams said she was told by BCBSNM that she needs to have three different home care providers, which seems like a waste of resources. She is concerned that consumers are not getting what they need.

Ellen Pinnes, attorney and health policy consultant, said she is concerned about data from the HSD since the switch to Arizona mental health providers. In a recent presentation to the Legislative Finance Committee (LFC), the HSD touted increased numbers of consumers receiving behavioral health services. She wanted to call subcommittee members' attention to the

fact that during the last two quarters of 2013, service levels had dropped significantly, and this needs to be taken into account.

Presbyterian Medical Services (PMS) Report on Behavioral Health Services and Capacity

Doug Smith, executive vice president, PMS, described the history of PMS, which is not affiliated with Presbyterian Healthcare Services, Presbyterian Hospitals or Presbyterian Health Plan. PMS is a successor to the United Presbyterian Church's mission work that began in 1901 and was incorporated in 1969 as a New Mexico-based 501(c)(3) organization (see handout). While PMS started out providing only medical services, community needs soon drove it to diversify and to provide clinical integration. Today, PMS provides services to more than 60,000 individuals in 45 health centers in 16 New Mexico counties, Mr. Smith said. PMS is a designated behavioral health core service agency and conducts approximately 140,000 visits annually, in addition to operating a 16-bed adolescent residential treatment center in San Juan County and providing veterans' and family support services. PMS also operates 27 early childhood education facilities, two home care and hospice centers and five senior centers, and it employs 1,150 individuals statewide.

Bill Belzer, director of behavioral health for PMS, described the nonprofit organization's integrated model of behavioral health services delivery, which includes co-located medical and behavioral health programs, the use of fully integrated electronic health records, universal screening for depression and for substance abuse, telephonic psychiatric consultation for primary care providers, outreach to remote communities and populations, housing and employment support, 24/7 crisis services, patient-centered medical homes and comprehensive community support services. Mr. Belzer also outlined PMS' extensive use of evidence-based practices, and he provided a chart of behavioral health users by quarter that showed a drop of 1,400 consumers between the second and fourth quarters of 2013 (see handout). In June 2013, PMS was one of 15 New Mexico behavioral health care providers whose Medicaid payments were suspended following allegations of fraud by the HSD. In October 2013, PMS settled with the state for $4 million.

On questioning, Mr. Smith, Mr. Belzer and subcommittee members discussed the following topics.

Change in business structure. Asked if PMS was urged to sell its business to an Arizona provider, the executives confirmed that representatives of the HSD, Diana McWilliams and Larry Heyeck, initially told the executives that they could either transition to an Arizona provider or operate under temporary management by an Arizona company. PMS was asked to partner with La Frontera and was urged to terminate all employees, who would then be hired by La Frontera. After resolution of the credible allegations of fraud, PMS was told the employees then could be terminated by La Frontera and rehired by PMS. This plan was dropped when PMS informed the HSD representatives that laying off that many people would require advance notice under federal law and could not be done quickly.

Request for good-cause exception hearing. Within days of being informed of fraud allegations against it, PMS filed a request for a good-cause exception hearing to restore Medicaid funding. PMS did not receive a formal denial of this request for an exception and for a hearing, Mr. Smith said, but was told by HSD representatives that the request would be denied until the attorney general completed his investigation. The state, however, was willing to discuss a settlement. PMS considered laying off 230 employees statewide and the impact of this layoff on services that the organization provides to several thousand consumers, Mr. Smith said, but decided instead to continue operating on its reserves.

Dealings with OptumHealth New Mexico (Optum). In the five years prior to the allegations of fraud against PMS, the company did not receive any notices from Optum of program integrity problems, nor was it ever approached regarding overbilling or other performance issues, Mr. Smith said. PMS staff worked regularly with Optum during this period and was never told of any concerns; regular Optum audits of PMS gave it scores ranging from 88 percent to 97 percent. Mr. Smith confirmed that Elizabeth Martin, chief executive officer of Optum, was involved in settlement discussions.

Terms of settlement. PMS settled with the HSD in order to stay in business, Mr. Smith said. Behavioral health was about 20 percent of its services, and by the date of settlement in late October 2013, discussions had continued for three months, and the nonprofit was within weeks of exhausting its reserves. The $4 million settlement was based on an extrapolated amount of possible overbilling determined in the Public Consulting Group, Inc. (PCG) audit conducted by the HSD of 15 suspected agencies. PMS disagreed with PCG's findings, Mr. Smith said. PMS' own internal audits had not identified any problems, and once the company was able to see the PCG audit during settlement discussions (the document had to be returned to the HSD as a condition of settlement) and to examine the transactions flagged by PCG, there were zero findings, Mr. Smith said, absolutely not any fraud. PCG told PMS that the HSD would not allow PCG to consider PMS' evidence. The settlement was not a fine or penalty, did not require an admission of guilt and cleared PMS of civil but not criminal liability, Mr. Smith explained. PMS agreed to release the state from future legal action. To date, PMS has not been contacted by the Office of the Attorney General.

Motivation for today's testimony. Mr. Smith and Mr. Belzer said they agreed to speak out at this subcommittee meeting because they are proud of what PMS has accomplished and its commitment to continue services during the extended financial crisis. PMS desires to be a good partner to the state, the executives asserted, and they would like to see remedies put into place so that this cannot happen again.

Results First Cost Benefit Analysis of Behavioral Health Services

Ashleigh Holand is manager of state policy for the Results First Initiative, a collaborative project of The Pew Charitable Trusts and the MacArthur Foundation that is helping state leaders to invest in programs that work (see handout). By identifying current program investments and considering whether the benefits justify the costs, states like New Mexico have been using

rigorous evidence to identify programs that achieve the best results. The first step is to conduct a program inventory, Ms. Holand said, providing statistics from the state's criminal justice programs. Step two is to assess program costs per participant; step three is to predict and monetize outcomes (long-term benefits); and the final step is a cost-benefit ratio for each program. Results First provides a software program and data that incorporate many national studies in its templates.

Jon Courtney, Ph.D., program evaluation manager for the LFC, where the state's Results First Initiative is being implemented, presented a new research report on evidence-based behavioral health programs (see handout). Dr. Courtney noted that the state continues to lead the nation in damaging substance abuse and mental health outcomes despite four transformations of the behavioral health system over the past two decades. The report identifies some programs that are potentially good investments for the state in light of the Medicaid expansion and more than $537 million budgeted for behavioral health services in fiscal year 2015. The service strategy known as Screening, Brief Intervention and Referral to Treatment (SBIRT) has proven effective, but grant funding ran out. Fortunately, a new grant has been received. Because the HSD claims data are not very detailed, close analysis is hampered, and the state's Interagency Behavioral Health Purchasing Collaborative does not have a comprehensive grasp on what it is spending, Dr. Courtney said.

Charles Sallee, deputy director of the LFC, said that with New Mexico spending over half a billion dollars and a lot more in the future as Medicaid expands, this is a key strategic moment to target and implement what works. Two key categories to look at are supportive housing and assertive community treatment, Mr. Sallee said, urging a focus of resources on high needs. He also urged consideration of multigernational impacts, including maternal depression, which can cause lasting damage to infants. Mr. Sallee said that the HSD is currently exploring the possibility of including SBIRT as a Medicaid-reimbursable service, and the LFC is examining the possibility of using Medicaid funding for supportive housing.

Project ECHO Proposal to Expand Capacity to Provide Behavioral Health Services in Primary Care

Miriam Komaromy, M.D., associate director of Project ECHO and associate professor of internal medicine at UNMHSC, presented a five-year plan to expand access to treatment for mental health and substance use disorders in a primary care setting (see handout). Known as the ECHO Access Expansion Project, the program would train small teams of primary care providers (a nurse practitioner or physician assistant plus a community health worker and a consulting physician) working in rural and underserved areas to provide high-quality intensive services. Training and support for the primary care team would be provided through the Project ECHO Integrated Addictions and Psychiatry (IAP) Program, Dr. Komaromy said. A pilot version of the proposed project is currently in progress, and in the initial four months of operation, four teams have delivered more than 2,200 visits focused on behavioral health or substance use disorders. The goal of the larger project is to establish clinic teams in 20 community health centers throughout the state that will provide screening, diagnosis and treatment and ongoing case-based

learning and mentorship through the IAP teleECHO program. It is anticipated that, after certain changes to billing codes, team members ultimately will be able to submit sufficient claims to support their salaries. In order to provide a high-quality independent evaluation of program outcomes, an external evaluator, Mathematica Policy Research in Princeton, New Jersey, is prepared to offer an evaluation of the program (see handout). Tina Carlson, manager of behavioral health and addictions at Project ECHO, said that integration into primary care settings is a very cost-effective way to screen and treat these conditions.

Heading Home Proposal

Dennis Plummer, chief executive officer of Albuquerque Heading Home (AHH), described a massive outreach by 250 volunteers from multiple organizations who surveyed people in the Albuquerque area living on the streets or in shelters. According to Jodie Jepson, deputy director of AHH, 1,301 persons were interviewed, 978 of whom were persons experiencing chronic homelessness and who were medically vulnerable. Since then, more than 400 individuals have been permanently housed. It was a multifocused, community-wide assessment, Mr. Plummer said, and it was the result of months of meetings and planning. Those interviewed were prioritized by greatest health risks (see handouts). After 12 months, there has been an 82 percent success rate, according to Mr. Plummer.

Heading Home uses a systematic model that can be replicated, Mr. Plummer said, and includes the provision of housing dollars (vouchers), case management, ongoing facilitation of partner agency work and collaboration on data gathering and research. Mental illness is addressed by assertive community treatment with an interdisciplinary team providing direct care, case management and a link to 24/7 services. Other services provided include social, educational and life skills support. AHH has significantly reduced homelessness in Albuquerque, as well as emergency room visits, Mr. Plummer asserted. A recent study of cost-effectiveness of the AHH program, conducted for the City of Albuquerque by the UNM Institute for Social Research (see handout) found that AHH saved 31.6 percent, or about $12,831.68 per study group member. A flow chart prepared by the federal Substance Abuse and Mental Health Services Administration captures the AHH model (see handout), according to Mr. Plummer, and a homeless management information system required by the federal Department of Housing and Urban Development provides a coordinated assessment and unified database that can be used for intake statewide.

Last year, a team from the City of Anaheim came to Albuquerque to observe the AHH program for possible use in the California community, and it is now moving forward. Mr. Plummer said he would like to seek funding to teach the AHH model to other communities that would then come up with their own solutions. He has heard of interest by Las Cruces and Gallup, but the AHH has not officially approached other cities since it cannot guarantee any funding, Mr. Plummer said. A subcomittee member noted that even though the mayor of Albuquerque has put his support behind the organization, Mr. Plummer remains "the captain of the team" and is very much responsible for the remarkable success of this collaboration.

Public Comment

Jim Jackson, executive director of Disability Rights New Mexico, said his organization supports great programs like the last two described to subcommittee members, and he urged them to take the lead in expanding access with these programs and to work to convince legislative colleagues to support them.

Cora Williams said she was homeless for 35 years, and she thinks the AHH program is outstanding. If a person has been out on the street, that person has posttraumatic stress disorder (PTSD), she said, and often takes drugs to just to survive. It is terrifying, she said. Medical marijuana works to address symptoms of PTSD, so why is it not covered by insurance?, she asked.

A letter from Daniel Kerlinsky, M.D., an Albuquerque psychiatrist, urged that each city and town in New Mexico conduct a mental health parity day to talk about depression, suicide, anger management, substance abuse, parenting and marital problems in the context of health and the right to health care. Most New Mexicans have no idea that there is a MHPAEA, Dr. Kerlinsky wrote. An education program is needed so that people can break down the barriers to getting help, and the MHPAEA should obligate health insurance companies to develop services wherever a need is identified.

Adjournment

There being no more business before the subcommittee, the meeting adjourned at 4:54 p.m.

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

November 7, 2014
Room 322, State Capitol
Santa Fe

The fourth meeting of the Behavioral Health Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Elizabeth "Liz" Thomson, chair, on Friday, November 7, 2014, at 8:35 a.m. in Room 322 of the State Capitol in Santa Fe.

Present
Rep. Elizabeth "Liz" Thomson, Chair
Sen. Bill B. O'Neill
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Rep. Edward C. Sandoval

Absent
Sen. Benny Shendo, Jr., Vice Chair
Sen. Sue Wilson Beffort
Sen. Craig W. Brandt
Rep. Sandra D. Jeff
Sen. Howie C. Morales
Rep. Paul A. Pacheco

Guest Legislator
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, LCS

Minutes Approval

Because the subcommittee will not meet again this year, the minutes for this meeting have not been officially approved by the subcommittee.

Guests

The guest list is in the meeting file.

Handouts

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

Friday, November 7

Welcome and Introductions

Representative Thomson welcomed those assembled and asked subcommittee members and staff to introduce themselves. The chair noted that this is the last meeting of the interim, and she described today's presentations as fulfillment of an assignment by the New Mexico Legislative Council to the subcommittee to identify realistic and achievable long-term solutions to address behavioral health needs in New Mexico. The council also asked that initiatives be phased over a five-year period. A working group was established by the subcommittee and identified seven proposals being presented today for vetting by the subcommittee as a whole. Representative Thomson said that because a subcommittee cannot endorse legislation, a letter of recommendation to the LHHS to endorse the legislation would be attached to each approved initiative.

FOCUS/Milagro Proposal

Andrew Hsi, M.D., M.P.H., is a professor of pediatrics and principal investigator for the FOCUS program at the University of New Mexico Health Sciences Center (UNMHSC). FOCUS provides supports and services for families of children from birth through three years of age who are at risk for or experiencing developmental delays. Dr. Hsi described the consequences for infants born to opioid-addicted mothers (one out of every 15 births at UNM Hospital) and the need to enhance early brain development starting in fetal life (see handouts). While residential treatment of pregnant substance-abusing women is available for a small number of Bernalillo County residents at Milagro in Albuquerque, most New Mexico communities do not have access to such services.

Larry Leeman, M.D., M.P.H., is medical director of the Milagro residential program, which provides substance abuse aftercare, recovery and support to pregnant and postpartum women and their infants, and he is also a professor of family and community medicine, obstetrics and gynecology and co-medical director of the Mother Baby Unit at UNM Hospital. Dr. Leeman described details of a proposed FOCUS/Milagro project that would expand medical home services to three additional communities and serve up to 400 women annually (see handout). If left untreated, lifelong injury can occur to babies born to mothers who are addicted to drugs, Dr. Leeman explained, and there are few resources in New Mexico for treatment. The proposed joint program would offer wraparound services in a medical home model with extensive case management. Currently, the Milagro program is based in Albuquerque, and while participants come from throughout the state, transportation remains a struggle for most.

Marcia Moriarta, a clinical psychologist who is an associate professor of pediatrics and executive director of the Center for Development and Disability at UNMHSC, emphasized the importance of early intervention and home visiting as a universal model, and she described her role in FOCUS/Milagro as one of integrating the various resources for treatment and prevention.

On questioning by subcommittee members, Dr. Hsi described the three components of the $3.5-million, five-year program request: 1) training and technical assistance, with early intervention specialists housed at a center of excellence at UNMHSC; 2) funding for an additional three communities to develop provider networks and local centers for excellence; and 3) direct funding for additional providers in two other communities by fiscal year 2018. A member asked for a more detailed budget. Currently, limited activities are being funded by Medicaid, the Family Infant Toddler Program and the federal home-visiting program from the Children, Youth and Families Department.

A letter of recommendation to the LHHS was approved, and Senator O'Neill agreed to sponsor the bill.

Update on New Mexico Crisis and Access Line (NMCAL) and Proposal for Behavioral Health Clearinghouse and Help Line

Phil Evans, president and chief executive officer (CEO) of NMCAL, appeared with J. Martin Rodriguez, program manager, to describe details of the crisis access line that provides professional counselors 24/7 for New Mexico (see handouts). Mr. Evans said he and others have been working diligently to get the word out about the crisis line, and they have recently completed circuit of conferences and meetings with organizations in communities throughout the state. The crisis line (855-NMCRISIS) provides specially trained counselors who hold at least a master's degree in a behavioral health-related field who speak with callers who have concerns about suicide, drugs and alcohol, anger, domestic abuse and many other mental health issues. Counselors employ solution-focused brief therapy techniques and mental health first aid, and they may involve emergency services if warranted by safety concerns. The development of a crisis line came out of House Joint Memorial 17 in 2011, Mr. Evans said, and his parent company, ProtoCall Services, Inc., based in Portland, Oregon, was contracted by OptumHealth New Mexico as part of the Interagency Behavioral Health Purchasing Collaborative in December 2012. The line became active in February 2013 and handled 3,093 calls in its first year of operation, in addition to answering another 3,011 calls for core service agency crisis lines. The number of callers is increasing significantly each month, he said.

On questioning by subcommittee members, Mr. Rodriguez and Mr. Evans said their company is a privately held corporation and that it was contracted, without bid, by OptumHealth New Mexico utilizing non-Medicaid funds. ProtoCall does not have contracts with any of Centennial Care's four managed care organizations (MCOs), Mr. Evans said; he assumes the MCOs all have their own call lines. He emphasized that NMCAL has immediate interpretive services available for callers whose first language is not English, and he said efforts are under way to add services for the Navajo Nation. Providing referral for follow-up services is important for many callers, he said, and NMCAL maintains a current database of local providers. The 2013 contract for ProtoCall in New Mexico was $900,200, Mr. Evans said, based on 4,000 calls a month, and the current contract ends on December 31. Discussions are under way with OptumHealth about the future, he said. A subcommittee member inquired about reports of a high-level OptumHealth executive being hired by NMCAL; Mr. Evans confirmed that Rosemary

Strunk, formerly senior director of service delivery for OptumHealth New Mexico, is now chief operating officer of ProtoCall Services, Inc.

Carolyn Bonham, M.D., associate director of the Brain and Behavioral Health Institute (BBHI) at UNMHSC, presented a proposal to fund a single source for referral and information for New Mexicans dealing with brain and behavioral health issues (see handout). Needs were identified by a coalition of 16 advocacy groups, including those that address stroke, Alzheimer's disease, brain injury, epilepsy, addictions, mental illness, autism, Parkinson's disease, Down syndrome, multiple sclerosis, congenital conditions and others. Priorities identified by the coalition included the need for information on access to care (specialists, available hospital beds, etc.); education for providers, patients and families; support, including respite, for patients and families; and basic needs such as transportation, housing and health care. Dr. Bonham detailed plans for a statewide mapping of existing resources and contact information and collaboration with all agencies and networks that coordinate and provide care for those with brain and behavioral health conditions. The clearinghouse and associated "warm line" phone service would utilize these collaborations to help individuals navigate the complex system of services and needs. A five-year budget presented by Dr. Bonham, broken out by year, totaled $1,737,500, plus $173,750 for program evaluation.

On questioning of Dr. Bonham, one member commented that it is not good to have a system of treatment based on medication, that the brain is exceedingly complex and that there are many different ways to treat it. Another member agreed with the collaborative approach of this proposal and applauded the benefit of bringing researchers across different disciplines to consult with one another. Dr. Bonham described plans to establish Domenici Hall on the UNM campus as a hub for the BBHI and plans in 2015 to establish a center for brain recovery and repair and to develop major new interdisciplinary programs utilizing federal funding.

The project was approved for a letter of recommendation to the LHHS for endorsement, and Senator Ortiz y Pino agreed to be the sponsor of the legislation.

Project ECHO Proposal to Expand Capacity to Provide Behavioral Health Services in Primary Care

Miriam Komaromy, M.D., associate director of Extension for Community Healthcare Outcomes (Project ECHO) and an associate professor of internal medicine at UNMHSC, described details of a plan to utilize tools and training in motivational interviewing to help engage patients with behavioral health and substance abuse issues in primary care settings (see handouts). Dr. Komaromy had presented this proposal to the subcommittee previously, but she was reviewing it for members' consideration today. The model involves training primary care clinical teams throughout the state led by nurse practitioners or physician assistants and including community health workers. These teams would be intensively trained through Project ECHO, then remain involved in weekly conferences with addiction specialists, psychiatrists and other specialists. It is a five-year plan with five new sites to be launched each year, for a total of 20, and will expand mental health and addiction services in a state that is largely rural and lacks

access to providers. Dr. Komaromy provided a budget breakdown for each year of the project, totaling $10,547,689 over five years, and stated that before the program ends, each nurse practitioner or physician assistant should be able to generate enough claims to fully support his or her salary. A Princeton, New Jersey, firm would provide evaluation of the project.

A subcommittee member lamented that all Medicaid behavioral health care dollars are tied up with Centennial Care and posited that this program would be a wiser use of those funds. The member said he would be willing to sponsor a bill to reallocate some of these dollars.

The project concept was recommended for endorsement by the LHHS, and Senator Ortiz y Pino agreed to sponsor the bill.

Proposal to Protect and Expand Behavioral and Primary Health Services in School-Based Health Clinics

Adrian Carver, president-elect of the board of directors of the New Mexico Alliance for School-Based Health Care, described his organization's proposal to protect and expand school-based health centers. It is a project that transcends politics and will provide significantly increased return on investment, Mr. Carver said (see handouts). The $3.325 million request for funding through the Office of School and Adolescent Health of the Department of Health (DOH) proposes to add 20 new clinics over a five-year period and to increase hours of operation at existing clinics. Studies show that the investment will increase the state's graduation rate, he asserted. Suzanne Gagnon, a long-time nurse practitioner and now a Robert Wood Johnson Foundation (RWJF) nursing and health policy fellow at the RWJF Nursing and Health Policy Collaborative, described the fluid relationship between health and education, and the economic benefit of place-based care. School-based health clinics offer primary care and behavioral health services in the same location, she said, and analyses of services provided show a potential sixfold return on investment for the community (see handout).

On questioning, a member asked the presenters whether clinics can be self-sustaining. Mr. Carver said it costs approximately $300,000 a year to run a clinic and about half of that may be reimbursable through Medicaid, depending on where the clinic is located. There are currently 52 school-based health clinics in New Mexico providing more than 45,000 visits a year. Previously, there were more clinics, but funding was reduced during the economic downturn and some clinics were closed, Mr. Carver explained. A member said he found the project budget confusing and suggested that a more detailed budget be developed with the Office of School and Adolescent Health before presentation to the Legislative Finance Committee.

The proposal was approved for recommendation to the LHHS, and Senator Ortiz y Pino agreed to sponsor the legislation.

Heading Home Proposal

Dennis Plummer, CEO of Albuquerque Heading Home, emphasized the strong connection between housing and health, and he asserted that state investments in the physical and

behavioral health systems are ineffective when someone does not have a home. Mr. Plummer said that there clearly is power behind the Heading Home model based on its success and that it is the smart way to do the right thing (see handout). He noted that Albuquerque Heading Home has been invited to present at an upcoming international conference in Brazil, and officials from Anaheim, California, who are looking into replicating the model in their community, have made several visits to Albuquerque. In addition, Albuquerque Heading Home was featured by the federal Substance Abuse and Mental Health Services Administration in its September 2014 newsletter (see handout). Albuquerque Heading Home is currently housing more than 400 individuals and families and has a retention rate of over 80 percent. Mr. Plummer described the basic tenets of the program and how it has resulted in more than 31 percent savings over the cost of services traditionally provided to the homeless population, as verified by several different studies (see handouts).

The $10.9 million proposal being set forth today would provide an opportunity to replicate the success of Albuquerque Heading Home in other New Mexico communities, Mr. Plummer said. Over a five-year period, targeted communities would include Las Cruces, Santa Fe, Farmington and Gallup, and the program budget includes the calculation that more than $5 million would be saved by the state over that same period (see handout). The five counties selected, including a ramp-up of the program in Albuquerque during the first year, are those that show the greatest need in the state, he said. Each community would have its own metrics, project manager and multiple case managers hired from existing agencies and would collaborate with other agencies and volunteers in the community. While there would be plenty of opportunity to tailor specific needs to the community, contracts would require that the successful Albuquerque model be followed. Nearly everyone has a family or home somewhere, Mr. Plummer commented about the homeless, but many have lost that connection. He has seen many families reunited once the homeless person becomes stabilized with housing.

This project was recommended for endorsement by the LHHS, and Senator Ortiz y Pino agreed to sponsor the legislation.

Proposal to Increase Psychiatric Nurse Practitioners in New Mexico

Pamela Schultz, Ph.D., R.N., associate dean and director of the School of Nursing at New Mexico State University (NMSU), presented a six-year proposal to increase the number of psychiatric/mental health nurse practitioners graduating from NMSU, which has the only program in the state (see handout). Dr. Schultz noted that the plan would include offering stipends and tuition assistance to students willing to sign an agreement to deliver services in rural and underserved areas upon graduation for at least three years, utilizing mobile devices and telehealth modalities. Challenges to the plan include identifying 24 qualified students each year to enter the program and locating sufficient clinical sites to support the expanded admissions, as well as increasing credentialed faculty. Dr. Schultz presented budgets for each of the six years, varying from $1.11 million to $1.54 million, and also described future plans for a nurse-managed clinic at NMSU, although this project has not yet been approved by the administration. The need

for more trained psychiatric health workers in New Mexico is critical because of the expansion of Medicaid and an estimated one-in-four adults living with a serious mental health condition.

Wayne Lindstrom, Ph.D., director of the Behavioral Health Services Division (BHSD) of the Human Services Department (HSD), who was in the audience, agreed that psychiatric nurse practitioners are important extenders to work force shortages, noting a greater need for these practitioners specializing in treating children. Dr. Schultz explained that there is only one certification, but courses have been added to the curriculum specific to treatment of children and adolescents, as well as to the elderly. Vicente Vargas, state director for the Office of Government Relations at NMSU, who also was in the audience, was urged by a subcommittee member to ask the Board of Regents of NMSU for its endorsement of this proposal.

This proposal was approved for a letter of recommendation to the LHHS, and Senator Papen offered to sponsor the legislation.

Behavioral Health and Primary Care Coordination: New Mexico Health Connections (NMHC) Perspective

Matt McFadden, senior director of behavioral health management for NMHC, told members he was very excited about the proposals he heard today, and he then proceeded to describe the advent of his own organization, which is run by a board of directors composed of physicians and clinicians. Profits go to lower premiums and improved benefits, Mr. McFadden said, and it came about because it was mandated by the federal Patient Protection and Affordable Care Act. As a nonprofit health insurance cooperative, NMHC is able to provide better coverage at a lower cost, he said. NMHC is committed to patient-centered coordinated care and has assembled a network of health care providers focused on keeping consumers healthy and out of the hospital. Mr. McFadden described three coordination-of-care projects that are under way: 1) coordinating care when it is not co-located; 2) coordinating co-located care; and 3) coordinating care that is fully integrated. NMHC is also in the first year of a pilot project for diabetes sufferers who are screened for behavioral health issues, and it plans to expand this project to cover other chronic disease sufferers. Educating behavioral health care providers to the benefits of coordinated care is another goal of the organization, he said.

A member noted that NMHC does, indeed, have the lowest premiums on the New Mexico Health Insurance Exchange. The member asked Mr. McFadden about "medical necessity" and how it is defined by the NMHC. It is defined according to New Mexico Medical Society guidelines and standards, Mr. McFadden said, but NMHC has the ability to override a determination. There is no limitation on the number of outpatient mental health visits, he added; NMHC leadership believes in mental health treatment. Asked about the finances of the nonprofit, Mr. McFadden said assets are better than expected and reserves have been left untouched so far.

During the delay before the next presentation, Ms. Mathis, at the behest of Senator Papen, passed out copies of documents provided by the HSD in response to Senator Papen's February 25

inquiry regarding the amount of funds still being withheld from provider agencies accused of fraud. The total dollar amount of claims and invoices currently subject to the pay hold is $11,339,515, according to the HSD spreadsheet provided, and these are being held in a non-interest-bearing account by OptumHealth New Mexico. A member noted that on page 3 of this packet, it is stated that Presbyterian Medical Services settlement funds were used to reimburse expenses of Valle Del Sol of New Mexico, Inc., and Turquoise Health and Wellness, Inc. The member said he found this source of payment to be very odd.

During the lull between presentations, a member asked Dr. Lindstrom for his opinion on the projects presented today. Dr. Lindstrom replied that the number-one priority should be to address work force issues. New Mexico is not producing or retaining enough service providers, Dr. Lindstrom said, and there are huge vacancies all across the state; with increased demand from the Medicaid expansion, it is the perfect storm. Money can be put in all of these programs, Dr. Lindstrom said, but without enough providers, what good will it do? He also pointed out that there are providers who are unable to be reimbursed; the laws are very complex and need to be reexamined. A member noted that New Mexico does not have reciprocity with other states for a social worker license and that this is a problem for providers. The upcoming legislative session would be a good time to address this, members of the subcommittee agreed.

Adolescent Transitional Living and Recovery Center Proposal

Jennifer Weiss-Burke, executive director of Healing Addiction in Our Community (HAC), presented a proposal seeking legislative funding for a transitional living and recovery center offering services that help reconnect adolescents in recovery to their families and communities and provide the motivation to remain in recovery (see handout). Ms. Weiss-Burke cited many previous accomplishments of her nonprofit organization, including service contracts with Bernalillo County and the City of Albuquerque, acquisition of capital outlay and United Way funds and, in collaboration with Bernalillo County, the purchase of six buildings on eight acres of land in the South Valley formerly owned by Hogares, Inc. Describing HAC's numerous collaborations for programs and services, Ms. Weiss-Burke said first-year funds are needed for a one-year pilot program at the center that will be a model for future operations. The pilot will serve a maximum of 10 males between the ages of 14 and 21, while HAC seeks to become licensed and certified as a group home able to access Medicaid funds. There has been a precipitous decline over the last decade in the number of psychiatric inpatient beds available in New Mexico, Ms. Weiss-Burke said, and there is reluctance by insurance companies and Medicaid to pay for long-term treatment. The need is particularly acute for adolescents who require inpatient treatment. Education, legislative activities and harm-reduction and abuse prevention campaigns are all part of HAC's current focus.

Ms. Weiss-Burke provided budget numbers for a five-year operation plan to serve up to 32 residents and projecting a total need of $1,023,601 in funding from the legislature for the five-year period. The HAC program has the capacity to save the lives of many young New Mexicans who are addicted and to return them whole to their families and communities, she said, instead of incurring the higher cost and harm that comes with incarceration.

The project was approved for a letter recommending endorsement to the LHHS. Senator Ortiz y Pino agreed to be the sponsor.

Youth Risk and Resiliency Survey

Dan Green, survey epidemiologist in the Injury and Behavioral Epidemiology Bureau of the DOH, described results of the 2013 New Mexico Youth Risk and Resiliency Survey (YRRS), which is conducted in the fall semester of odd-numbered years in middle school through high school as part of a national survey designed by the federal Centers for Disease Control and Prevention. The survey collects information on behaviors that risk student health and on protective (resiliency) factors, Mr. Green said (see handout). New Mexico is one of just a few states that produces data at county and school district levels. Partners, in addition to the DOH, include the Public Education Department, the BHSD, the UNM Prevention Research Center, school districts and the Navajo Nation, resulting in a very high-quality and detailed response, he said.

Participation in the 2013 YRRS involved 72 percent of students (16,390) in middle school and 67 percent of high school students (18,080), well above the 60 percent national average participation, Mr. Green noted. While New Mexico's students report drug and alcohol use at rates significantly higher than the national average, results from the 2013 YRRS do contain some good news, Mr. Green said: alcohol use, some forms of tobacco use, some drug use and behaviors associated with violence have declined. In mental health, there was no change in the number of students reporting persistent sadness, but there was a big drop in suicide ideation and in self-harm behaviors, he said. Resiliency factors include parental involvement with the student, contact with a teacher who believes in the student's potential for success and having a friend the same age who cares about the student. The results of the survey show clearly that resiliency is important, Mr. Green concluded. What parents, teachers and other adults say and do matters to youths.

Public Comment

David Burke urged support for HAC's adolescent treatment program, noting that it is a bipartisan proposition. Kids deserve a second chance, he said, regardless of what their addictions are. He invited legislators to come to Albuquerque and walk through the treatment center site. The results of three neighborhood meetings have been supportive of the project, he said, and plans now are to open the center in the first quarter of 2015. More than 150 volunteers have donated countless hours to this project, which will help youths from all over the state. Because HAC is a nonprofit, Mr. Burke suggested that funding come through the BHSD.

Adjournment

There being no more business before the subcommittee, the meeting was adjourned at 4:10 p.m.

DISABILITIES CONCERNS SUBCOMMITTEE MINUTES

MINUTES
of the
FIRST MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

August 15, 2014
Room 307, State Capitol
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, vice chair, on August 15, 2014 at 9:40 a.m. in Room 307 at the State Capitol in Santa Fe.

Present
Sen. Nancy Rodriguez, Vice Chair
Sen. Craig W. Brandt
Sen. Linda M. Lopez
Rep. James Roger Madalena

Absent
Rep. Doreen Y. Gallegos, Chair
Rep. Nora Espinoza

Advisory Members
Rep. Miguel P. Garcia
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta

Guest Legislator
Sen. Gerald Ortiz y Pino

Staff
Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)
Rebecca Griego, Records Officer, LCS
Nancy Ellis, LCS

Guests
The guest list is in the meeting file.

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

Friday, August 15

Call to Order and Introductions

Senator Rodriguez welcomed those assembled and asked subcommittee members and staff to introduce themselves.

Employment of Persons with Disabilities

Jim Jackson, executive director of Disability Rights New Mexico, gave members of the subcommittee an overview of two recent federal initiatives that could provide more jobs at higher wages for individuals with disabilities. He also described options for potential state legislation that could promote such employment by state contractors (see handout). Before detailing the federal initiatives, Mr. Jackson cited "dismal employment statistics" for persons with disabilities: over 11.8 percent of working-age New Mexicans have a disability; the unemployment rate for persons with disabilities is 6.5 to 7.2 percent higher than for nondisabled workers; and workers with disabilities earn 20 to 23 percent less than those without disabilities.

Section 503 of the federal Rehabilitation Act of 1973 applies to businesses that contract to provide goods and services to the government. It prohibits discrimination in employment against persons with disabilities and requires affirmative action to employ and promote persons with disabilities. Amendments to this section, which became effective this past March, apply to all federal contractors with contracts worth $10,000 or more. A written affirmative action plan is required of businesses with 50 or more employees and at least $50,000 in contracts. Major changes to the regulations include a work force utilization goal that at least seven percent of employees in each work group or company as a whole must be persons with disabilities as defined by the federal Americans with Disabilities Act of 1990 (ADA); new requirements for data reporting (number of applicants, how many self-identify as disabled and how many were hired); permission to ask applicants, pre-offer and, again, post-offer, to voluntarily disclose a disability as part of an affirmative action program; and a survey of existing employees on a voluntary basis every five years. A contractor not meeting the utilization goal is required to self-assess whether there are barriers to equal opportunity employment and, if so, must develop a plan to address those barriers. Mr. Jackson said that sheltered workshops cannot be used to meet the utilization goal and cannot be part of an affirmative action plan unless the company hires those persons in bona fide jobs at prevailing wages. If the overall goals of the new regulations are met, there could be employment for 600,000 additional persons with disabilities, Mr. Jackson said.

The second initiative is Executive Order #13658, issued by President Obama on February 12, 2014, that establishes a minimum wage of $10.10 for most employees of most federal contractors, the wage increasing each year based on the Consumer Price Index. This order applies to procurement contracts for construction covered by the federal Davis-Bacon Act, contracts for services provided to or on behalf of federal agencies covered by the federal Service Contract Act of 1965, contracts to operate concessions and contracts related to use of federal property or lands and involving services provided to federal employees, their dependents or the general public. The executive order does not apply to federal grants, contracts or grants to Indian

tribes, contracts for public utilities or contracts to provide materials, supplies or equipment to the federal government. Employees covered by this executive order include those entitled to minimum wage under the federal Fair Labor Standards Act of 1938 or the Service Contract Act, laborers and mechanics covered by the Davis-Bacon Act and employees covered because they are working on federal contracts. The order specifically includes workers with disabilities who are otherwise paid less than the minimum wage by contractors authorized to pay sub-minimum wage. Such workers now must be paid at least $10.10 per hour for work performed on federal contracts covered by the executive order, which is expected to be finalized no later than October 1, 2014.

Similar legislative initiatives could be adopted at the state level, Mr. Jackson said, requiring at least minimum wage for anyone working on a state contract. The state also could give preference in bidding as an option to address the significant underemployment of New Mexicans with disabilities.

On questioning, Mr. Jackson and subcommittee members discussed the following topics.

Legality of paying less than minimum wage to disabled workers. Mr. Jackson said that a New Mexico contractor can pay an employee with disabilities less if that individual is not as productive, but typically this is done through a nonprofit or a sheltered workshop, a process which must be monitored through periodic reports. Speaking from the audience, Mike Kivitz, president and chief executive officer (CEO) of Adelante Development Center in Albuquerque, said that when there is any payment differential, records must be kept to justify it. It is less efficient to have two people doing the job of one, he said, and containing costs means managing labor expenses. For-profit companies can do this as well as nonprofits, but if it was a good way to make money, then for-profits would be lining up. His organization agrees with increasing incentives, and the State Use Act does this.

Role of the State Use Act. The State Use Act is not a preference program, Mr. Jackson explained, rather it is a set-aside. A state agency or local public body contracting for services is required to first offer the contract to businesses or individuals who are on an approved list of vendors or products provided by persons with disabilities. A purchasing council determines and updates this list. A member asked who is on this council and whether the executive branch asserts control. The council has nine members, Mr. Jackson said, five of whom are state employees. Those five members pick the other four, two who represent either a nonprofit or contractor, and two who must be persons with disabilities. Mr. Jackson noted that Mr. Kivitz was a member of this council. There are issues with some purchasers who feel they should have the right to choose when it comes to contracting for professional services, Mr. Jackson said. The State Use Act has been effective, he said, with more than 500 New Mexicans working under it.

Expansion of ADA definitions of "disability". Definitions in the ADA have been updated and broadened from court decisions in related cases, Mr. Jackson said. He cited a United States Supreme Court ruling that eyeglasses or prosthetics can mitigate a disability and that an individual using these may not be classified as a person with a disability. A member inquired

about alcoholism and illegal drug use under ADA definitions. A recovering person is a protected category, Mr. Jackson said, including persons with a history of mental illness that is being controlled by medication. The member asked if the state could adopt the new federal Section 503 regulations. Yes it could, Mr. Jackson said, and it would be good public policy.

Update on Centennial Care (CC) for Developmental Disabilities (DD) Waiver Recipients and Persons on Wait List; Update from the Income Suppport Division of the Human Services Department (HSD)

Brent Earnest, deputy secretary, HSD, provided a fact sheet (see handout) to subcommittee members describing the successful transition to CC of more than 400,000 members on January 1, 2014 and of an additional 143,474 who have signed up under the adult Medicaid expansion category as of July 8, 2014. Mr. Earnest detailed new benefits and features of CC, including care coordination, community benefit, community interveners and a member rewards program intended to encourage individuals to become more active in their health care. He also described ongoing Native American advisory meetings that seek to facilitate enrollment, access to care and payment for services for Native Americans, as well as to address other concerns. Care coordination is central to the program, Mr. Earnest said, with every individual CC member receiving a health risk assessment. Many new initiatives were launched at the same time, he said, and some problems have been encountered with the state's ASPEN computer program in processing data from the four managed care organizations (MCOs) and with the eligibility portal. As problems arise, they are being addressed, he assured members. The HSD is meeting with the Department of Health (DOH) to help facilitate the release of state funding to increase DD waiver provider rates by November 1, if not sooner, Mr. Earnest said, and hopefully to make these increases retroactive to July 1.

On questioning, Mr. Earnest, Jennifer Thorne-Lehman, deputy director of the Developmental Disabilities Supports Division (DDSD), DOH, and subcommittee members addressed the following topics.

Need for accurate data reporting. Mr. Earnest and Ms. Thorne-Lehman agreed that information technology issues have created problems in the CC rollout, and they said that MCOs have been asked not to deny provider payment claims until a fix is in place. Members asked for, and Mr. Earnest and Ms. Thorne-Lehman agreed to provide, data on behavioral health dollars and how they are being spent, the number of individuals who have accessed applied behavioral analysis (ABA) for autism, the calendar and locations for quarterly consumer meetings, the number of members in each level of care coordination and a breakdown of categories for the approximately 6,300 individuals on the DD waiver central registry (wait list). Another member asked for an age breakdown of this list as well, and for information on the evaluation process for applicants.

Concerns about Supports Intensity Scale (SIS) evaluations. Several members asked about the current status of the SIS and asked for data on those who requested to retake the assessment. The vast majority of reassessments have been completed, Ms. Thorne-Lehman said, although she did not have specific data today on whether those reassessed individuals went up or down in

category, but she will get this to the subcommittee. The HSD has contracted with the University of New Mexico (UNM) to train for and conduct SIS assessments locally rather than using an out-of-state contractor, and the process is going much more smoothly. Also, families are better educated about the SIS beforehand, she said.

Efforts to reduce the DD waiver wait list. Ms. Thorne-Lehman said that last year, 400 individuals were brought off the wait list into waiver services. There were 326 letters of invitation sent out this spring, with 182 selecting either Mi Via or the DD waiver. Because this is below the target of 226, another batch of letters will be sent out, she said. There has been an increase in persons selecting Mi Via, which is a more cost-effective program, and perhaps after looking at the budget, it will allow additional persons to be moved off the wait list and into services.

Adequate staffing levels. Ms. Thorne-Lehman said that the DDSD hired two temporary workers in fiscal year (FY) 2014, and temporary workers are again being sought for FY 2015. One position has been posted as the result of retirement. Temporary workers are involved in efforts to update information on the wait list.

Outreach to Native Americans. A member asked that the MCOs make a report to the LHHS on outreach. He has heard much about a contract with Native American Professional Parent Resources, Inc., but has no idea how this group has spent the money. He would like a report to the Indian Affairs Committee as well, since he is concerned about getting the word out to rural tribal areas.

Provider Panel: Update on DOH Provider Rate Increases

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, spoke for her membership when she stated that the developmental delay and disability service systems are unsustainable and that provider agencies are struggling for survival due to increased operating costs and a lack of rate increases (see handouts). Funding for rate increases appropriated for Family Infant Toddler program (FIT) providers, the DD state general fund program providers and for Medicaid DD waiver providers, which has not yet been released, will help providers, she said, but it will not make them whole. Ms. Hatanaka said she is concerned that $1 million of this appropriation is in danger of reverting to the general fund since the DOH has taken so long to implement the increase. In addition to sustainable rate increases, she urged the DOH to streamline practices, simplify and reduce compliance costs and conduct a new FIT cost study since the recommendations of the previous 2003 study have never been fully funded (see handout). In addition to extreme fiscal challenges, provider agencies cannot compete with hospitals, schools and other entities in recruiting and maintaining staff.

Jim Copeland, executive director of Alta Mira Specialized Family Services, a nonprofit that serves people of all ages with developmental risks, delays or disabilities in Bernalillo County, expressed gratitude for the small provider rate increase. He said his organization lost more than $90,000 in funding last year, and the rates are based on a study that is 10 years old.

Early intervention providers continue to have additional requirements placed upon them, and a new federal law requires immediate services, even if the organization does not have the funding to provide them. The current rates do not cover the cost of services, he said.

Edward J. Kaul, CEO of ARCA, an Albuquerque nonprofit serving children and adults with developmental disabilities, noted that providers are being asked to serve persons with the highest level of needs at a very low rate. The legislature's help is needed to make this a sustainable system, he said. There has been a dramatic escalation in reporting and documentation requirements under the DD waiver, and there has been no support from the DOH for increased administrative costs. Mr. Kaul said his organization is eager to pay staff a living wage and benefits. At the core of a DD individual having a good life is knowing the staff and seeing them as members of the family.

Mr. Kivitz described 35 years of his organization's social service to the DD community. The last five years have been very rough, he said, and now Adelante is not sure it can survive. The nonprofit has lost $2.5 million since 2009, and Mr. Kivitz said it has been a nightmare trying to manage all of the additional standards. Adelante has lost $600,000 in each of the past two years as a provider of DD waiver services, and it may not be able to continue. Mr. Kivitz maintained that there is a disconnect between reality and the DDSD, drawing subcommittee members' attention to an invitation he just received to a "quality summit". If the state is serious about quality, he noted, it could cut the regulations. Providers have already given stacks of input to the DOH.

Donna Hooten has worked for LEADERS, a nonprofit assisting persons with developmental disabilities in Lea County, for the past 23 years and said she loves the people she has chosen to serve. In June 2011, her agency had to shut down its early childhood program due to financial losses. Since 2001, health insurance costs for employees have risen 94 percent, and the last increase for direct support staff was 24 cents per hour, and that was four years ago. With Lea County in an oil boom, Ms. Hooten said she cannot compete with other employers' wages, and LEADERS is now down 17 staff members. A $500,000 increase for provider rates statewide is a drop in the bucket, she said. Her agency will be $300,000 in the red by the end of the year and will have to dip into cash reserves, which will be gone in two years. Gary Beal, a long-time LEADERS board member, was recognized by the vice chair to speak from the audience. The strong economy in Hobbs makes it impossible for the nonprofit organization to compete with other employers, he said. There is nowhere else to turn, Ms. Hooten said, and she asked subcommittee members for their help.

On questioning, panel presenters, Ms. Thorne-Lehman and subcommittee members addressed the following topics.

Why is the DOH not requesting funds for rate increases? Ms. Thorne-Lehman said that because there have been reversions to the general fund over the last several years, it is thought that rate increases can be accomplished within the DD waiver budget. Another member inquired whether the department agrees that rate increases are needed; Ms. Thorne-Lehman said there is

agreement for the increases that have been requested. Asked if the state sets the rates, she said that it does, but the rates have to be approved by the federal government; regulations that came out in March require a transition plan to increase rates.

Importance of rate increases in the Legislative Finance Committee (LFC) budget process. A subcommittee member commented that legislators are sympathetic to this issue, but nothing happens. Rate increases have to be in the LFC budget or they are going nowhere. The vice chair said she would ask the LFC staff to make it a priority.

Autism Update Panel

Patricia Osbourn, deputy director of the UNM Center for Development and Disability (CDD) and director of the Autism and Other Developmental Disabilities Program at the UNM CDD (see handout), said the world of autism is changing rapidly. Prevalence of autism spectrum disorder (ASD) is now one in 68 children, according to the latest report from the federal Centers for Disease Control and Prevention, Ms. Osbourn said. In New Mexico, 370 to 390 new cases are being diagnosed every year. At the UNM CDD, there are two multidisciplinary clinics, one for children under the age of three and the other for three-year-olds up to the age of 21, the latter group not having the benefit of early intervention. The ratio of males to females with ASD diagnosis is five to one, she said, with nearly half at average or above-average IQ. The wait list for evaluation in New Mexico is long — 10 months — and many school districts will not serve these students unless they have an evaluation from UNM, further delaying help for these children.

A lot of research is being conducted on ASD currently, and the American Academy of Pediatrics is recommending that screening be done at 18 and 24 months to rule out ASD using valid screening tools, Ms. Osbourn said. ABA does benefit children in early intervention, and Medicaid will pay for this, but details have not yet been worked out. ABA is expensive, requiring 15 to 20 hours per week of hands-on interaction by persons who are supervised. A registered behavior technician will be required to have 40 hours of training, and the UNM CDD will be piloting a program this year for 40 individuals. The UNM CDD has received numerous calls from Medicaid MCOs for autism-specific assistance, and many families have reported problems with behavioral health services, she said. The behavioral piece of ASD is huge.

Gay Finlayson, education and outreach manager of the UNM CDD, said the advent of CC has affected this population. Last year, funding was appropriated to establish an oversight team for MCOs to problem-solve on autism, she said, and hopefully to establish a standard approach to out-of-state residential treatment, which can cost upwards of $250,000 a year. Residential treatment is not a preferred approach and is done strictly for safety issues when the child is a danger to self or others. Ms. Finlayson said there is a need to look at best practices, since many out-of-state residential programs do not have autism expertise. Medicaid home- and community-based services for ASD are not reimbursed by CC. School educators are very interested in ASD and eager for training (see handout), and the UNM CDD is hoping to partner with other groups to help make significant changes.

Ms. Finlayson was asked by a member about a residential program in Albuquerque. There is a program in Albuquerque where families have been sending their children, she said, but there have been some problems, and it is not on the UNM CDD's list of recommended facilities. Asked whether CC and the MCOs have been helpful, Ms. Finlayson said that care coordination has been difficult and that efforts to resolve ABA therapy issues have been delayed until October.

Public Comment

Robert Kegel, a parent and an advocate for the developmentally disabled, provided subcommittee members with a copy of a stipulated interim agreement from United States district court between John and Karin Waldrop, parents of a disabled individual, and the HSD (see handout). The agreement, dated June 26, 2014, provides that people in SIS categories C through G who feel that their health and safety are at risk can go through the H application process. The SIS was designed by bureaucrats and is against state law, Mr. Kegel asserted, because it was done without proper geographic meeting distribution or public meeting notices. Mr. Kegel described difficulties for a friend whose daughter needed more care than her SIS category allowed and who faced extended delays in paperwork to change categories and for case manager replacement. The daughter is now in hospice.

Mr. Kegel also referred to a deposition taken last week regarding the Burns rate study for a trial that begins Monday. Burns was brought in by the state to set the rates the state wanted, Mr. Kegel asserted, but all that is needed now is to plug real numbers from providers into the Burns framework. He added that the department can easily obtain a blanket waiver from the Centers for Medicare and Medicaid Services for rate increases, instead of waiting to go through each and every small rate change. Critics claim that New Mexico's DD waiver costs are among the highest in the nation, Mr. Kegel said, but this is not true. He would ask them to compare instead the states' administrative costs for the DD waiver program, contending that New Mexico's administrative costs are extraordinary and among the highest in the nation. These folks think they are money managers, Mr. Kegel concluded, but they are not folks who care for people.

Adjournment

There being no further business, the subcommittee adjourned at 3:40 p.m.

MINUTES
of the
SECOND MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

September 9, 2014
Barbara Hubbard Room, Pan American Center
New Mexico State University
Las Cruces

The second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Doreen Y. Gallegos, chair, on Tuesday, September 9, 2014, at 9:15 a.m. in the Barbara Hubbard Room of the Pan American Center at New Mexico State University (NMSU) in Las Cruces.

Present	**Absent**
Rep. Doreen Y. Gallegos, Chair	
Sen. Nancy Rodriguez, Vice Chair	
Sen. Craig W. Brandt	
Rep. Nora Espinoza	
Sen. Linda M. Lopez	
Rep. James Roger Madalena	

Advisory Members	
Rep. Phillip M. Archuleta	Rep. Miguel P. Garcia
Rep. Edward C. Sandoval	
Rep. Elizabeth "Liz" Thomson	

Guest Legislators
Sen. Howie C. Morales
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen
Sen. William P. Soules

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

Guests
The guest list is in the meeting file.

Handouts

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

Tuesday, September 9

Call to Order and Introductions

Representative Gallegos welcomed those assembled and asked subcommittee members and staff to introduce themselves. She then introduced Garrey E. Carruthers, president of NMSU and former governor of New Mexico.

Welcome

President Carruthers welcomed the subcommittee to the NMSU campus and described several recent developments, including near-completion of construction on a nondenominational spiritual center funded by a private donation, as well as the upcoming grand opening of Pete V. Domenici Hall, which will house the Domenici Institute for Public Policy. President Carruthers also described plans for a privately funded $26 million College of Osteopathic Medicine to be located at NMSU. While the college will be privately owned and operated, its students will pay full student fees and become an integral part of the campus. Osteopathic medical schools tend to produce more primary care doctors, which are in short supply in New Mexico, President Carruthers noted, and similar privately owned schools are already operating at Auburn University and Virginia Tech. A full presentation about plans for the new osteopathic college will be made at tomorrow's meeting of the LHHS.

Southern New Mexico Provider Panel Update

Pam Lillibridge, chief executive officer (CEO) and president, Tresco, described her organization as a nonprofit based in Las Cruces that has provided supports and services for developmentally delayed or disabled children and adults in southern New Mexico for more than 30 years. The success of agency programs is not in doubt, Ms. Lillibridge asserted, but their sustainability is. Tresco struggles to keep and retain staff despite the small increase in Family Infant Toddler (FIT) program provider rates, with competition for providers coming from public schools and other government entities. Ms. Lillibridge also held up a two-inch-thick, 268-page stack of state regulations and standards with which the agency must comply — up from just 49 pages in 1998. Health insurance costs for her organization increased by 40 percent last year, she said, and the transition to Centennial Care (CC) has been rocky. Ms. Lillibridge touted the success of Tresco's supported employment programs, but she said her organization has been challenged by lowered reimbursement rates for these programs. She urged the state to revisit rates and standards and to look at which programs actually work.

Evangeline H. Zamora, CEO, Life Quest, Inc., described her organization, a community-based nonprofit that has provided services to individuals and their families with or at risk for developmental disabilities for more than 35 years. Life Quest is based in Silver City and serves Grant, Luna, Hidalgo and Catron counties. Ms. Zamora described grave difficulties for the

organization, which began to see declines in revenue in 2012 following changes in rates and difficulties with the new Supports Intensity Scale (SIS) assessment. As a consequence, her board of directors decided to eliminate supportive living services, along with initiating salary cuts, benefits reductions, elimination of raises and the layoff of 20 employees. Therapists often have to travel a long way, sometimes as many as four hours, for one hour of reimbursement, Ms. Zamora said, and she would like to echo Ms. Lillibridge's comments that this system is unsustainable. Both CEOs lamented the delay of the rate increase for service providers on the Medicaid developmental disabilities (DD) waiver. FIT providers were given a raise, but DD waiver providers are still waiting, they said.

Peggy Denson-O'Neill, CEO, Zia Therapy Center, Inc., described her organization, which is based in Alamogordo and has provided services in Otero County for 54 years. Ms. Denson-O'Neill also described financial difficulties for her organization and problems with hiring and retaining employees. Zia can no longer afford to provide insurance for employees, she said, and while her organization used to have a very experienced staff, this is no longer true; the result is what she described as an alarming loss of institutional memory. In Zia's FIT program, there has been reduced revenue, coupled with increased unfunded mandates from the federal Patient Protection and Affordable Care Act and Race to the Top, and the difficult proposition of an increased minimum wage statewide. The DD wait list is a problem, she said, but the system cannot provide the services and centers will continue to close. Ms. Denson-O'Neill sounded an alarm to subcommittee members: rate increases for providers are crucial to the survival of services in New Mexico.

On questioning, Ms. Lillibridge, Ms. Zamora, Ms. Denson-O'Neill and subcommittee members addressed the following topics.

How to convey the critical nature of this issue to the Legislative Finance Committee (LFC). A member commented that unless rate increases are in the budget, nothing will happen. Ruby Ann Esquibel, principal LFC analyst, who was in the audience, responded that a one-hour hearing on the Department of Health (DOH) budget preview is scheduled for October 30 at 12:30 p.m. at the State Capitol, and all are invited to attend. Members agreed that more than five minutes in front of the LFC would be required to make a persuasive case for rate increases, and they urged Ms. Esquibel to take their concerns back to the LFC director. Ms. Esquibel said rate increases are part of the DOH budget, but another member cautioned that if the increase is part of the DOH budget, money likely will not get to where it needs to go. A guest legislator agreed with members' concerns and urged a more formal request to the LFC in the form of a letter. A motion was made, seconded and passed unanimously to send a letter from both this subcommittee and the LHHS chairs and vice chairs to request time for this issue to be presented to the LFC.

The burden of increased regulation. Ms. Lillibridge explained that the stack of papers she held up for subcommittee members represents state service standards for providers; it is equivalent to a day-to-day operations manual, she said. The standards, which also are used by

the Quality Management Bureau of the DOH to evaluate providers, have increased tenfold since 1998.

Where is the $500,000 appropriated for DD waiver provider rate increases by July 1? Cathy Stevenson, deputy secretary, DOH, speaking from her seat in the audience, said that those DD provider funds are part of the complex Medicaid budget, and because of information technology (IT) difficulties and the need for federal approval, the funds have not yet been released. The delayed provider rate increases are expected to be released in October or November, Ms. Stevenson said, and they will be retroactive to July 1.

What happened to clients whose services have been eliminated? Ms. Zamora said that some Life Quest clients were picked up by a for-profit agency in Grant County, but there were folks being served under the state general fund that were not picked up. For clients on DD waiver services, some may have to move to other counties in order to continue to receive services, she said.

The chair thanked the panel presenters, adding that she felt subcommittee members needed to hear the realities facing these providers and hear about services that already have been dropped.

Navigating Autism Services in Southern New Mexico

Abel Covarrubias, CEO, Aprendamos Intervention Team, and board chair and co-founder, Hearts for Autism Fund, provided some statistics for autism, which is five times more likely to occur in boys than girls and usually becomes evident before the age of three. Autism has a huge economic impact, Mr. Covarrubias said, with costs estimated at $17,000 annually to care for a child with autism and overall costs to society of $11.5 billion each year. It takes four to six months to get an evaluation for a child under three years old, he said, and for children over age three, there is a nine-to-12-month wait list at the University of New Mexico (UNM). There is a limited number of psychologists who are qualified to diagnose autism, Mr. Covarrubias said, and he would like to see additional funding for more teams at a local level to diagnose and provide early intervention services.

Marisa Cano, Hearts for Autism Fund board member, parent liaison, teacher and the parent of two children with autism, said she knows first-hand the many challenges of diagnosis and treatment. Some families have a diagnosis from a neuropsychologist, but they lack the full workup and evaluation required by schools in order to tailor services, she said. Behavior therapy teaches functional skills in order for a child to become productive and to engage with family and society. Parents with Medicaid have better access to services with no co-pay, but insured children often do not get services because co-pays are a barrier. Ms. Cano said she was doing initial visits with families, planning to hand them off to other resources, but those have not materialized under CC, nor under private insurance, either. She has had to make the decision for her family to stop working in order to care for her children, but then her family no longer has the financial resources to pay for therapy. Under CC, everything has come to a standstill, Ms. Cano said, because the guidelines for autism spectrum disorder are not available.

Michael Gutierrez, certified applied behavior analysis (ABA) therapist, said he helps to identify children's deficits and address these deficits with new adaptive skills. ABA is an intense and specialized therapy for young children and has shown a success rate of 50 percent who can enter a regular kindergarten classroom, Mr. Gutierrez said. While there are thousands of certified ABA therapists nationwide, there are only 25 to 30 such therapists in New Mexico, and more need to be brought into the state. Early intervention can decrease the average lifetime cost of $2.4 million per person by two-thirds, Mr. Gutierrez asserted.

A member asked what would be needed to create a local team. Mr. Covarrubias explained that there are specific criteria about which professionals should be on such a team. If funding were to become available, his board would locate the appropriate staff for the program. Ms. Cano agreed that the community desires a local option; not everyone can afford the travel to UNM or the co-pays for evaluations. The presenters said they want to put funding for a Las Cruces center on the legislators' radar and also to ask that consumers and providers be included on the state's Autism Coordination of Care Council, which now consists only of representatives of managed care organizations and state agencies.

Tour of Speech and Hearing Center/Luncheon Presentation on NMSU Cleft Palate and Rural Outreach Programs

Hearing loss in New Mexico adults and children has many different causes, and the Edgar R. Garrett Speech and Hearing Center at NMSU has remained dedicated for more than 60 years to providing cutting-edge diagnoses, treatments and services. During a luncheon tour, subcommittee members were introduced to staff and to several state-of-the-art instruments used in the clinic, and introduced to a group of consumers and family members who provided heart-rending accounts of successful treatment and excellent follow-up from staff at the center. The ultimate goal for the center's consumers of all ages is independence.

A PowerPoint presentation by the Department of Special Education and Communication Disorders during lunch highlighted NMSU's Cleft Lip and Palate Center (see handout), which provides surgery and follow-up speech and dental services for approximately 50 cases a year, as well as clinical training for graduate students. Arrowhead Medical Academy, a satellite facility for the speech and hearing center, will open in October, providing hearing aid services to the community for the first time in a corporate partnership with ReSound. The presentation also described autism services and research, with NMSU providing assistive technology for classroom instruction and teacher training for a graduate certificate in autism. The autism program aims to improve screening and early diagnosis and to create statewide clearinghouses and conferences to disseminate information on evidence-based practices to schools, parents, caregivers and other interested parties.

DOH Update: DD Waiver Wait List; SIS; Provider Rate Increases; Vacancy Rates

In response to a request from the subcommittee's chair and vice chair for up-to-date information on the above topics, Ms. Stevenson provided information to members (see handout) with current details on the Medicaid DD waiver program. As of June 30, 2014, there were 3,988

individuals being served on the DD waiver, and an additional 601 individuals were enrolled in Mi Via (self-directed services), bringing the total to 4,589, Ms. Stevenson said. As of August 15, 2014, there were 6,052 individuals on the DD central registry (wait list), broken down as follows: 1,404 in "start" status (new applications), 696 in "pending" status (eligibility not yet determined), 397 in "allocation on hold" status and 3,625 in "completed" status. Ms. Stevenson also presented a draft spreadsheet (not yet vetted with Medicaid) showing program costs, allocations and reversions for fiscal year (FY) 2014 and projections through FY 2016. The program reversion to the general fund for FY 2014 is $6,863,509. This number is projected to be $1,830,766 for FY 2015, while a shortfall of $4,472,076 is projected for FY 2016, which Ms. Stevenson said she was confident could be covered by changes within the DOH. The DD waiver program budget is over $102 million. Ms. Stevenson noted that the DD waiver wait list is down for the first time, and she said the DOH goal is to at least keep even.

Several pages of Ms. Stevenson's handout detailed increased rates (ranging between 1.5 to three percent) for customized in-home support, supported living and customized community support groups, as well as rate increases in FY 2015 for some individual supported employment (see handout). The DOH will continue to work with stakeholders and Medicaid on the best systemic approach to address needs on a long-term basis, she said. Ms. Stevenson reiterated that the reason additional funding approved by the legislature last year to increase DD waiver provider rates has not yet been distributed is due to IT problems, but these will be resolved no later than November, and rate increases will be retroactive to July 1, 2014.

Regarding questions about additional staffing needs, Ms. Stevenson said that in recent years, funding for services has grown, but funding for system development and staff has not. She asserted that current language in the state budget does not provide the flexibility needed to address provider and staff capacity. Allowing flexibility in the use of funds that cannot be spent for direct service or appropriating available funds more purposefully across budgeting categories would assist the DD waiver program to operate more effectively.

Lastly, Ms. Stevenson provided members with a graph of DD waiver consumers in each of the SIS group categories (A through G) utilized to determine levels of service need (see handout). The total number of individuals who have been given the SIS assessment is 3,895. Ms. Stevenson said that New Mexico contractors, rather than out-of-state contractors, are now being utilized to conduct the assessments, and the DOH has been working closely under a contract with UNM on training.

On questioning, Ms. Stevenson and subcommittee members addressed the following topics.

Why has the DOH not asked for additional funding to reduce the DD wait list? Ms. Stevenson said that this decision is an administrative one and is an effort to manage the program with resources already in place. Ms. Stevenson denied that the current 15 percent vacancy rate in the department is a factor in not moving more people forward onto the waiver. Last year, 418

individuals were brought into the program, she noted, with this number including the 70 who replaced individuals already on the waiver who died or moved out of state. A member noted that moving 300-plus persons off the list each year does not seem like a strategy. Ms. Stevenson responded that the state cannot spend more money than it has in the budget. She confirmed that the DOH's FY 2016 budget request of $102 million for its Developmental Disabilities Supports Division does not include any new funding to take individuals off the wait list onto the waiver, noting that capacity is an issue. If there are not enough providers to deliver more services, the services will not happen, she said. The division has been meeting with providers, Ms. Stevenson said, and plans to return to an hourly calculation for rates rather than the current 15-minute measure, which has been difficult for providers. She agreed that increased documentation has become a burden to providers, and she said one of her staff is currently working to simplify and streamline the department's regulations. Ms. Stevenson said the DOH would be supportive of an independent rate study, but she cautioned that funding not be given to the department for this, as the study would immediately become suspect. A member expressed disappointment that departments continue to bring in flat budgets and said there does not appear to be much commitment to the DD community. Ms. Stevenson responded that the DOH is committed to take whatever funds are available and to use whatever flexibility it is given to get DD consumers off the wait list and into services.

Questions about reassessment and changes to SIS scores. Ms. Stevenson said that all adults on the DD waiver have received an SIS assessment. Looking at the graph she provided, a member noted that it looked like a bell curve instead of individualized assessments. Ms. Stevenson said she would expect this type of distribution, and she noted that before the SIS, there was an annual resource assessment for each consumer. The department is trying to be a better steward of the money, she added, and now some services require preauthorization. Under questioning, Ms. Stevenson estimated that between 650 and 700 SIS reassessments have been completed, but she did not have these exact numbers, nor numbers of how many scores changed to a higher level of need. Six months ago, the figure was high — about 70 percent, she said. The first SIS costs $850, and the reassessment is a higher cost, but Ms. Stevenson did not have those figures available.

Comparison of services and provider rates to those in other states. Ms. Stevenson said rates are higher in New Mexico, but it is very difficult to compare services and rates nationally. New Mexico offers more services than many other states, and new services have recently been added. She reiterated her support for an independent rate study.

Public Comment

Doris Husted, public policy director for the ARC NM, mother of a DD waiver consumer and chair of the Central Registry Subcommittee (formerly the Senate Memorial 20 Task Force), which is working on a plan for the state to move people off the waiting list into services, told members that increasing capacity is not just a DOH issue. The Human Services Department and its Income Support Division (ISD) are involved, and there has to be capacity at the ISD for

processing certifications, she said. Funding to keep staff is critical, because if staff changes every few months, quality of services will suffer. Long-term relationships are paramount.

Carol Bernstein, a parent advocate, said the system is not working. The SIS was originally intended to assess ability, not to be paired with funding. Once a certain score is achieved, that is the level of funding unless damage can be shown. Therapy is gone, gains are lost and everything is a bigger mess, she said. The department says people are not complaining: half of these folks do not have a place to work, do not have command of the English language and often have no guardian. Ms. Bernstein questioned the role of the SIS in reducing the wait list and asked if it is worth it.

Jim Jackson, executive director of Disability Rights New Mexico, summarized today's testimony: providers need rate increases and yet the DOH has not asked for a single penny for this. There is no push by the DOH to get people off the wait list into the waiver, no plan to make any progress with the wait list and no new money requested. It feels like we are in exactly the same place as last year, he said. There have been complaints, and his organization has been in federal district court with eight families on specific issues, including problems with fair hearings; a ruling is expected later this year. Mr. Jackson advised legislators to insist on regular data from the department and to pass a bill directing the department to come up with a plan and budget to reduce the DD wait list.

Maureen Grant, an employee of Tresco, said access to care for those with disabilities is a continuing challenge in Las Cruces. Someone who was getting 30 to 40 hours of service now cannot get help to go to the doctor because hours have been reduced. Moving forward, the aging population will need more support and help paying for medications.

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, reminded the subcommittee that her members are still desperately awaiting the small rate increase promised to them starting July 1. She urged that last year's $500,000 for FIT provider rate increases and the $500,000 for DD waiver providers become an annual part of the DOH budget. It is not fair to compare New Mexico rates to other states because New Mexico is one of the few states that does not have public institutions, so outpatient rates appear more costly.

Al Sanchez said he has spent 27 years working in supported employment. Lives are being changed for the better with a dedicated direct care staff, he said, but fair compensation is a critical issue. Staff needs to be compensated fairly. This is an economic issue, he said: jobs can be created by serving these individuals.

Wes Jackson, president of the student body at NMSU, told the subcommittee that paratransit services for students with disabilities have been outsourced to the City of Las Cruces and are working well. It is hoped that the program can be expanded in the future.

Adjournment

There being no further business, the subcommittee adjourned at 4:00 p.m.

MINUTES
of the
THIRD MEETING
of the
DISABILITIES CONCERNS SUBCOMMITTEE
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

October 9, 2014
Hotel Albuquerque, Franciscan Room
Albuquerque

The third meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Representative Doreen Y. Gallegos, chair, on Thursday, October 9, 2014, at 10:28 a.m. at the Hotel Albuquerque in Albuquerque.

Present
Rep. Doreen Y. Gallegos, Chair
Sen. Nancy Rodriguez, Vice Chair
Sen. Linda M. Lopez
Rep. James Roger Madalena

Absent
Sen. Craig W. Brandt
Rep. Nora Espinoza

Advisory Members
Rep. Miguel P. Garcia
Rep. Edward C. Sandoval
Rep. Elizabeth "Liz" Thomson

Rep. Phillip M. Archuleta

Guest Legislators
Sen. Gerald Ortiz y Pino
Sen. Mary Kay Papen

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

Guests
The guest list is in the meeting file.

Minutes Approval
Because the committee will not meet again this year, the minutes for this meeting have not been officially approved by the committee.

Handouts

All handouts and other written material are in the meeting file.

Thursday, October 9

Welcome and Introductions

Representative Gallegos welcomed subcommittee members, staff and members of the audience, many of whom are attending the three-day Southwest Conference on Disability being held concurrently at Hotel Albuquerque. It was noted that 2015 is the twenty-fifth anniversary of the federal Americans with Disabilities Act of 1990 (ADA) and the fiftieth anniversary of Medicaid.

Repeal of the Federal Marriage Penalty for Persons with Disabilities

Marilyn Martinez, advocate for the disabled, is an artist and long-time proponent of changing federal law so persons with disabilities do not lose half of their benefits by getting married. Ms. Martinez said she has been writing to New Mexico's congressional delegation since 2000, and she feels the time is right to make this effort again. She provided members with a copy of a 2007 memorial from the state legislature requesting federal action on this and information about the Supplemental Security Income (SSI) Restoration Act of 2014 (S.2089) that was introduced in the U.S. Senate last year and proposes to restore some, but not all, of the benefits to married persons who are disabled. Nat Dean, who has traumatic brain injury and is also an advocate for this change, provided a sample letter for subcommittee members, legislators and other interested persons requesting New Mexico's congressional delegates to urge removal of this federal penalty. Ms. Martinez said that SSI is the only federal assistance program to penalize individuals for marriage; neither the Temporary Assistance for Needy Families Program nor the Supplemental Nutrition Assistance Program has a similar penalty. The marriage penalty under SSI perpetuates the image of disabled persons not being expected to fully participate in society, she said.

Upon questioning, Ms. Martinez provided details of the current law, apparently based on the philosophy that two people can live more cheaply than one. Two disabled individuals can live together and each gets full benefits, but if they get married, their benefits are reduced 24.9 percent, and the amount of resources each can hold is reduced. If only one person in the marriage is disabled and receives SSI benefits, the penalty still applies, and individuals may lose their benefits altogether depending upon the couple's income and assets. A member commented on Ms. Martinez's extensive efforts on behalf of the disabled community, including hosting a public access television show about disability issues, and stated that this penalty helps keep people in poverty by preventing them from saving to buy a house or car, or for education or retirement. Another member made a motion to direct LCS staff to prepare letters to the Social Security Administration and other appropriate agencies and departments and urged that an effort be made to revisit the 2007 memorial. The motion was seconded and passed unanimously.

Provider Rates Increases

Anna Otero Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, acknowledged that she has appeared multiple times this interim to testify on the need for provider rate increases, and she said she is extremely concerned that disaster is looming; she is trying to provide education about the crumbling provider infrastructure. Some agencies are no longer providing certain services, others have laid off staff and some are closing their doors altogether. Recently, she and other advocates met with Keith Gardner, the governor's chief of staff, and provided a letter to the governor from the New Mexico Family Infant Toddler (FIT) Interagency Coordinating Council asking for rate increases to prevent many agencies from discontinuing FIT services (see handout).

Mark Johnson, chief executive officer (CEO) of Easter Seals/El Mirador, thanked members of the subcommittee for their advocacy, and he described his agency's 40-year history of providing community-based services in northern New Mexico. The rate structure of the developmental disability (DD) waiver program directly impacts the financial viability of his own organization, Mr. Johnson said. Direct care professionals have stringent hiring requirements — drug screens and criminal record and background checks — yet pay is low and turnover is high, often because of burnout. It is very difficult to find qualified staff willing to work with this population, he said, and the high turnover impacts compliance and quality improvement. Six organizations already have left the region because they could not maintain their agencies on current rates of reimbursement.

Rex Davidson, executive director of Las Cumbres Community Services, said his organization serves 6,000 square miles in northern New Mexico with a variety of support services. Las Cumbres is headquartered in Espanola, is the FIT provider in Rio Arriba County and provides behavioral health and other services in Los Alamos, Santa Fe and Espanola. It is very challenging to provide community-based services in rural areas, Mr. Davidson said, and now many organizations with boards of directors are having to make tough decisions on which programs to keep. His organization spent $250,000 on travel last year, and the mileage paid to employees for home-based services is not reimbursed. He thanked legislators for the rate increase approved last year that his providers have not yet received; whether that increase will be enough to make a difference remains to be seen. Supported employment is being lost across the state, Mr. Davidson reported, because services cost more to provide than are reimbursed. Supported living also is not financially viable. Work force issues are much worse now than they were nine months ago because Centennial Care's four large managed care organizations (MCOs) offered many of his employees as much as 80 percent more than they were making with Las Cumbres, Mr. Davidson said, and it simply was not possible to compete. Audits are now conducted two to three times a year, and while they should be constructive, they are adversarial, he said. More agencies are going to be lost, and the situation is critical.

Gwendolyn Kiwanuka is director of adult services for LifeRoots, an Albuquerque nonprofit organization that provides services to children and adults with developmental, physical and behavioral disabilities. Inadequate reimbursement has forced her agency to cut back on

supported employment, and LifeRoots providers also are still waiting for the rate increase promised in July. Agencies are expected to deliver quality services, but LifeRoots has not been able to give staff rate increases for the last five years, Ms. Kiwanuka said. She urged members to convince the state to establish appropriate rates.

Peggy O'Neill, CEO of Zia Therapy Center, Inc., in Alamogordo, told members that during the last fiscal year, four different DD waiver services lost significant amounts of revenue at her agency. The FIT Program lost $102,000 and in previous years was staffed by personnel with over 20 years experience; now their most experienced provider has been with the center for just 18 months. They train providers, then they get hired away, Ms. O'Neill said. New Mexico has been at the top in quality for the FIT Program, but the state has been subsidizing it on the backs of providers, she asserted. Without immediate help, her company is going to be closing programs. Zia has been an important employer in the community, she said, and emergency funding is needed as soon as possible.

Ms. Hatanaka told subcommittee members that $5 million is needed for the DD general fund program, $5 million is needed for Medicaid DD waiver services and $5 million is needed for the FIT Program.

On questioning, panel participants and subcommittee members discussed the following topics.

Status of the rate increases. Cathy Stevenson, director of the Developmental Disabilities Supports Division, Department of Health, who was recognized by the chair from the audience, said that the increased rates will be implemented by November 1 and will be retroactive to July 1, 2014. Delays are due to needed changes in codes with Medicaid and information technology issues with New Mexico's Medicaid computer system. Ms. Stevenson said her division is monitoring this delay daily. A member noted that if money is not in the proposed budget at the Legislative Finance Committee (LFC), rate increases will not get funded. Ms. Hatanaka said that her providers have been allotted 10 minutes to present to the LFC in late October. The chair provided a copy of a letter dated October 1, 2014 from the subcommittee to the LFC requesting additional time for service providers to present their urgent issues.

Why audits are increasing. Mr. Davidson said audits are conducted by the state, the MCOs, the attorney general, Xerox and OptumHealth. There are program audits, financial audits and *Jackson* compliance audits, he said, and their numbers have increased dramatically in the past two years. His company spends a lot of time and money on staff to handle these audits. Too many entities can request whatever they want for whatever time frame they desire, Mr. Johnson said. A subcommittee member asserted that multiple audits are a waste of taxpayer money and agency resources, while many issues that matter greatly are not getting the resources.

Status of Easter Seals/El Mirador fraud investigation. Mr. Johnson said the Human Services Department (HSD) re-referred Easter Seals/El Mirador's case back to the attorney

general after it had been cleared of fraud because the HSD maintained that the wrong criteria had been used in the investigation. While Mr. Johnson was told it would take just a few weeks to clear it up, it has now been more than four months, and no one from the Office of the Attorney General has contacted Easter Seals/El Mirador. A member asked about funds that have been withheld from Easter Seals/El Mirador for Medicaid services. The funds — $650,000 for services that were delivered — are still being withheld, Mr. Johnson said, adding that to this day, there has been no disclosure of the allegations and no due process; his company has been waiting for 17 months.

Accounting of agency funds held in escrow by OptumHealth. The chair asked if there was anyone in the audience from OptumHealth or the HSD who could explain what is going on with that escrow account. Hearing no response, a member moved that a letter be sent to the HSD asking for a complete accounting from OptumHealth of all funds being held back from all 15 agencies and of any interest earned. The motion was seconded and approved unanimously.

2014 House Memorial 9 (HM 9) Status Report

Elizabeth Peterson, director of the Brain Injury Advisory Council, said that HM 9 directed the council to conduct a statewide concussion needs assessment for middle and high school athletes and for veterans to address concerns about people who have suffered concussions and not obtained proper diagnosis and treatment. Presenting with Ms. Peterson was Robert Thoma, Ph.D., associate professor in the Department of Psychiatry and Behavioral Sciences and the Center for Neuropsychological Services at the University of New Mexico (UNM) School of Medicine.

Dr. Thoma said a team already has been assembled to support this cutting-edge study, including participation from UNM's Brain and Behavioral Health Institute. The youth concussion study received human-subject approval in early fall, and now an awareness program is under way aimed at coaches, pediatricians, primary care providers and others, he said. A second study will involve the Veterans' Services Department in assessing veterans who suffer from traumatic brain injury and determining what resources are available to them. There is no funding for the veterans' study yet, Dr. Thoma said, but a team of UNM medical students has begun to gather information. Ms. Peterson emphasized that service gaps need to be identified for all New Mexico residents and a comprehensive system of treatment needs to be developed, especially in rural areas.

2014 House Memorial 87 (HM 87) Report

Susan Gray, chair, Governor's Commission on Disability (GCD), and Heather Stanton and Yvonne Dance, both of the Homeland Security and Emergency Management Department (HSEMD), provided reports on HM 87 (see handouts). This memorial requested the GCD to ensure that New Mexico's emergency operations plan (EOP) complies with Title II of the ADA and to identify barriers to compliance with or deficiencies in the plan. Ms. Gray referred to well-publicized problems with evacuations of people with disabilities after Hurricane Katrina in New

Orleans and Hurricane Sandy in New York City, and she emphasized the state's legal obligation to provide these individuals with appropriate emergency evacuation plans.

Formal recommendations of the work group, presented by Ms. Stanton, included a revision of the EOP to include explicit language regarding compliance with Title II of the ADA; incorporation of an accessible statewide emergency mass notification system into the EOP and emergency management, with a funded position at the HSEMD to manage this; and changes in state law to provide the HSEMD with the regulatory authority and personnel to adequately oversee ADA compliance of all current local emergency plans. Additionally, the work group advised the creation of a second task force to be charged with reviewing literature for the best evidence-based practice, an analysis of barriers and potential solutions, and the development of an inclusive ADA-compliant plan. This plan should include provisions for needs assessment guidance, technical support and training and individual preparedness and determine details and funding for the additional HSEMD position.

In conclusion, Ms. Gray said, it is in the best interests of the state to take a proactive approach to planning for and including individuals with disabilities in emergency management and response. Not only is this the law, she said, but also the state bears considerable liability for its disabled residents in the event of a disaster.

During discussion following the presentation on HM 87, Anthony Alarid, access specialist with the GCD, described a long-standing issue at the State Capitol regarding restrooms. There is no women's restroom off the legislative house lounge, and female members and staff must walk to a different part of the building to access a restroom. Mr. Alarid presented plans to turn the existing men's restroom into a women's restroom and convert an existing unisex restroom into the men's restroom. The elimination of the unisex restroom requires a code variance; an alternative location for the required unisex restroom has been identified on the second floor and will allow greater public access. Mr. Alarid provided members with copies of the code variance request, floor plans and plans for funding of the new unisex restroom.

Update on *Waldrop v. New Mexico Human Services Department*

Jim Jackson, executive director of Disability Rights New Mexico (DRNM), introduced Jason Gordon, a staff attorney with DRNM who is working on litigation filed last January in federal court against the HSD regarding its provision of services under the DD waiver and its use of the Supports Intensity Scale (SIS) tool. In 2013, the HSD began using the SIS tool to determine support needs for every individual on the DD waiver, with each being assigned a letter group A through G. The budget for services is capped for each group with few exceptions, G being those with the most intense needs. This has resulted in fewer services than previously available to some in the A and B groups, Mr. Gordon explained, and his organization has received numerous complaints from consumers and treatment providers about the reduction in services. An interim agreement has been reached with the state, Mr. Gordon reported, so those individuals in groups A and B would not be forced to change their living situations or have their

therapies reduced during the pendency of this litigation. A three-day hearing was held in August, and it is anticipated that a ruling may come by the end of the year.

There are three major problems being addressed by this lawsuit, Mr. Jackson explained. The first of these is that the conduct of the SIS assessment is not sufficiently individualized as required by federal law when consumers are assigned to one of the large groups. Service providers who attended SIS assessments have reported that their input was not taken into account. A second issue is that the SIS is purported to be one of many factors taken into account in determining service level needs, but it appears that the SIS is being used as the sole measure, Mr. Jackson said. The third issue involves due process violations; federal Medicaid law requires a fair hearing process, and this has not been working the way the law requires, Mr. Jackson asserted. A SIS evaluation takes two to three hours, but the evaluator is never brought to court during a fair hearing. Instead, the state brings in several HSD employees who testify in general terms, but who have never even met the consumer who was evaluated. Additionally, a budget has to be made and approved in order to be appealed, and there has been considerable confusion among caregivers and case managers about the appeal process. The DRNM asserts that the appeal process should have been promulgated as rules, and it is asking the court to restore benefits to consumers until the case is decided.

Mr. Jackson explained that the DRNM is not asking the court to set aside the SIS. The state has every right to choose an assessment tool, he said. What is being asked is for the state to comply with state and federal law in its assessment process. If a consumer loses services, that individual must be allowed to dispute the decision, and this has not been happening. In multiple DRNM lawsuits brought in district court, all were decided in favor of DD waiver participants, he said.

On questioning by subcommittee members, Mr. Jackson described the Fair Hearings Bureau within the HSD, which makes the determination, with the director of the Medical Assistance Division (MAD) of the HSD making the final decision. Generally, SIS assignment cases pursued on behalf of consumers by the DRNM in administrative hearings (approximately 15) have been decided in favor of the HSD, he said. A member noted that in some states, the SIS is being utilized to determine when more services are needed instead of as a tool to dismantle services. It is constituents who are in limbo, the member asserted, adding that perhaps New Mexico should go back to the drawing board.

Proposed Amendment to the State Use Act

Scott Scanland, lobbyist for San Juan College and the City of Farmington, distributed a copy of the proposed legislation to members (see handout). Senator William E. Sharer's bill would add one percent to the five percent advantage already established in the State Use Act to create a preference for certain businesses owned by or operated in the interest of persons with disabilities. It also would require a formal request for proposals and competitive bid process that would render the system one of "preference" instead of an automatic set-aside with no competition. This legislation would continue the New Mexico Council for Purchasing from

Persons with Disabilities' role in the process but would eliminate the exemption from the provisions of the Procurement Code.

Senator Sharer answered members' questions about the State Use Act and changes that he is proposing. The state purchasing agent is the head of the council, and its membership is composed of more than just state employees; it also includes persons with disabilities who own a business and other persons with disabilities. A member commented that persons with disabilities can be mainstreamed and should compete just like anyone else, but agreed that it is appropriate to give a slight preference.

Minutes Approved

Minutes from the September 9, 2014 meeting were unanimously approved, with the correction that Senator Lopez was present, not absent as listed.

Public Comment

Sheila Johnson said she came to the meeting today to ask for help with her daughter's service dog that is in need of medical care. She pointed out that Medicaid will pay up to $20,000 for a specialized wheelchair, but her request for reimbursement of more than $10,000 for the service dog has been denied, even though the dog's services have been "prescribed". Ms. Johnson said she has been doing fundraisers and has contacted the American Service Dogs and rescue at Petco and other organizations for help, but she does not know where else to turn. A subcommittee member agreed that there is a need to help pay for these dogs and suggested that this concern be brought to the MAD.

Danny Palma said he has a child on the DD waiver wait list and reported that it is a myth that New Mexico's waiver is among the most expensive in the country. Mr. Palma provided a spreadsheet with detailed information about this (see handout). However, New Mexico's wait list is 900 percent longer than the average state's wait list. There is never going to be enough capacity, Mr. Palma said, but that should not be a reason to delay funds for getting more people off of the wait list and into services.

Jim Parker spoke about the importance of access to medical marijuana, with more people able to use it for pain, muscle spasms and sleep disorders, among others. Mr. Parker said he is tired of the negative side effects from using pharmaceuticals and that he intends to apply for a prescription for medical marijuana. It is unfortunate that insurance will not cover this remedy, Mr. Parker said, and he urged legislators to look into this.

Ms. Stanton, who testified earlier on HM 87, said she is personally passionate about the importance of including the disabled in emergency planning. She pointed out the class action lawsuit against former Mayor Michael Bloomberg in New York City for ad hoc accommodations during Hurricane Sandy is driving the urgency of action in New Mexico, stating that advance planning is in the best interests of all residents.

Charles Powell said he was speaking on behalf of a woman who is blind and uses a service dog. She has suffered many indignities at the hands of private businesses and public employees, he said. The root of the problem is that people who serve the public do not know what the law requires of them, Mr. Powell said. Private businesses and public agencies should require their employees to be aware of ADA requirements so that those with disabilities do not have to suffer indignities.

June Montoya has a 27-year-old daughter on the DD waiver who is looking for a more independent living situation, but she does not find a lot of options. She wants to live with roommates of her own choosing who are closer to her in age. Supported living situations are limited, Ms. Montoya said, and she is hoping to find more options that will work for her daughter rather than options determined by a provider agency.

Ellen Pinnes, an attorney with DRNM, said she wants to follow up on the State Use Act discussion, which is a complex issue. One of the shortcomings of the act is that it does not promote integrated employment. Ms. Pinnes said she would be happy to work with any group seeking to promote everyday employment rather than having a totally separate system.

Adjournment

There being no further business, the subcommittee adjourned at 4:30 p.m.

ENDORSED LEGISLATION

2015 Legislation Endorsed by the Legislative Health and Human Services Committee

1	197295.1	assisted outpatient treatment	Sen. Mary Kay Papen
2	197308.6	psychotropics & children	Rep. Nora Espinoza
3	197321.1	Medicaid home visiting	Rep. James Roger Madalena
4	197322.1	Medicaid newborn home visiting	Sen. Gerald Ortiz y Pino
5	197379.1	5-yr plan for DD waiting list	Sen. William P. Soules
6	197397.5	dental therapy	Sen. Benny Shendo, Jr.
7	197417.1	Medicaid provider due process	Sen. Mary Kay Papen
8	197425.1	LHHS Committee changes	Sen. Gerald Ortiz y Pino
9	197483.1	UNM Pain Management Center	Sen. Michael Padilla
10	197492.1	WICHE funding for dental students	Sen. Michael Padilla
11	197496.1	UNM research on oculopharyngeal MD	Sen. Michael Padilla
12	197499.2	victims of human trafficking services	Sen. Gerald Ortiz y Pino
13	197500.2	supportive housing/CYFD	Rep. Elizabeth "Liz" Thomson
14	197607.1	vaccine purchasing	Sen. Bill B. O'Neill
15	197639.2	SJM: health care innovation waiver	Sen. Jacob R. Candelaria
16	197668.5	universal motorcycle safety helmets	Sen. Peter Wirth
17	197670.1	amend Adolescent Treatment Hospital Act	Sen. Gerald Ortiz y Pino
18	197678.3	HM: parental leave working group	Rep. Gail Chasey
19	197710.1	sexual assault services in correctional facilities	Rep. Emily Kane
20	197714.1	sexual assault services in correctional facilities	Rep. Christine Trujillo
21	197761.3	pregnancy accommodation	Rep. Gail Chasey
22	197774.2	SJM: LGBT health disparities task force	Sen. Jacob R. Candelaria
23	197806.1	provider nondiscrimination	Sen. Mary Kay Papen
24	197818.2	behavioral health parity	Rep. Elizabeth "Liz" Thomson
25	197910.1	small group health plan transparency	State Auditor Timothy M. Keller
26	197942.1	BA/DDS appropriation to UNM	Sen. Howie C. Morales
27	197990.1	inmates & Medicaid enrollment	Sen. Gerald Ortiz y Pino
28	198019.2	health security	Sen. Howie C. Morales
29	198138.1	Focus Milagro program funding	Sen. Bill B. O'Neill

30	198139.1	beh health warm line & clearinghouse	Sen. Gerald Ortiz y Pino
31	198143.1	SJM: explore basic health plan	Sen. Gerald Ortiz y Pino
32	198144.1	beh health training in community clinics	Sen. Gerald Ortiz y Pino
33	198148.1	PMH nurse practitioners at NMSU	Sen. Mary Kay Papen
34	198153.1	beh health in school-based health centers	Sen. Gerald Ortiz y Pino
35	198155.1	West Mesa SB health center	Sen. Jacob R. Candelaria
36	198158.1	voter registration through NMHIX	Sen. Jacob R. Candelaria
37	198160.1	state employee obesity coverage	Sen. Jacob R. Candelaria
38	198176.1	supportive housing - Heading Home	Sen. Gerald Ortiz y Pino
39	198177.1	adolescent in-state trans. services	Sen. Gerald Ortiz y Pino
40	198179.1	all-payer claims database	Sen. Linda M. Lopez
41	198311.1	statewide nurse advice line participation	Sen. Sue Wilson Beffort

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
AND THE COURTS, CORRECTIONS AND JUSTICE COMMITTEE

AN ACT

RELATING TO HEALTH CARE; ENACTING THE ASSISTED OUTPATIENT TREATMENT ACT; PROVIDING FOR ASSISTED OUTPATIENT TREATMENT PROCEEDINGS; REQUIRING PUBLIC HEALTH SURVEILLANCE AND OVERSIGHT; PROVIDING FOR SEQUESTRATION AND CONFIDENTIALITY OF RECORDS; PROVIDING FOR PENALTIES; AMENDING THE MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CODE TO REQUIRE DATA COLLECTION FOR CERTAIN PROCEEDINGS; MAKING APPROPRIATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 17 of this act may be cited as the "Assisted Outpatient Treatment Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the Assisted Outpatient Treatment Act:

A. "advance directive for mental health treatment"

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means an individual instruction or power of attorney for mental health treatment made pursuant to the Mental Health Care Treatment Decisions Act;

B. "assertive community treatment" means a team treatment approach designed to provide comprehensive community-based psychiatric treatment, rehabilitation and support to persons with serious and persistent mental illness;

C. "assisted outpatient treatment" means categories of outpatient services ordered by a district court, including case management services or assertive community treatment team services, prescribed to treat a patient's mental illness and to assist a patient in living and functioning in the community or to attempt to prevent a relapse or deterioration that may reasonably be predicted to result in harm to the patient or another or the need for hospitalization. Assisted outpatient treatment may include:

(1) medication;

(2) periodic blood tests or urinalysis to determine compliance with prescribed medications;

(3) individual or group therapy;

(4) day or partial-day programming activities;

(5) educational and vocational training or activities;

(6) alcohol and substance abuse treatment and counseling;

underscored material = new
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(7) periodic blood tests or urinalysis for the presence of alcohol or illegal drugs for a patient with a history of alcohol or substance abuse;

(8) supervision of living arrangements; and

(9) any other services prescribed to treat the patient's mental illness and to assist the patient in living and functioning in the community, or to attempt to prevent a deterioration of the patient's mental or physical condition;

D. "covered entity" means a health plan, a health care clearinghouse or a health care provider that transmits any health information in electronic form;

E. "department" means the department of health;

F. "least restrictive appropriate alternative" means treatment and conditions that:

(1) are no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives; and

(2) do not restrict physical movement or require residential care, except as reasonably necessary for the administration of treatment or the protection of the patient;

G. "mandated service" means a service specified in a court order requiring assisted outpatient treatment;

H. "mental illness" means a substantial disorder of thought, mood or behavior that impairs a person's judgment, but does not mean developmental disability;

I. "patient" means a person receiving assisted

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outpatient treatment pursuant to a court order;

J. "protected health information" means individually identifiable health information transmitted by or maintained in an electronic form or any other form or media that relates to the:

(1) past, present or future physical or mental health or condition of an individual;

(2) provision of health care to an individual; or

(3) payment for the provision of health care to an individual;

K. "provider" means an individual or organization licensed, certified or otherwise authorized or permitted by law to provide mental health diagnosis or treatment in the ordinary course of business or practice of a profession;

L. "qualified protective order" means, with respect to protected health information, an order of a district court or stipulation of parties to a proceeding under the Assisted Outpatient Treatment Act;

M. "respondent" means a person who is the subject of a petition for assisted outpatient treatment; and

N. "treatment guardian" means a person appointed pursuant to Section 43-1-15 NMSA 1978 to make mental health treatment decisions for a person who has been found by clear and convincing evidence to be incapable of making the person's

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own mental health treatment decisions.

SECTION 3. [NEW MATERIAL] ASSISTED OUTPATIENT TREATMENT--CRITERIA.--A person may be ordered to participate in assisted outpatient treatment if the court finds by clear and convincing evidence that the person:

A. is eighteen years of age or older;

B. is suffering from a primary diagnosis of mental illness;

C. is unlikely to survive safely in the community without supervision, based on a clinical determination;

D. has:

(1) entered and the court has accepted a plea of guilty but mentally ill, or been found guilty but mentally ill or been found incompetent to stand trial; or

(2) demonstrated a history of lack of compliance with treatment for mental illness that has:

(a) at least twice within the last forty-eight months, been a significant factor in necessitating hospitalization or necessitating receipt of services in a forensic or other mental health unit or a correctional facility; provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period;

(b) resulted in one or more acts of

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serious violent behavior toward self or others or threats of, or attempts at, serious physical harm to self or others within the last forty-eight months; provided that the forty-eight-month period shall be extended by the length of any hospitalization or incarceration of the person that occurred within the forty-eight-month period; or

(c) resulted in the person being hospitalized or incarcerated for six months or more and the person is to be discharged or released within the next thirty days or was discharged or released within the past sixty days;

E. is unwilling or unlikely, as a result of mental illness, to participate voluntarily in outpatient treatment that would enable the person to live safely in the community without court supervision;

F. in view of the person's treatment history and current behavior, is in need of assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the person or another person; and

G. will likely benefit from assisted outpatient treatment.

SECTION 4. [NEW MATERIAL] PETITION TO THE COURT.--

A. A petition for an order authorizing assisted outpatient treatment may be filed in the district court for the county in which the respondent is present or reasonably

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believed to be present. A petition shall be filed only by the following persons:

(1) a person eighteen years of age or older who resides with the respondent;

(2) the parent or spouse of the respondent;

(3) the sibling or child of the respondent; provided that the sibling or child is eighteen years of age or older;

(4) the director of a hospital where the respondent is hospitalized;

(5) the director of a public or charitable organization or agency or a home where the respondent resides and that provides mental health services to the respondent;

(6) a psychiatrist who either supervises the treatment of or treats the respondent for a mental illness or has supervised or treated the respondent for mental illness within the past forty-eight months;

(7) a provider or social services official of the city or county where the respondent is present or reasonably believed to be present; or

(8) a parole officer or probation officer assigned to supervise the respondent.

B. The petition shall include:

(1) each criterion for assisted outpatient treatment as set forth in Section 3 of the Assisted Outpatient

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Treatment Act;

(2) facts that support the petitioner's belief that the respondent meets each criterion; provided that the hearing on the petition need not be limited to the stated facts; and

(3) whether the respondent is present or is reasonably believed to be present within the county where the petition is filed.

C. The petition shall be accompanied by an affidavit of a physician and shall state that:

(1) the physician has personally examined the respondent no more than ten days prior to the filing of the petition, that the physician recommends assisted outpatient treatment for the respondent and that the physician is willing and able to testify at the hearing on the petition either in person or by contemporaneous transmission from a different location; or

(2) no more than ten days prior to the filing of the petition, the physician or the physician's designee has made appropriate attempts to elicit the cooperation of the respondent but has not been successful in persuading the respondent to submit to an examination, that the physician has reason to believe, based on the most reliable information available to the physician, that the respondent meets the criteria for assisted outpatient treatment and that the

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physician is willing and able to examine the respondent and testify at the hearing on the petition either in person or by contemporaneous transmission from a different location.

SECTION 5. [NEW MATERIAL] APPLICATION FOR QUALIFIED PROTECTIVE ORDER--CONTENTS OF ORDER.--

A. A motion seeking a qualified protective order shall accompany each petition for an order authorizing assisted outpatient treatment.

B. The qualified protective order shall provide that:

(1) all parties to the proceeding and their attorneys are authorized to receive, subpoena and transmit protected health information pertaining to the respondent for purposes of the proceeding;

(2) all covered entities are authorized to disclose protected health information pertaining to the respondent to all attorneys of record in the proceeding;

(3) the parties and their attorneys are permitted to use the protected health information of the respondent in any manner reasonably connected to the proceeding, including disclosure to attorney support staff, experts, copy services, consultants and court reporters;

(4) within forty-five days after the later of the exhaustion of all appeals or the date on which the respondent is no longer receiving assisted outpatient

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treatment, the parties and their attorneys and any person or entity in possession of protected health information received from a party or the party's attorney in the course of the proceeding shall destroy all copies of protected health information pertaining to the respondent, except that counsel are not required to secure the return or destruction of protected health information submitted to the court;

(5) nothing in the order controls or limits the use of protected health information pertaining to the respondent that comes into the possession of a party or the party's attorney from a source other than a covered entity; and

(6) nothing in the order authorizes counsel for the petitioner to obtain medical records or information through means other than formal discovery requests, subpoenas, depositions or other lawful process, or pursuant to a patient authorization.

SECTION 6. [NEW MATERIAL] HEARING--RIGHTS OF RESPONDENT--EXAMINATION BY A PHYSICIAN.--

A. Upon receipt of a petition for an order authorizing assisted outpatient treatment, the court shall fix a date for a hearing:

(1) no later than seven days after the date of service or attempted service or as stipulated by the parties, or upon a showing of good cause, no later than thirty days after the date of service or attempted service; or

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(2) if the respondent is hospitalized at the time of filing of the petition, before discharge of the respondent and in sufficient time to arrange for a continuous transition from inpatient treatment to assisted outpatient treatment.

B. A copy of the petition and notice of hearing shall be served, in the same manner as a summons, on the petitioner, the respondent, the physician whose affirmation or affidavit accompanied the petition, the current provider, if any, and any other person that the court deems advisable.

C. If, on the date that the petition is filed, the respondent is under the supervision of a treatment guardian, a copy of the petition and notice of hearing shall be served, in the same manner as a summons, on the treatment guardian and on the court that appointed such treatment guardian.

D. The respondent shall be represented by counsel at all stages of the proceedings. The respondent shall have the right to present evidence and cross-examine witnesses. A record of the hearing shall be made, and the respondent shall have a right to an expeditious appeal to the court of appeals according to the rules of appellate procedure of the supreme court.

E. If the respondent fails to appear at the hearing after notice, and significant attempts to elicit the attendance of the respondent have failed, the court may conduct the

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hearing in the respondent's absence, setting forth the factual basis for conducting the hearing without the presence of the respondent.

F. The court shall not order assisted outpatient treatment for the respondent unless a physician, who has personally examined the respondent within ten days prior to the filing of the petition, testifies at the hearing in person or by contemporaneous transmission from a different location.

G. If the respondent has refused to be examined by a physician and the court finds reasonable grounds to believe that the allegations of the petition are true, the court may direct a peace officer to take the respondent into custody and transport the respondent to a provider for examination by a physician. The examination of the respondent may be performed by the physician whose affidavit accompanied the petition. If the examination is performed by another physician, the examining physician shall be authorized to consult with the physician whose affidavit accompanied the petition. No respondent taken into custody pursuant to this subsection shall be detained longer than necessary or longer than twenty-four hours.

SECTION 7. [NEW MATERIAL] WRITTEN PROPOSED TREATMENT PLAN.--

A. The court shall not order assisted outpatient treatment unless a physician:

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(1) provides a written proposed treatment plan to the court; and

(2) testifies in person or by contemporaneous transmission from a different location to explain the written proposed treatment plan.

B. In developing a written proposed treatment plan, the physician shall take into account, if existing, an advance directive for mental health treatment and provide the following persons with an opportunity to actively participate in the development of the plan:

(1) the respondent;

(2) the treating physician;

(3) upon the request of the respondent, an individual significant to the respondent, including any relative, close friend or individual otherwise concerned with the welfare of the respondent; and

(4) any court-appointed surrogate decision-maker, including a guardian or treatment guardian, who has previously been authorized by a court to make substitute decisions regarding the respondent's mental health.

C. The written proposed treatment plan shall include case management services or an assertive community treatment team to provide care coordination and assisted outpatient treatment services recommended by the physician. If the written proposed treatment plan includes medication, it

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shall state whether such medication should be self-administered or should be administered by an authorized professional and shall specify type and dosage range of medication most likely to provide maximum benefit for the respondent.

D. If the written proposed treatment plan includes alcohol or substance abuse counseling and treatment, the plan may include a provision requiring relevant testing for either alcohol or abused substances; provided that the physician's clinical basis for recommending such plan provides sufficient facts for the court to find that:

(1) the respondent has a history of alcohol or substance abuse that is clinically related to the mental illness; and

(2) such testing is necessary to prevent a relapse or deterioration that would be likely to result in serious harm to the respondent or others.

E. Testimony explaining the written proposed treatment plan shall include:

(1) the recommended assisted outpatient treatment, the rationale for the recommended assisted outpatient treatment and the facts that establish that such treatment is the least restrictive appropriate alternative;

(2) information regarding the respondent's access to, and the availability of, recommended assisted outpatient treatment in the community; and

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(3) if the recommended assisted outpatient treatment includes medication, the types or classes of medication that should be authorized, the beneficial and detrimental physical and mental effects of such medication and whether such medication should be self-administered or should be administered by an authorized professional.

SECTION 8. [NEW MATERIAL] DISPOSITION.--

A. If the respondent has an advance directive for mental health treatment or a personal representative, agent, surrogate, guardian or individual designated by the respondent to make health care decisions, the court shall take into account any advance directive for mental health treatment or directions by the personal representative, agent, surrogate, guardian or individual designated by the respondent in determining whether to adopt the written proposed treatment plan in an order mandating assisted outpatient treatment.

B. The court shall not enter an order authorizing assisted outpatient treatment for a respondent with a court-appointed surrogate decision-maker, including a guardian or treatment guardian, without notice to such surrogate decision-maker and an opportunity for hearing as provided in Section 6 of the Assisted Outpatient Treatment Act.

C. After a hearing and consideration of all relevant evidence, the court shall order the respondent to receive assisted outpatient treatment if it finds:

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(1) by clear and convincing evidence that grounds for assisted outpatient treatment have been established;

(2) that assisted outpatient treatment is the least restrictive appropriate alternative; and

(3) that assisted outpatient treatment is in the respondent's best interest.

D. The court's order shall:

(1) provide for an initial period of outpatient treatment not to exceed one year;

(2) specify the assisted outpatient treatment services that the respondent is to receive; and

(3) direct a specified provider to provide or arrange for all assisted outpatient treatment for the patient throughout the period of the order.

E. The court may order the respondent to self-administer psychotropic drugs or accept the administration of such drugs by an authorized professional. The order shall be effective for the duration of the respondent's assisted outpatient treatment.

F. The court may not order treatment that has not been recommended by the examining physician and included in the written proposed treatment plan for assisted outpatient treatment.

G. The court may order assisted outpatient

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treatment as an alternative to involuntary inpatient commitment if it finds assisted outpatient treatment to be a less restrictive alternative to accomplish treatment plan objectives.

H. For the duration of the assisted outpatient treatment and any additional periods of treatment ordered, the court may at any time on its own motion set a status hearing or conference and shall be authorized to require the attendance of the parties and their counsel, expert witnesses, treatment and service providers, case managers and such other persons as the court deems necessary.

SECTION 9. [NEW MATERIAL] EFFECT OF DETERMINATION THAT RESPONDENT IS IN NEED OF ASSISTED OUTPATIENT TREATMENT.--The determination by a court that a person is in need of assisted outpatient treatment shall not be construed as or deemed to be a determination that such person is incompetent pursuant to Section 43-1-11 NMSA 1978.

SECTION 10. [NEW MATERIAL] APPLICATIONS FOR CONTINUED PERIODS OF TREATMENT.--

A. If a provider determines that the condition of a patient requires further assisted outpatient treatment, the provider shall seek, prior to the expiration of the period of assisted outpatient treatment ordered by the court, a subsequent order authorizing continued assisted outpatient treatment for a period not to exceed one year from the date of

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the subsequent order. If the court's disposition of the application does not occur prior to the expiration date of the current order, the current order shall remain in effect until the court's disposition.

B. A patient may be ordered to participate in continued assisted outpatient treatment if the court finds that the patient:

(1) continues to suffer from a primary diagnosis of mental illness;

(2) is unlikely to survive safely in the community without supervision, based on a clinical determination;

(3) is unwilling or unlikely, as a result of mental illness, to participate voluntarily in outpatient treatment that would enable the patient to live safely in the community without court supervision;

(4) in view of the patient's treatment history and current behavior, is in need of continued assisted outpatient treatment in order to prevent a relapse or deterioration that would be likely to result in serious harm to the patient or another person; and

(5) will likely benefit from continued assisted outpatient treatment.

SECTION 11. [NEW MATERIAL] APPLICATION TO STAY, VACATE, MODIFY OR ENFORCE AN ORDER.--

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A. In addition to any other right or remedy available by law with respect to the court order for assisted outpatient treatment, the patient, the patient's attorney or any court-appointed surrogate decision-maker, including a guardian or treatment guardian, who has previously been authorized by a court to make substitute decisions regarding the patient's mental health may apply to the court to stay, vacate, modify or enforce the order. A copy of the application shall be served on the specified provider and the original petitioner.

B. The specified provider shall apply to the court for approval before instituting a proposed material change in mandated services or assisted outpatient treatment unless such change is contemplated in the order. An application for approval shall be served upon those persons required to be served with notice of a petition for an order authorizing assisted outpatient treatment. Nonmaterial changes may be instituted by the provider without court approval. For purposes of this subsection, "material change" means an addition or deletion of a category of assisted outpatient treatment and does not include a change in medication or dosage that, based upon the clinical judgment of the treating physician, is in the best interest of the patient.

C. A court order requiring periodic blood tests or urinalysis for the presence of alcohol or abused substances

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shall be subject to review after six months by a physician, who shall be authorized to terminate such blood tests or urinalysis without further action by the court.

SECTION 12. [NEW MATERIAL] FAILURE TO COMPLY WITH ASSISTED OUTPATIENT TREATMENT.--

A. A physician may determine that a patient has failed to comply with assisted outpatient treatment if, in the clinical judgment of the physician:

(1) the patient has failed a blood test, urinalysis or alcohol or drug test as required by the court order or has materially failed to comply with the treatment as ordered by the court despite efforts made to solicit compliance; and

(2) the patient needs an examination to determine whether hospitalization is necessary pursuant to the Mental Health and Developmental Disabilities Code.

B. Upon the request of a physician, a provider may transport a patient to any hospital authorized to receive such patient for the performance of an examination.

C. If deemed necessary and upon the request of a physician, a provider may request the aid of a peace officer to take the patient into custody and accompany the provider in transporting the patient to any hospital authorized to receive such patient. A peace officer shall carry out a provider's directive pursuant to this section.

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D. The patient may be retained for observation, care, treatment and further examination in the hospital for up to seventy-two hours to permit a physician to determine whether the patient is in need of hospitalization pursuant to the Mental Health and Developmental Disabilities Code. Any continued involuntary retention in a hospital beyond the initial seventy-two-hour period shall be in accordance with the provisions of the Mental Health and Developmental Disabilities Code relating to the involuntary admission and retention of a patient. If, at any time during the seventy-two-hour period, the patient is determined not to meet the involuntary admission and retention provisions of the Mental Health and Developmental Disabilities Code and the patient does not agree to stay in the hospital as a voluntary or informal patient, the patient must be released.

E. A patient's failure to comply with an order of assisted outpatient treatment is not grounds for involuntary civil commitment or a finding of contempt of court.

SECTION 13. [NEW MATERIAL] PUBLIC HEALTH SURVEILLANCE AND OVERSIGHT OF ASSISTED OUTPATIENT TREATMENT.--The department, in collaboration with the interagency behavioral health purchasing collaborative, shall conduct public health surveillance and oversight of assisted outpatient treatment through each county public health office.

SECTION 14. [NEW MATERIAL] COMBINATION OR COORDINATION OF

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EFFORTS AND FUNDING.--Nothing in the Assisted Outpatient Treatment Act shall be construed to preclude:

A. the combination or coordination of efforts among local governmental units, hospitals and other local service providers in providing assisted outpatient treatment; or

B. public or private funding of the administration or operation of assisted outpatient treatment services or infrastructure.

SECTION 15. [NEW MATERIAL] SEQUESTRATION AND CONFIDENTIALITY OF RECORDS.--

A. A petition for an order authorizing assisted outpatient treatment shall be entitled "In the Matter of _____" and shall set forth with specificity:

(1) the facts necessary to invoke the jurisdiction of the court;

(2) the name, birth date and residence address of the respondent; and

(3) any other substantive matters required by the Assisted Outpatient Treatment Act to be set forth in the petition.

B. All records or information containing protected health information relating to the respondent, including all pleadings and other documents filed in the matter, social records, diagnostic evaluations, psychiatric or psychologic

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reports, videotapes, transcripts and audio recordings of interviews and examinations, recorded testimony and the assisted outpatient treatment plan that was produced or obtained as part of a proceeding pursuant to the Assisted Outpatient Treatment Act shall be confidential and closed to the public.

C. The records described in Subsection B of this section shall be disclosed only to the parties and:

(1) court personnel;

(2) court-appointed special advocates;

(3) attorneys representing parties to the proceeding;

(4) the respondent's personal representative, agent, surrogate, guardian or individual designated by the respondent to make health care decisions;

(5) the respondent's treatment guardian;

(6) peace officers requested by the court to perform any duties or functions related to the respondent as deemed appropriate by the court;

(7) providers involved in the evaluation or treatment of the respondent;

(8) public health authorities or entities conducting public health surveillance or research or as otherwise authorized by law; and

(9) any other person or entity, by order of the

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court, having a legitimate interest in the case or the work of the court.

D. A person who intentionally releases any information or records closed to the public pursuant to the Assisted Outpatient Treatment Act or who releases or makes other use of the records in violation of that act is guilty of a petty misdemeanor.

SECTION 16. [NEW MATERIAL] CRIMINAL PROSECUTION.--A person who knowingly makes a false statement or provides false information or false testimony in a petition for an order authorizing assisted outpatient treatment is guilty of a petty misdemeanor.

SECTION 17. [NEW MATERIAL] EDUCATIONAL MATERIALS.--The department and the interagency behavioral health purchasing collaborative, in consultation with the administrative office of the courts, shall prepare educational and training materials on the provisions of the Assisted Outpatient Treatment Act, which shall be made available no later than January 1, 2016 to providers, judges, court personnel, peace officers and the general public.

SECTION 18. Section 43-1-3 NMSA 1978 (being Laws 1977, Chapter 279, Section 2, as amended) is amended to read:

"43-1-3. DEFINITIONS.--As used in the Mental Health and Developmental Disabilities Code:

A. "aversive stimuli" means anything that, because

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it is believed to be unreasonably unpleasant, uncomfortable or distasteful to the client, is administered or done to the client for the purpose of reducing the frequency of a behavior, but does not include verbal therapies, physical restrictions to prevent imminent harm to self or others or psychotropic medications that are not used for purposes of punishment;

B. "client" means any patient who is requesting or receiving mental health services or any person requesting or receiving developmental disabilities services or who is present in a mental health or developmental disabilities facility for the purpose of receiving such services or who has been placed in a mental health or developmental disabilities facility by the person's parent or guardian or by any court order;

C. "code" means the Mental Health and Developmental Disabilities Code;

D. "consistent with the least drastic means principle" means that the habilitation or treatment and the conditions of habilitation or treatment for the client, separately and in combination:

(1) are no more harsh, hazardous or intrusive than necessary to achieve acceptable treatment objectives for the client;

(2) involve no restrictions on physical movement and no requirement for residential care except as reasonably necessary for the administration of treatment or for the

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protection of the client or others from physical injury; and

(3) are conducted at the suitable available facility closest to the client's place of residence;

E. "convulsive treatment" means any form of mental health treatment that depends upon creation of a convulsion by any means, including but not limited to electroconvulsive treatment and insulin coma treatment;

F. "court" means a district court of New Mexico;

G. "department" or "division" means the behavioral health services division of the human services department;

H. "developmental disability" means a disability of a person that is attributable to mental retardation, cerebral palsy, autism or neurological dysfunction that requires treatment or habilitation similar to that provided to persons with mental retardation;

I. "evaluation facility" means a community mental health or developmental disability program or a medical facility that has psychiatric or developmental disability services available, including the New Mexico behavioral health institute at Las Vegas, the Los Lunas medical center or, if none of the foregoing is reasonably available or appropriate, the office of a physician or a certified psychologist, and that is capable of performing a mental status examination adequate to determine the need for involuntary treatment;

J. "experimental treatment" means any mental health

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or developmental disabilities treatment that presents significant risk of physical harm, but does not include accepted treatment used in competent practice of medicine and psychology and supported by scientifically acceptable studies;

K. "grave passive neglect" means failure to provide for basic personal or medical needs or for one's own safety to such an extent that it is more likely than not that serious bodily harm will result in the near future;

L. "habilitation" means the process by which professional persons and their staff assist a client with a developmental disability in acquiring and maintaining those skills and behaviors that enable the person to cope more effectively with the demands of the person's self and environment and to raise the level of the person's physical, mental and social efficiency. "Habilitation" includes but is not limited to programs of formal, structured education and treatment;

M. "likelihood of serious harm to oneself" means that it is more likely than not that in the near future the person will attempt to commit suicide or will cause serious bodily harm to the person's self by violent or other self-destructive means, including but not limited to grave passive neglect;

N. "likelihood of serious harm to others" means that it is more likely than not that in the near future a

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person will inflict serious, unjustified bodily harm on another person or commit a criminal sexual offense, as evidenced by behavior causing, attempting or threatening such harm, which behavior gives rise to a reasonable fear of such harm from the person;

O. "medical emergency" means any physical or mental health emergency that requires immediate medical intervention;

[~~O.~~] P. "mental disorder" means substantial disorder of a person's emotional processes, thought or cognition that grossly impairs judgment, behavior or capacity to recognize reality, but does not mean developmental disability;

[~~P.~~] Q. "mental health or developmental disabilities professional" means a physician or other professional who by training or experience is qualified to work with persons with a mental disorder or a developmental disability;

[~~Q.~~] R. "physician" or "certified psychologist", when used for the purpose of hospital admittance or discharge, means a physician or certified psychologist who has been granted admitting privileges at a hospital licensed by the department of health, if such privileges are required;

S. "protected health information" means individually identifiable health information transmitted by or maintained in an electronic form or any other form or media

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that relates to the:

(1) past, present or future physical or mental health or condition of an individual;

(2) provision of health care to an individual; or

(3) payment for the provision of health care to an individual;

[~~R.~~] T. "psychosurgery":

(1) means those operations currently referred to as lobotomy, psychiatric surgery and behavioral surgery and all other forms of brain surgery if the surgery is performed for the purpose of the following:

(a) modification or control of thoughts, feelings, actions or behavior rather than the treatment of a known and diagnosed physical disease of the brain;

(b) treatment of abnormal brain function or normal brain tissue in order to control thoughts, feelings, actions or behavior; or

(c) treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions or behavior when the abnormality is not an established cause for those thoughts, feelings, actions or behavior; and

(2) does not include prefrontal sonic treatment in which there is no destruction of brain tissue;

[~~S.~~] U. "qualified mental health professional

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licensed for independent practice" means an independent social worker, a licensed professional clinical mental health counselor, a marriage and family therapist, a certified nurse practitioner or a clinical nurse specialist with a specialty in mental health, all of whom by training and experience are qualified to work with persons with a mental disorder;

[~~T.~~] V. "residential treatment or habilitation program" means diagnosis, evaluation, care, treatment or habilitation rendered inside or on the premises of a mental health or developmental disabilities facility, hospital, clinic, institution or supervisory residence or nursing home when the client resides on the premises; and

[~~U.~~] W. "treatment" means any effort to accomplish a significant change in the mental or emotional condition or behavior of the client."

SECTION 19. Section 43-1-19 NMSA 1978 (being Laws 1977, Chapter 279, Section 18, as amended) is amended to read:

"43-1-19. DISCLOSURE OF INFORMATION.--

A. Except as otherwise provided in the code, no person shall, without the authorization of the client, disclose or transmit any confidential information from which a person well acquainted with the client might recognize the client as the described person, or any code, number or other means that can be used to match the client with confidential information regarding the client.

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B. Authorization from the client shall not be required for the disclosure or transmission of confidential information in the following circumstances:

(1) when the request is from a mental health or developmental disability professional or from an employee or trainee working with a person with a mental disability or developmental disability, to the extent that the practice, employment or training on behalf of the client requires access to such information is necessary;

(2) when such disclosure is necessary to prevent a medical emergency or to protect against a clear and substantial risk of imminent serious physical injury or death inflicted by the client on the client's self or another;

(3) when the disclosure of such information is to the primary caregiver of the client and the disclosure is only of information necessary for the continuity of the client's treatment in the judgment of the treating physician or certified psychologist who discloses the information; or

(4) when such disclosure is to an insurer contractually obligated to pay part or all of the expenses relating to the treatment of the client at the residential facility. The information disclosed shall be limited to data identifying the client, facility and treating or supervising physician and the dates and duration of the residential treatment. It shall not be a defense to an insurer's

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obligation to pay that the information relating to the residential treatment of the client, apart from information disclosed pursuant to this section, has not been disclosed to the insurer.

C. No authorization given for the transmission or disclosure of confidential information shall be effective unless it:

(1) is in writing and signed; and

(2) contains a statement of the client's right to examine and copy the information to be disclosed, the name or title of the proposed recipient of the information and a description of the use that may be made of the information.

D. The client has a right of access to confidential information and has the right to make copies of any information and to submit clarifying or correcting statements and other documentation of reasonable length for inclusion with the confidential information. The statements and other documentation shall be kept with the relevant confidential information, shall accompany it in the event of disclosure and shall be governed by the provisions of this section to the extent they contain confidential information. Nothing in this subsection shall prohibit the denial of access to such records when a physician or other mental health or developmental disabilities professional believes and notes in the client's medical records that such disclosure would not be in the best

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interests of the client. In any such case, the client has the right to petition the court for an order granting such access.

E. Where there exists evidence that the client whose consent to disclosure of confidential information is sought is incapable of giving or withholding valid consent and the client does not have a guardian or treatment guardian appointed by a court, the person seeking such authorization shall petition the court for the appointment of a treatment guardian to make a substitute decision for the client, except that if the client is less than fourteen years of age, the client's parent or guardian is authorized to consent to disclosure on behalf of the client.

F. Information concerning a client disclosed under this section shall not be released to any other person, agency or governmental entity or placed in files or computerized data banks accessible to any persons not otherwise authorized to obtain information under this section.

G. Nothing in the code shall limit the confidentiality rights afforded by federal statute or regulation.

H. A person appointed as a treatment guardian in accordance with the Mental Health and Developmental Disabilities Code may act as the client's personal representative pursuant to the federal Health Insurance Portability and Accountability Act of 1996, Sections 1171-1179

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of the Social Security Act, 42 U.S.C. Section 1320d, as amended, and applicable federal regulations to obtain access to the client's protected health information, including mental health information and relevant physical health information, and may communicate with the client's health care providers in furtherance of such treatment."

SECTION 20. A new section of the Mental Health and Developmental Disabilities Code is enacted to read:

"[NEW MATERIAL] COMPILATION OF DATA FOR COURT-ORDERED MENTAL HEALTH TREATMENT AND APPOINTMENT OF TREATMENT GUARDIAN.--

A. The clerk of each court with jurisdiction to order assisted outpatient treatment pursuant to the Assisted Outpatient Treatment Act or involuntary commitment pursuant to the Mental Health and Developmental Disabilities Code shall provide a monthly report to the administrative office of the courts with the following information for the previous month:

(1) the number of petitions for assisted outpatient treatment filed with the court;

(2) the number of petitions for involuntary commitment of an adult pursuant to Section 43-1-11 NMSA 1978 filed with the court;

(3) the number of petitions for extended commitment of adults pursuant to Section 43-1-12 NMSA 1978 filed with the court;

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(4) the number of petitions for involuntary commitment of developmentally disabled adults to residential care pursuant to Section 43-1-13 NMSA 1978 filed with the court;

(5) the number of petitions for appointment of a treatment guardian pursuant to Section 43-1-15 NMSA 1978 filed with the court; and

(6) the disposition of each case included in the monthly report, including the number of orders for inpatient mental health services and the number of orders for outpatient mental health services.

B. Beginning September 1, 2015, the administrative office of the courts shall quarterly provide the information reported to it pursuant to Subsection A of this section to the:

(1) department of health; and

(2) interagency behavioral health purchasing collaborative.

C. The provisions of Subsections A and B of this section do not require the production of protected health information, information deemed confidential under Subsection B of Section 15 of the Assisted Outpatient Treatment Act or information protected from disclosure under Section 43-1-19 NMSA 1978."

SECTION 21. APPROPRIATIONS.--

A. Three million dollars ($3,000,000) is

appropriated from the general fund to the department of health for expenditure in fiscal year 2016 to conduct public health surveillance and oversight of assisted outpatient treatment programs pursuant to the Assisted Outpatient Treatment Act through each county public health office. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

B. Two hundred seventy-five thousand dollars ($275,000) is appropriated from the general fund to the administrative office of the courts for expenditure in fiscal year 2016 to hire personnel and to conduct necessary training to compile and report data relating to court-ordered mental health treatment and proceedings to appoint treatment guardians as required by the Mental Health and Developmental Disabilities Code; and to contract for attorney services required by the Assisted Outpatient Treatment Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

C. Two hundred thousand dollars ($200,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal years 2016 through 2018 to contract for a study to evaluate the implementation and effectiveness of assisted outpatient treatment in New Mexico for the period of July 1, 2015 through December 31, 2017 conducted under the auspices of the

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university of New Mexico health sciences center. Any unexpended or unencumbered balance remaining at the end of fiscal year 2018 shall revert to the general fund.

SECTION 22. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2015.

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO CHILDREN; ENACTING A NEW SECTION OF THE PUBLIC SCHOOL CODE TO PROHIBIT SCHOOL PERSONNEL FROM COMPELLING STUDENTS TO USE PSYCHOTROPIC MEDICATIONS; AMENDING A SECTION OF THE CHILDREN'S CODE TO PROVIDE THAT A PARENT'S, GUARDIAN'S OR CUSTODIAN'S REFUSAL TO CONSENT TO ADMINISTRATION OF A PSYCHOTROPIC MEDICATION TO A CHILD IS NOT GROUNDS PER SE FOR PROTECTIVE CUSTODY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public School Code is enacted to read:

"[NEW MATERIAL] PSYCHOTROPIC MEDICATION--PROHIBITION ON COMPULSION.--

A. Each local school board or governing body shall develop and promulgate policies that prohibit school personnel

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from denying any student access to programs or services because the parent or guardian of the student has refused to place the student on psychotropic medication.

B. School personnel may share school-based observations of a student's academic, functional and behavioral performance with the student's parent or guardian and offer program options and other forms of assistance that are available to the parent or guardian and the student based on those observations. However, an employee or agent of a school district or governing body shall not compel or attempt to compel any specific actions by the parent or guardian or require that a student take a psychotropic medication.

C. School personnel shall not require a student to undergo psychological screening unless the parent or guardian of that student gives prior written consent before each instance of pscyhological screening.

D. As used in this section:

(1) "psychotropic medication" means a drug that shall not be dispensed or administered without a prescription, whose primary indication for use has been approved by the federal food and drug administration for the treatment of mental disorders and that is listed as a psychotherapeutic agent in drug facts and comparisons or in the American hospital formulary service; and

(2) "school personnel" means a person that is an

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employee, agent or volunteer of a school district or other governing body of a public school."

SECTION 2. Section 32A-4-6 NMSA 1978 (being Laws 1993, Chapter 77, Section 100, as amended) is amended to read:

"32A-4-6. TAKING INTO CUSTODY--PENALTY.--

A. A child may be held or taken into custody:

(1) by a law enforcement officer when the officer has evidence giving rise to reasonable grounds to believe that the child is abused or neglected and that there is an immediate threat to the child's safety; provided that the law enforcement officer contacts the department to enable the department to conduct an on-site safety assessment to determine whether it is appropriate to take the child into immediate custody, except that a child may be taken into custody by a law enforcement officer without a protective services assessment being conducted if:

(a) the child's parent, guardian or custodian has attempted, conspired to cause or caused great bodily harm to the child or great bodily harm or death to the child's sibling;

(b) the child's parent, guardian or custodian has attempted, conspired to cause or caused great bodily harm or death to another parent, guardian or custodian of the child;

(c) the child has been abandoned;

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(d) the child is in need of emergency medical care;

(e) the department is not available to conduct a safety assessment in a timely manner; or

(f) the child is in imminent risk of abuse; or

(2) by medical personnel when there are reasonable grounds to believe that the child has been injured as a result of abuse or neglect and that the child may be at risk of further injury if returned to the child's parent, guardian or custodian. The medical personnel shall hold the child until a law enforcement officer is available to take custody of the child pursuant to Paragraph (1) of this subsection [~~A of this section~~].

B. When a child is taken into custody by law enforcement, the department is not compelled to place the child in an out-of-home placement and may release the child to the child's parent, guardian or custodian.

C. When a child is taken into custody, the department shall make reasonable efforts to determine whether the child is an Indian child.

D. If a child taken into custody is an Indian child and is alleged to be neglected or abused, the department shall give notice to the agent of the Indian child's tribe in accordance with the federal Indian Child Welfare Act of 1978.

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E. Any person who intentionally interferes with protection of a child, as provided by Subsection A of this section, is guilty of a petty misdemeanor.

F. A child shall not be taken into protective custody solely on the grounds that the child's parent, guardian or custodian refuses to consent to the administration of a psychotropic medication to the child."

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; ENACTING A NEW SECTION OF THE PUBLIC ASSISTANCE ACT TO REQUIRE THE SECRETARY OF HUMAN SERVICES TO ESTABLISH A MEDICAID HOME VISITING SERVICES FOR INFANTS BORN TO MEDICAID RECIPIENTS AND FOR THE INFANTS' FAMILIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] MEDICAID INFANT AND FAMILY HOME VISITING PROGRAM.--

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the secretary shall establish a home visiting program to provide home visiting services for infants who are born to

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medicaid recipients and for the infants' families. The home visiting program shall provide for at least six visits where home visiting services are provided to an infant or the infant's family during the infant's first year of life.

B. As used in this section, "home visiting program" means a program that:

(1) uses home visiting as a primary service delivery strategy;

(2) offers services to an infant and the infant's family that the infant's family receives on a voluntary basis;

(3) provides a comprehensive array of services that:

(a) are designed to promote child well-being and prevent adverse childhood experiences;

(b) promote parental competence and successful early childhood health and development by building long-term relationships with families and optimizing the relationships between parents and children in their home environments; and

(c) deliver a variety of informational, educational, developmental, referral and other supports to an infant and the infant's family;

(4) is research-based and grounded in relevant, empirically based best practices and knowledge that is linked

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to and measures the following outcomes:

(a) infants who are nurtured by their parents and caregivers;

(b) children who are physically and mentally healthy;

(c) infants and families who are safe; and

(d) families who are connected to formal and informal supports in their communities;

(5) has comprehensive home visiting standards that ensure high-quality service delivery and continuous quality improvement;

(6) has demonstrated significant, sustained positive outcomes;

(7) follows program standards that the secretary has established by rule and that specify the purpose, outcomes, duration and frequency of home visiting services;

(8) follows research-based protocols;

(9) employs well-trained and competent staff and provides continual professional supervision and development relevant to the specific program or model being delivered;

(10) demonstrates strong links to other community-based services;

(11) operates within an organization that ensures compliance with home visiting standards;

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(12) continually evaluates performance to ensure fidelity to the program standards;

(13) collects data on program activities and program outcomes; and

(14) is culturally and linguistically appropriate."

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; ENACTING A NEW SECTION OF THE PUBLIC ASSISTANCE ACT TO REQUIRE THE SECRETARY OF HUMAN SERVICES TO AMEND THE MEDICAID STATE PLAN TO PROVIDE HOME VISITING SERVICES FOR INFANTS BORN TO MEDICAID RECIPIENTS AND FOR THE INFANTS' FAMILIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Public Assistance Act is enacted to read:

"[NEW MATERIAL] MEDICAID INFANT AND FAMILY HOME VISITING PROGRAM.--

A. Consistent with the federal act and subject to the appropriation and availability of federal and state funds, the secretary shall establish a home visiting program to provide home visiting services for infants who are born to

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medicaid recipients and for the infants' families. The home visiting program shall provide for at least six visits where home visiting services are provided to an infant or the infant's family during the infant's first year of life.

B. As used in this section, "home visiting program" means a program that:

(1) uses home visiting as a primary service delivery strategy;

(2) offers services to an infant and the infant's family that the infant's family receives on a voluntary basis;

(3) provides a comprehensive array of services that:

(a) are designed to promote child well-being and prevent adverse childhood experiences;

(b) promote parental competence and successful early childhood health and development by building long-term relationships with families and optimizing the relationships between parents and children in their home environments; and

(c) deliver a variety of informational, educational, developmental, referral and other supports to an infant and the infant's family;

(4) is research-based and grounded in relevant, empirically based best practices and knowledge that is linked

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to and measures the following outcomes:

(a) infants who are nurtured by their parents and caregivers;

(b) children who are physically and mentally healthy;

(c) infants and families who are safe; and

(d) families who are connected to formal and informal supports in their communities;

(5) has comprehensive home visiting standards that ensure high-quality service delivery and continuous quality improvement;

(6) has demonstrated significant, sustained positive outcomes;

(7) follows program standards that the secretary has established by rule and that specify the purpose, outcomes, duration and frequency of home visiting services;

(8) follows research-based protocols;

(9) employs well-trained and competent staff and provides continual professional supervision and development relevant to the specific program or model being delivered;

(10) demonstrates strong links to other community-based services;

(11) operates within an organization that ensures compliance with home visiting standards;

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(12) continually evaluates performance to ensure fidelity to the program standards;

(13) collects data on program activities and program outcomes; and

(14) is culturally and linguistically appropriate."

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; REQUIRING THE HUMAN SERVICES DEPARTMENT AND THE DEPARTMENT OF HEALTH TO CREATE A FIVE-YEAR PLAN FOR INCREASING ALLOCATIONS TO DEVELOPMENTAL DISABILITIES MEDICAID WAIVER PROGRAM SUPPORTS AND SERVICES; PROVIDING FOR ANNUAL REPORTING TO THE LEGISLATURE; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] DEVELOPMENTAL DISABILITIES--MEDICAID HOME- AND COMMUNITY-BASED SUPPORTS AND SERVICES--FIVE-YEAR PLAN FOR INCREASING ALLOCATIONS FROM CENTRAL REGISTRY FOR ENROLLMENT IN SERVICES.--By September 1, 2015 and each year thereafter, the human services department and the department of health shall collaborate to create and report to the legislative finance committee and the legislative health and human services committee their rolling five-year plan for

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increasing allocations from the central registry for developmental disabilities medicaid home- and community-based supports and services and enrolling individuals awaiting allocation in the developmental disability medicaid home- and community-based waiver program. On an annual basis thereafter, the department of health and the human services department shall update the plan to cover the subsequent five years and report the updated plan to the legislative finance committee and the legislative health and human services committee. The plan shall be designed in a manner that, at the end of any five-year period, the time between any individual's placement on the central registry and the individual's allocation in developmental disability home- and community-based waiver supports and services is no greater than three years. The plan shall include:

A. the number of individuals who are on the central registry and not yet receiving waiver supports and services, by age, county of residence and years on the central registry;

B. an estimate of the costs of providing waiver supports and services to individuals who are eligible for supports and services but are not yet receiving them; and

C. a target for the number of individuals to be moved from the central registry into waiver supports and services over the five-year period covered by the plan and the amount of new state funding needed each year to meet the

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target.

SECTION 2. APPROPRIATION.--Twenty-five million dollars ($25,000,000) is appropriated from the general fund to the department of health for expenditure in fiscal year 2016 to fund supports and services for individuals enrolled in a developmental disability medicaid home- and community-based waiver program and to allow enrollment of eligible individuals listed on the department of health's central registry who are currently awaiting allocation of supports and services through the developmental disability medicaid waiver program. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AND THE INDIAN AFFAIRS COMMITTEE

AN ACT

RELATING TO HEALTH CARE; AMENDING AND ENACTING SECTIONS OF THE DENTAL HEALTH CARE ACT; PROVIDING FOR LICENSURE AND A SCOPE OF PRACTICE FOR DENTAL THERAPISTS; PROVIDING FOR THE REGULATION, LICENSURE AND DISCIPLINE OF DENTAL THERAPISTS; AMENDING SECTIONS OF THE GROSS RECEIPTS AND COMPENSATING TAX ACT, THE NEW MEXICO DRUG, DEVICE AND COSMETIC ACT, THE PUBLIC ASSISTANCE ACT, CHAPTER 59A, ARTICLE 22 NMSA 1978, THE NONPROFIT HEALTH CARE PLAN LAW AND THE IMPAIRED DENTISTS AND DENTAL HYGIENISTS ACT; RENAMING THE IMPAIRED DENTISTS AND DENTAL HYGIENISTS ACT AS THE "IMPAIRED DENTAL PROFESSIONALS ACT"; PROVIDING PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 61-5A-2 NMSA 1978 (being Laws 1994, Chapter 55, Section 2, as amended) is amended to read:

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"61-5A-2. PURPOSE.--

A. In the interest of the public health, safety and welfare and to protect the public from the improper, unprofessional, incompetent and unlawful practice of dentistry, dental therapy and dental hygiene, it is necessary to provide laws and rules controlling the granting and use of the privilege to practice dentistry, dental therapy and dental hygiene and to establish a board of dental health care, a joint committee and a dental hygienists committee to implement and enforce those laws and rules.

B. The primary duties of the New Mexico board of dental health care are:

(1) to issue licenses to qualified dentists and owners of dental practices;

(2) to certify qualified dental assistants, expanded-function dental auxiliaries and community dental health coordinators;

(3) to issue licenses to dental therapists in accordance with the recommendation of the joint committee;

[~~(3)~~] (4) to issue licenses to dental hygienists [~~through~~] in accordance with the recommendation of the [~~dental hygienists~~] committee;

[~~(4)~~] (5) to discipline incompetent or unprofessional dentists; dental assistants; owners of dental practices; [~~and, through the~~] dental therapists in accordance

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with the recommendation of the joint committee; and dental hygienists in accordance with the recommendation of the committee [~~dental hygienists~~]; and

[~~(5)~~] (6) to aid in the rehabilitation of impaired dentists, dental therapists and dental hygienists for the purpose of protecting the public."

SECTION 2. Section 61-5A-3 NMSA 1978 (being Laws 1994, Chapter 55, Section 3, as amended) is amended to read:

"61-5A-3. DEFINITIONS.--As used in the Dental Health Care Act:

A. "assessment" means the review and documentation of the oral condition, and the recognition and documentation of deviations from the healthy condition, without a diagnosis to determine the cause or nature of disease or its treatment;

B. "board" means the New Mexico board of dental health care;

C. "certified dental assistant" means an individual certified by the dental assisting national board;

D. "collaborative dental hygiene practice" means a New Mexico licensed dental hygienist practicing according to Subsections D through G of Section 61-5A-4 NMSA 1978;

E. "committee" means the New Mexico dental hygienists committee;

F. "community dental health coordinator" means a dental assistant, a dental hygienist or other trained personnel

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certified by the board as a community dental health coordinator to provide educational, preventive and limited palliative care and assessment services working collaboratively under the general supervision of a licensed dentist in settings other than traditional dental offices and clinics;

G. "consulting dentist" means a dentist who has entered into an approved agreement to provide consultation and create protocols with a collaborating dental hygienist and, when required, to provide diagnosis and authorization for services, in accordance with the rules of the board and the committee;

H. "dental assistant certified in expanded functions" means a dental assistant who meets specific qualifications set forth by rule of the board;

I. "dental health professional shortage area" means a geographic area of the state designated by a federal or state agency as having a significantly limited number of dental health care providers;

[~~H.~~] J. "dental hygiene-focused assessment" means the documentation of existing oral and relevant system conditions and the identification of potential oral disease to develop, communicate, implement and evaluate a plan of oral hygiene care and treatment;

[~~I. "dental assistant certified in expanded functions" means a dental assistant who meets specific~~

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~~qualifications set forth by rule of the board;~~

~~J.~~] K. "dental hygienist" means an individual who has graduated and received a degree from a dental hygiene educational program that is accredited by the commission on dental accreditation, that provides a minimum of two academic years of dental hygiene curriculum and that is an institution of higher education; and "dental hygienist" means, except as the context otherwise requires, an individual who holds a license to practice dental hygiene in New Mexico;

[~~K.~~] L. "dental laboratory" means any place where dental restorative, prosthetic, cosmetic and therapeutic devices or orthodontic appliances are fabricated, altered or repaired by one or more persons under the orders and authorization of a dentist;

[~~L.~~] M. "dental technician" means an individual, other than a licensed dentist, who fabricates, alters, repairs or assists in the fabrication, alteration or repair of dental restorative, prosthetic, cosmetic and therapeutic devices or orthodontic appliances under the orders and authorization of a dentist;

N. "dental therapist" means an individual licensed to practice dental therapy in the state;

O. "dental therapist management agreement" means a written general supervision agreement between a dentist and a dental therapist;

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P. "dental therapy representative" means an individual who:

(1) publicly supports or recommends the practice of dental therapy in the state;

(2) has knowledge of the practice of dental therapy or of the educational or licensing requirements for the practice of dental therapy; and

(3) has been nominated by a representative of:

(a) New Mexico health resources, inc.;

(b) health action New Mexico;

(c) a state or regional dental therapists' association; or

(d) an institution of higher education located in New Mexico that has a dental therapist education program;

[~~M.~~] Q. "dentist" means an individual who has graduated and received a degree from a school of dentistry that is accredited by the commission on dental accreditation and, except as the context otherwise requires, who holds a license to practice dentistry in New Mexico;

[~~N.~~] R. "direct supervision" means the process under which an act is performed when a dentist or a dental therapist licensed pursuant to the Dental Health Care Act:

(1) is physically present throughout the performance of the act;

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(2) orders, controls and accepts full professional responsibility for the act performed; and

(3) evaluates and approves the procedure performed before the patient departs the care setting;

[~~O.~~] S. "expanded-function dental auxiliary" means a dental assistant, dental hygienist or other dental practitioner that has received education beyond that required for licensure or certification in that individual's scope of practice and that has been certified by the board as an expanded-function dental auxiliary who works under the direct supervision of a dentist;

[~~P. "general supervision" means the authorization by a dentist of the procedures to be used by a dental hygienist, dental assistant or dental student and the execution of the procedures in accordance with a dentist's diagnosis and treatment plan at a time the dentist is not physically present and in facilities as designated by rule of the board;~~]

T. "general supervision" means a dentist's authorization of the procedures that are executed:

(1) by a dental therapist, dental hygienist, dental assistant or dental student while the dentist is not physically present in the facility where a procedure is taking place; and

(2) in accordance with the following:

(a) for a dental therapist, in

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accordance with the dental therapist's diagnosis and treatment plan; and

(b) for a dental hygienist, dental assistant or dental student, in accordance with a dentist's diagnosis and treatment plan;

[~~Q.~~] U. "indirect supervision" means that a dentist or dental therapist, or in certain settings a dental hygienist or dental assistant certified in expanded functions, is present in the treatment facility while authorized treatments are being performed by a dental therapist, unlicensed graduate of a dental therapy education program, dental hygienist, dental assistant or dental student;

V. "joint committee" means the New Mexico dental therapist joint committee that makes recommendations to the board relating to the regulation of the practice of dental therapy and licensure of dental therapists;

[~~R.~~] W. "non-dentist owner" means an individual not licensed as a dentist in New Mexico or a corporate entity not owned by a majority interest of a New Mexico licensed dentist that employs or contracts with a dentist, dental therapist or dental hygienist to provide dental, dental therapy or dental hygiene services;

[~~S.~~] X. "palliative procedures" means nonsurgical, reversible procedures that are meant to alleviate pain and stabilize acute or emergent problems; [~~and~~]

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Y. "store-and-forward technology" means electronic information, imaging and communication, including interactive audio, video and data communications, that is transferred or recorded or otherwise stored for asynchronous use;

[~~T.~~] Z. "teledentistry" means a dentist's use of health information technology in real time to provide limited diagnostic and treatment planning services in cooperation with another dentist, a dental therapist, a dental hygienist, a community dental health coordinator or a student enrolled in a program of study to become a dental assistant, dental hygienist, dental therapist or dentist; and

AA. "telehealth" means the use of electronic information, imaging and communication technologies, including interactive audio, video and data communications, as well as store-and-forward technologies, to provide and support health care delivery, diagnosis, consultation treatment, transfer of medical data and education."

SECTION 3. Section 61-5A-9 NMSA 1978 (being Laws 1994, Chapter 55, Section 9, as amended by Laws 2003, Chapter 408, Section 5 and by Laws 2003, Chapter 409, Section 7) is amended to read:

"61-5A-9. COMMITTEE CREATED--POWERS.--

A. There is created the nine-member "New Mexico dental hygienists committee". The committee [~~shall be~~] is administratively attached to the regulation and licensing

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department. The committee [~~shall consist~~] consists of five dental hygienists, two dentists and two public members. The dental hygienists shall be actively practicing and have been licensed practitioners and residents of New Mexico for a period of five years preceding the date of their appointment. The dentists and public members shall be members of the board and shall be elected annually to sit on the committee by those members sitting on the board.

B. The governor may appoint the dental hygienists from a list of names submitted by the New Mexico dental hygienists association. There shall be one member from each district. Members shall serve until their successors have been appointed. No more than one member may be employed by or receive remuneration from a dental or dental hygiene educational institution.

C. Appointments for dental hygienist members shall be for terms of five years. Appointments shall be made so that the term of one dental hygienist expires on July 1 of each year.

D. A committee member failing to attend three committee or board meetings, either regular or special, during the committee member's term shall automatically be removed as a member of the committee unless excused from attendance by the committee for good cause shown. Members of the committee not sitting on the board shall not be required or allowed to attend

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board disciplinary hearings.

E. A committee member shall not serve more than two full terms on any state-chartered board whose responsibility includes the regulation of practice or licensure of dentistry or dental hygiene in New Mexico. A partial term of three or more years shall be considered a full term.

F. In the event of a vacancy, the secretary of the committee shall immediately notify the governor, the committee and board members and the New Mexico dental hygienists association of the reason for its occurrence and action taken by the committee, so as to expedite appointment of a new committee member.

G. The committee shall meet at least four times every year, and no more than two meetings shall be public rules hearings. Regular meetings shall not be more than one hundred twenty days apart. The committee may also hold special meetings and emergency meetings in accordance with the rules of the board and committee, upon written notification to all members of the committee and the board.

H. Members of the committee shall be reimbursed as provided in the Per Diem and Mileage Act and shall receive no other compensation, perquisite or allowance.

I. A simple majority of the committee members currently serving shall constitute a quorum, provided at least two of that quorum are not hygienist members and three are

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hygienist members.

J. The committee shall elect officers annually as deemed necessary to administer its duties and as provided in rules [~~and regulations~~] of the board and committee.

K. The committee shall make recommendations to the board, for ratification pursuant to Section 61-5A-11 NMSA 1978, relating to the regulation, examination, licensing, continuing education, scope of practice, standard of care, issuance of investigative subpoenas and discipline of dental hygienists.

L. In accordance with the Uniform Licensing Act, for any cause stated in the Dental Health Care Act, the committee may make its recommendations to the board in matters involving the granting, denial, review, censure, reprimand, fining and placement on probation and stipulation, suspension and revocation of licenses to practice dental hygiene."

SECTION 4. Section 61-5A-10 NMSA 1978 (being Laws 1994, Chapter 55, Section 10, as amended) is amended to read:

"61-5A-10. POWERS AND DUTIES OF THE BOARD [~~AND COMMITTEE~~].--In addition to any other authority provided by law, the board [~~and the committee, when designated~~] shall:

A. enforce and administer the provisions of the Dental Health Care Act and the Dental Amalgam Waste Reduction Act;

B. adopt, publish, file and revise, in accordance with the Uniform Licensing Act and the State Rules Act, all

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rules as may be necessary to:

(1) regulate the examination and licensure of dentists, [~~and, through the committee, regulate the examination and licensure of~~] dental therapists and dental hygienists;

(2) provide for the examination and certification of dental assistants by the board;

(3) provide for the regulation of dental technicians by the board;

(4) regulate the practice of dentistry, [~~and~~] dental assisting, [~~and, through the committee, regulate the practice of~~] dental therapy and dental hygiene; and

(5) provide for the regulation and licensure of non-dentist owners by the board;

C. adopt and use a seal;

D. administer oaths to all applicants, witnesses and others appearing before the board or the committee, as appropriate;

E. keep an accurate record of all meetings, receipts and disbursements;

F. grant, deny, review, suspend and revoke licenses and certificates to practice dentistry, dental assisting, [~~and, through the committee~~] dental therapy and dental hygiene and censure, reprimand, fine and place on probation and stipulation dentists, dental assistants, [~~and, through the committee~~] dental therapists and dental hygienists, in accordance with the

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Uniform Licensing Act for any cause stated in the Dental Health Care Act and the Dental Amalgam Waste Reduction Act;

G. grant, deny, review, suspend and revoke licenses to own dental practices and censure, reprimand, fine and place on probation and stipulation non-dentist owners, in accordance with the Uniform Licensing Act, for any cause stated in the Dental Health Care Act and the Dental Amalgam Waste Reduction Act;

H. maintain records of the name, address, license number and such other demographic data as may serve the needs of the board of licensees, together with a record of license renewals, suspensions, revocations, probations, stipulations, censures, reprimands and fines. The board shall make available composite reports of demographic data but shall limit public access to information regarding individuals to their names, addresses, license numbers and license actions or as required by statute;

I. hire and contract for services from persons as necessary to carry out the board's duties;

J. establish ad hoc committees whose members shall be appointed by the chair with the advice and consent of the board or committee and shall include at least one member of the board or committee as it deems necessary for carrying on its business;

K. have the authority to pay per diem and mileage

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to individuals who are appointed by the board or the committee to serve on ad hoc committees;

L. have the authority to hire or contract with investigators to investigate possible violations of the Dental Health Care Act and the Dental Amalgam Waste Reduction Act;

M. have the authority to issue investigative subpoenas prior to the issuance of a notice of contemplated action for the purpose of investigating complaints against dentists, dental assistants, [~~and, through the committee~~] dental therapists and dental hygienists licensed under the Dental Health Care Act and the Dental Amalgam Waste Reduction Act;

N. have the authority to sue or be sued and to retain the services of an attorney at law for counsel and representation regarding the carrying out of the board's duties;

O. have the authority to create and maintain a formulary, in consultation with the board of pharmacy, of medications that a dental therapist or dental hygienist may prescribe, administer or dispense in accordance with rules the board has promulgated; and

P. establish continuing education or continued competency requirements for dentists, certified dental assistants in expanded functions, dental technicians, [~~and, through the committee~~] dental therapists and dental

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hygienists."

SECTION 5. A new section of the Dental Health Care Act is enacted to read:

"[NEW MATERIAL] NEW MEXICO DENTAL THERAPIST JOINT COMMITTEE--CREATION--MEMBERSHIP.--

A. There is created the thirteen-member "New Mexico dental therapist joint committee". The joint committee shall consist of thirteen members, including:

(1) five current members of the board who are dentists;

(2) five current members of the New Mexico dental hygienists committee who are dental hygienists;

(3) one dental therapist or dental therapy representative; and

(4) two current public members of the board.

B. The joint committee shall make recommendations to the board, for ratification pursuant to Section 61-5A-11 NMSA 1978, relating to the regulation, examination, licensing, continuing education, scope of practice, standard of care, issuance of investigative subpoenas and discipline of dental therapists.

C. Within thirty days of the effective date of this 2015 act, the governor shall appoint the dental therapist or dental therapy representative member of the joint committee from a list of names submitted by New Mexico health resources,

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inc., health action New Mexico, a state or regional dental therapists' association or a state institution of higher education that has a dental therapy education program.

D. Appointment of the dental therapist or dental therapy representative member shall be for a term of five years.

E. A quorum at a meeting of the joint committee shall include the dental therapist member or dental therapy representative member of the joint committee.

F. In accordance with the Uniform Licensing Act, for any cause stated in the Dental Health Care Act, the joint committee may make its recommendations to the board in matters involving the granting, denial, review, censure, reprimand, fining and placement on probation and stipulation, suspension and revocation of licenses to practice dental therapy.

G. By August 1, 2015, the joint committee shall recommend for adoption and promulgation by the board rules relating to the practice of dental therapy."

SECTION 6. Section 61-5A-11 NMSA 1978 (being Laws 1994, Chapter 55, Section 11) is amended to read:

"61-5A-11. RATIFICATION OF DENTAL HYGIENIST COMMITTEE RECOMMENDATIONS--JOINT COMMITTEE RECOMMENDATIONS.--

A. The board shall ratify the recommendations of the dental hygienist committee or the joint committee unless the board makes a specific finding that a recommendation is:

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(1) beyond the jurisdiction of the dental hygienist committee or the joint committee;

(2) an undue financial impact upon the board; or

(3) not supported by the record.

B. The board shall provide the necessary [~~expenditures~~] funding for expenses incurred by the dental hygienist committee, [~~and~~] the joint committee or the board in implementing and executing [~~the~~] ratified recommendations."

SECTION 7. Section 61-5A-14.1 NMSA 1978 (being Laws 2011, Chapter 113, Section 10) is amended to read:

"61-5A-14.1. PUBLIC-SERVICE LICENSURE.--[~~The board or the committee may issue a temporary public-service license to practice dentistry or dental hygiene to an applicant who is licensed to practice dentistry or dental hygiene in another state or territory of the United States or who is enrolled as a dental resident in a residency program in this state and the commission on dental accreditation has accredited that program. That applicant shall be otherwise qualified to practice dentistry or dental hygiene in this state. The following provisions shall apply:~~

~~A. the applicant for public-service licensure shall hold a valid license in good standing in another state or territory of the United States or be enrolled as a dental resident in a residency program in the state that the commission on dental accreditation has accredited;~~

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~~B. a temporary public-service license issued to a dental residency student who has not taken and passed a clinical examination accepted by the board shall not be renewed after the student has completed the residency program;~~

~~C. the applicant shall practice dentistry or dental hygiene under the sponsorship of or in association with a licensed New Mexico dentist or dental hygienist;~~

~~D. the public-service license may be issued for those activities as stipulated by the board or committee in the rules of the board. It may be issued upon written application of the applicant when accompanied by such proof of qualifications as the secretary-treasurer of the board or committee, in the secretary-treasurer's discretion, may require. Public-service licensees shall engage in only those activities specified on the public-service license for the time designated, and the public-service license shall identify the licensed New Mexico dentist or dental hygienist who will sponsor or associate with the applicant during the time the applicant practices dentistry or dental hygiene in New Mexico;~~

~~E.~~] A. The board may issue a temporary public-service license to practice dentistry to an applicant who is licensed to practice dentistry in another state or territory of the United States or who is enrolled as a dental resident in a residency program in the state that the commission on dental accreditation has accredited. The applicant shall be otherwise

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qualified to practice dentistry in the state. The board shall not renew the temporary public-service license of a dental residency student who has completed the student's residency program. The applicant shall practice dentistry under the sponsorship of or in association with a licensed New Mexico dentist, who shall be identified on the public-service license. A public-service licensee shall engage only in those activities the board specifies on the public-service license. The board may issue the public-service license upon an applicant's written application when accompanied by proof of qualifications as specified in board rules.

B. Upon the recommendation of the joint committee, the board shall issue a temporary public-service license to practice dental therapy to an applicant who is licensed to practice dental therapy in another state or another territory of the United States. The applicant shall be otherwise qualified to practice dental therapy in the state. The applicant shall practice dental therapy under the sponsorship of or in association with a licensed New Mexico dentist, dental therapist or dental hygienist, who shall be identified on the public-service license. A public-service licensee shall engage only in those activities specified on the public-service license. Upon the joint committee's recommendation, the board shall issue the public-service license upon an applicant's written application when accompanied by proof of qualifications

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as specified in board rules.

C. Upon the recommendation of the committee, the board shall issue a temporary public-service license to practice dental hygiene to an applicant who is licensed to practice dental hygiene in another state or another territory of the United States. The applicant shall be otherwise qualified to practice dental hygiene in the state. The applicant shall practice dental hygiene under the sponsorship of or in association with a licensed New Mexico dentist, dental therapist or dental hygienist, who shall be identified on the public-service license. A public-service licensee shall engage only in those activities specified on the public-service license. Upon the recommendation of the committee, the board shall issue the public-service license upon an applicant's written application when accompanied by proof of qualifications as specified in board rules.

D. The following provisions shall apply to any public-service licensure granted pursuant to this section:

(1) a public-service license shall be valid only for the time designated on the public-service license;

(2) the sponsoring or associating dentist, dental therapist or dental hygienist shall submit an affidavit attesting to the qualifications of the applicant and the activities the applicant will perform; and

[~~F.~~] (3) the public-service license shall be

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issued for a period not to exceed twelve months and may be renewed upon application and payment of required fees.

[~~G. the~~] E. An application for a public-service license under this section shall be accompanied by a license fee.

[~~H. the~~] F. A public-service licensee shall be required to comply with the Dental Health Care Act and all rules promulgated pursuant to that act. [~~and~~

~~I.~~] G. A dentist, dental therapist or dental hygienist providing dental care services to a charitable dental care project may provide dental care pursuant to a presumptive temporary public-service license valid for a period of no longer than three days. The dentist, dental therapist or dental hygienist shall be otherwise subject to the provisions of this section and board rules governing public-service licensure. This presumptive temporary public-service license is only valid when:

(1) the dentist, dental therapist or dental hygienist receives no compensation;

(2) the project is sponsored by an entity that meets the board's definition of "entity" and that the board has approved to undertake the charitable project;

(3) the dental care is performed within the limits of the license that the dentist, dental therapist or dental hygienist holds in another jurisdiction;

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(4) upon request, the out-of-state dentist, dental therapist or dental hygienist produces any document necessary to verify the dentist's, dental therapist's or dental hygienist's credentials; and

(5) the out-of-state dentist, dental therapist or dental hygienist works under the indirect supervision of a dentist, dental therapist or dental hygienist licensed in this state."

SECTION 8. Section 61-5A-15 NMSA 1978 (being Laws 1994, Chapter 55, Section 15) is amended to read:

"61-5A-15. CONTENT OF [~~LICENSE~~] LICENSES AND CERTIFICATES--DISPLAY OF [~~LICENSE--RENEWALS--RETIRE LICENSE~~] LICENSES AND CERTIFICATES.--

A. All dental licenses issued by the board shall bear:

(1) a serial number;

(2) the full name of the licensee;

(3) the date of issue;

(4) the seal of the board;

(5) if the license is a specialty license, the specialty to which practice is limited;

(6) the signatures of a majority of the board members; and

(7) the attestation of the board president and secretary.

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B. All dental therapist licenses issued by the board shall bear:

(1) a serial number;

(2) the full name of the licensee;

(3) the date of issue;

(4) the seal of the board;

(5) the signatures of a majority of the joint committee members; and

(6) the attestation of the board president and secretary.

[~~B.~~] C. All dental hygienist licenses issued by the board shall bear:

(1) a serial number;

(2) the full name of the licensee;

(3) the date of issue;

(4) the seal of the board;

(5) the signatures of a majority of the committee members; and

(6) the attestation of the board president and secretary.

[~~C.~~] D. Certificates issued to dental assistants shall bear:

(1) a serial number;

(2) the full name of the assistant;

(3) the date of issue;

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(4) the date of expiration;

(5) the expanded functions certified to perform; and

(6) the attestation of the board secretary.

[~~D.~~] E. All licenses and certificates shall be displayed in a conspicuous place in the office where the holder practices. The license or certificate shall, upon request, be exhibited to any [~~of the members~~] member or authorized agent of the board, the joint committee or the committee [~~or its authorized agent~~]."

SECTION 9. Section 61-5A-21 NMSA 1978 (being Laws 1994, Chapter 55, Section 21, as amended) is amended to read:

"61-5A-21. DISCIPLINARY PROCEEDINGS--APPLICATION OF UNIFORM LICENSING ACT.--

A. In accordance with the Uniform Licensing Act and rules of the board, the board [~~and committee~~] may fine and may deny, revoke, suspend, stipulate or otherwise limit any license or certificate, including those of licensed non-dentist owners, held or applied for under the Dental Health Care Act, upon findings by the board [~~or the committee~~] that the licensee, certificate holder or applicant:

(1) is guilty of fraud or deceit in procuring or attempting to procure a license or certificate;

(2) has been convicted of a crime punishable by incarceration in a federal prison or state penitentiary;

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provided a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence of such conviction;

(3) is guilty of gross incompetence or gross negligence, as defined by rules of the board, in the practice of dentistry, dental therapy, dental hygiene or dental assisting;

(4) is habitually intemperate or is addicted to the use of habit-forming drugs or is addicted to any vice to such degree as to render the licensee unfit to practice;

(5) is guilty of unprofessional conduct as defined by rule;

(6) is guilty of any violation of the Controlled Substances Act;

(7) has violated any provisions of the Dental Health Care Act or rule or regulation of the board [~~or the committee~~];

(8) is guilty of willfully or negligently practicing beyond the scope of licensure;

(9) is guilty of practicing dentistry, dental therapy or dental hygiene without a license or aiding or abetting the practice of dentistry, dental therapy or dental hygiene by a person not licensed under the Dental Health Care Act;

(10) is guilty of obtaining or attempting to

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obtain any fee by fraud or misrepresentation or has otherwise acted in a manner or by conduct likely to deceive, defraud or harm the public;

(11) is guilty of patient abandonment;

(12) is guilty of failing to report to the board any adverse action taken against the licensee by a licensing authority, peer review body, malpractice insurance carrier or other entity as defined in rules of the board [~~and the committee~~];

(13) has had a license, certificate or registration to practice as a dentist, dental therapist or dental hygienist revoked, suspended, denied, stipulated or otherwise limited in any jurisdiction, territory or possession of the United States or another country for actions of the licensee similar to acts described in this subsection. A certified copy of the decision of the jurisdiction taking such disciplinary action will be conclusive evidence; or

(14) has failed to furnish the board, its investigators or its representatives with information requested by the board, the joint committee or the committee in the course of an official investigation.

B. Disciplinary proceedings may be instituted by sworn complaint by any person, including a board, joint committee or committee member, and shall conform with the provisions of the Uniform Licensing Act.

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[~~C. Licensees and certificate holders shall bear the costs of disciplinary proceedings unless exonerated.~~

~~D. Any person filing a sworn complaint shall be immune from liability arising out of civil action if the complaint is filed in good faith and without actual malice.~~

~~E.~~] C. Licensees whose licenses are in a probationary status shall pay reasonable expenses for maintaining probationary status, including but not limited to laboratory costs when laboratory testing of biological fluids or accounting costs when audits are included as a condition of probation."

SECTION 10. Section 61-5A-24 NMSA 1978 (being Laws 1994, Chapter 55, Section 24) is amended to read:

"61-5A-24. INJUNCTION TO STOP UNLICENSED DENTAL, DENTAL THERAPY OR DENTAL HYGIENE PRACTICE.--

A. The attorney general, the district attorney, the board, the joint committee, the committee or any citizen of any county where any person practices dentistry, dental therapy or dental hygiene without possessing a valid license to do so may, in accordance with the laws of New Mexico governing injunctions, maintain an action in the name of the state to enjoin such person from practicing dentistry, dental therapy or dental hygiene until a valid license to practice dentistry, dental therapy or dental hygiene is secured [~~and~~]. Any person who has been enjoined who violates the injunction shall be

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punished for contempt of court; provided that the injunction does not relieve any person practicing dentistry, dental therapy or dental hygiene without a valid license from a criminal prosecution [~~therefore~~] as provided by law.

B. In charging any person in a complaint for injunction, or in an affidavit, information or indictment with practicing dentistry, dental therapy or dental hygiene without a valid license, it is sufficient to charge that the person did, upon a certain day and in a certain county, engage in the practice of dentistry, dental therapy or dental hygiene without a valid license, without averring any further or more particular facts concerning the same."

SECTION 11. A new section of the Dental Health Care Act is enacted to read:

"[NEW MATERIAL] DENTAL THERAPY PRACTICE--SCOPE OF PRACTICE.--

A. As used in the Dental Health Care Act, "dental therapy practice" means the application of the science of the prevention and treatment of oral disease through education, prevention, assessment, diagnosis and clinical and other therapeutic services under the general supervision of a dentist. "Dental therapy practice" includes the practice of dental hygiene, as provided in Subsection B of Section 61-5A-4 NMSA 1978, and:

(1) behavioral management, oral health

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instruction and disease prevention education, including nutritional counseling and dietary analysis;

(2) diagnosis of dental disease and the formulation of an individualized treatment plan, including caries risk assessment;

(3) preliminary charting of the oral cavity;

(4) prescribing, exposing and interpreting radiographs;

(5) mechanical polishing of teeth and restorations;

(6) application of topical preventive or prophylactic agents, including fluoride varnishes and pit and fissure sealants;

(7) pulp vitality testing;

(8) application of desensitizing medication or resin;

(9) fabrication of athletic mouthguards;

(10) placement of temporary restoration;

(11) tissue conditioning and soft reline;

(12) traumatic restorative therapy;

(13) dressing changes;

(14) emergency replacement and stabilization of an avulsed or dislodged tooth to prevent the unintended loss of a tooth or teeth;

(15) administration of local anesthetic;

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(16) extractions of primary teeth;

(17) extractions of permanent teeth that are not impacted and that do not need sectioning or an incision for removal;

(18) emergency palliative treatment of dental pain;

(19) placement and removal of space maintainers;

(20) cavity preparation;

(21) restoration of primary and permanent teeth;

(22) placement of temporary crowns;

(23) preparation and placement of pre-formed crowns;

(24) pulpotomy of primary teeth;

(25) indirect and direct pulp capping on primary and permanent teeth;

(26) suture removal;

(27) brush biopsies;

(28) simple repairs and adjustments to removable prosthetic appliances;

(29) re-cementing of permanent crowns;

(30) prevention of potential orthodontic problems by early identification and appropriate referral;

(31) prevention, identification and management of dental and medical emergencies and maintenance of current basic life-support certification;

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(32) dispensing and administration of analgesics, anti-inflammatory medications and antibiotics only within the parameters of a dental therapist management agreement; and

(33) other related services as permitted by board rules.

B. A dental therapist shall practice under the general supervision of a dentist pursuant to a written supervision agreement between the dentist and the dental therapist. The board shall adopt and promulgate rules to establish minimum requirements for dental therapist management agreements.

C. General supervision of a dental therapist by a dentist includes communication between the dental therapist and dentist by use of telehealth.

D. A dental therapist may provide dental therapy services in private and public dental and medical offices, public and community medical facilities, federal Indian health service facilities, schools, hospitals and long-term care facilities and other settings located in dental health professional shortage areas as established in rules that the board has adopted and promulgated.

E. After five consecutive years of employment with the same employer as a dental therapist, fifteen percent of the patients that the dental therapist serves shall be medicaid

recipients.

F. To practice under the general supervision of a dentist, a dental therapist shall enter into a dental therapist management agreement with a dentist. The dental therapist management agreement shall set forth the scope of practice and conditions under which the dentist will provide general supervision of the dental therapist. A dental therapist management agreement shall not be subject to board or joint committee approval. The dental therapist management agreement shall be:

(1) submitted annually to the joint committee; and

(2) signed and maintained by the dentist and dental therapist.

G. A dentist and a dental therapist shall notify the joint committee upon the dissolution of their dental therapist management agreement.

H. A dental therapist may supervise under direct or indirect supervision dental assistants and dental hygienists. The dental therapist management agreement shall set forth the scope of practice and conditions under which the dental therapist may supervise dental assistants and dental hygienists."

SECTION 12. A new section of the Dental Health Care Act is enacted to read:

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"[NEW MATERIAL] DENTAL THERAPISTS--LICENSURE--UNAUTHORIZED PRACTICE--IMPAIRED LICENSEES--DISCIPLINE--PENALTIES.--

A. To be licensed as a dental therapist, an applicant shall:

(1) be licensed as a dental hygienist;

(2) have passed a written examination covering the laws and rules for practice in the state; and

(3) have submitted, to the joint committee for its approval and recommendation, proof:

(a) of graduation and receipt of a degree from a dental therapy education program that provides a competency-based curriculum, developed in partnership with an accredited institution of higher education;

(b) of passage of a competency-based examination given by a nationally recognized regional testing agency if available or, if not available, by an institution of higher education with a dental therapy education program; and

(c) after graduation from a dental therapist competency-based education program, of having completed a minimum of four hundred additional clinical hours under the indirect supervision of a dentist.

B. Upon notification from the dental therapy education program that the dental therapist applicant has graduated from the education program and passed the competency-based examination, the board, in accordance with the

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joint committee's recommendation, shall issue a permit for the applicant to practice during the applicant's requirement to complete four hundred additional clinical hours pursuant to Subparagraph (c) of Paragraph (3) of Subsection A of this section.

C. In accordance with the joint committee's recommendation, the board shall issue a license to practice as a dental therapist without a practical or clinical examination to an applicant who is a licensed dental therapist by examination under the laws of another state or territory of the United States; provided that:

(1) the applicant's dental therapy license has been in good standing in that jurisdiction for the two years immediately preceding the application for licensure;

(2) the applicant has a valid license to practice dental hygiene in that jurisdiction; and

(3) the applicant meets the requirements relating to licensure as a dental therapist pursuant to the Dental Health Care Act, including payment of appropriate fees and passing of an examination covering the laws and rules of practice in the state.

D. After an applicant has met the qualifications set forth in Subsections A through C of this section, the board, in accordance with the joint committee's recommendation, shall issue the applicant a license to practice as a dental

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therapist.

E. A dental therapist shall renew the dental therapist's license triennially in accordance with board rules.

F. A person who practices as a dental therapist or who attempts to practice as a dental therapist in violation of the provisions of the Dental Health Care Act or without a license entitling the person to practice as a dental therapist in the state is guilty of a misdemeanor pursuant to Section 31-19-1 NMSA 1978. Each occurrence of practicing as a dental therapist or attempting to practice as a dental therapist without complying with the Dental Health Care Act shall be a separate violation.

G. Nothing in this section shall preclude an individual from pursuing a degree in a combined dental therapy and dental hygiene education program.

H. By August 1, 2015, the joint committee shall establish rules relating to the practice of dental therapy in accordance with the Dental Health Care Act. By December 31, 2015, the board shall ratify, adopt and promulgate the rules the joint committee has established pursuant to this section, unless the board finds good cause not to ratify the rules that the joint committee recommends because the rules:

(1) are beyond the jurisdiction of the committee;

(2) will impose an undue financial impact upon

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the board; or

(3) are not supported by the record.

I. In the event that the board has failed, without good cause as described in Subsection H of this section, by December 31, 2015 to ratify, adopt and promulgate rules the joint committee has established pursuant to this section, the board shall be deemed to have adopted and shall promulgate those rules.

J. The joint committee shall establish, and, unless it finds due cause in accordance with the provisions of Subsection H of this section, the board shall ratify, adopt and promulgate rules to provide for the expedited issuance of a dental therapy license to an applicant after that applicant has received a license to practice dental hygiene.

K. For purposes of this section, "entity" means a corporation, business trust, estate, trust, partnership, limited liability company, association, organization, joint venture or any legal or commercial entity. As used in the Dental Health Care Act, "entity" excludes an individual or natural person."

SECTION 13. A new section of the Dental Health Care Act is enacted to read:

"[NEW MATERIAL] FEES.--In accordance with the provisions of Section 61-5A-11 NMSA 1978, the board shall establish a schedule of fees for dental therapists that shall be equivalent

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to fifty percent of the fees established for dental hygienists pursuant to Section 61-5A-20 NMSA 1978."

SECTION 14. Section 7-9-93 NMSA 1978 (being Laws 2004, Chapter 116, Section 6, as amended) is amended to read:

"7-9-93. DEDUCTION--GROSS RECEIPTS--CERTAIN RECEIPTS FOR SERVICES PROVIDED BY HEALTH CARE PRACTITIONER.--

A. Receipts from payments by a managed health care provider or health care insurer for commercial contract services or medicare part C services provided by a health care practitioner that are not otherwise deductible pursuant to another provision of the Gross Receipts and Compensating Tax Act may be deducted from gross receipts, provided that the services are within the scope of practice of the person providing the service. Receipts from fee-for-service payments by a health care insurer may not be deducted from gross receipts. The deduction provided by this section shall be separately stated by the taxpayer.

B. For the purposes of this section:

(1) "commercial contract services" means health care services performed by a health care practitioner pursuant to a contract with a managed health care provider or health care insurer other than those health care services provided for medicare patients pursuant to Title 18 of the federal Social Security Act or for medicaid patients pursuant to Title 19 or Title 21 of the federal Social Security Act;

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(2) "health care insurer" means a person that:

(a) has a valid certificate of authority in good standing pursuant to the New Mexico Insurance Code to act as an insurer, health maintenance organization or nonprofit health care plan or prepaid dental plan; and

(b) contracts to reimburse licensed health care practitioners for providing basic health services to enrollees at negotiated fee rates;

(3) "health care practitioner" means:

(a) a chiropractic physician licensed pursuant to the provisions of the Chiropractic Physician Practice Act;

(b) a dentist, dental therapist or dental hygienist licensed pursuant to the Dental Health Care Act;

(c) a doctor of oriental medicine licensed pursuant to the provisions of the Acupuncture and Oriental Medicine Practice Act;

(d) an optometrist licensed pursuant to the provisions of the Optometry Act;

(e) an osteopathic physician licensed pursuant to the provisions of Chapter 61, Article 10 NMSA 1978 or an osteopathic physician's assistant licensed pursuant to the provisions of the Osteopathic Physicians' Assistants Act;

(f) a physical therapist licensed

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pursuant to the provisions of the Physical Therapy Act;

(g) a physician or physician assistant licensed pursuant to the provisions of Chapter 61, Article 6 NMSA 1978;

(h) a podiatrist licensed pursuant to the provisions of the Podiatry Act;

(i) a psychologist licensed pursuant to the provisions of the Professional Psychologist Act;

(j) a registered lay midwife registered by the department of health;

(k) a registered nurse or licensed practical nurse licensed pursuant to the provisions of the Nursing Practice Act;

(l) a registered occupational therapist licensed pursuant to the provisions of the Occupational Therapy Act;

(m) a respiratory care practitioner licensed pursuant to the provisions of the Respiratory Care Act;

(n) a speech-language pathologist or audiologist licensed pursuant to the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act;

(o) a professional clinical mental health counselor, marriage and family therapist or professional art therapist licensed pursuant to the provisions of the

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Counseling and Therapy Practice Act who has obtained a master's degree or a doctorate;

(p) an independent social worker licensed pursuant to the provisions of the Social Work Practice Act; and

(q) a clinical laboratory that is accredited pursuant to 42 U.S.C. Section 263a but that is not a laboratory in a physician's office or in a hospital defined pursuant to 42 U.S.C. Section 1395x;

(4) "managed health care provider" means a person that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in a plan through its own employed health care providers or by contracting with selected or participating health care providers. "Managed health care provider" includes only those persons that provide comprehensive basic health care services to enrollees on a contract basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

(g) independent physician-provider

organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations; and

(5) "medicare part C services" means services performed pursuant to a contract with a managed health care provider for medicare patients pursuant to Title 18 of the federal Social Security Act."

SECTION 15. Section 26-1-2 NMSA 1978 (being Laws 1967, Chapter 23, Section 2, as amended) is amended to read:

"26-1-2. DEFINITIONS.--As used in the New Mexico Drug, Device and Cosmetic Act:

A. "board" means the board of pharmacy or its duly authorized agent;

B. "person" includes an individual, partnership, corporation, association, institution or establishment;

C. "biological product" means a virus, therapeutic serum, toxin, antitoxin or analogous product applicable to the prevention, treatment or cure of diseases or injuries of humans and domestic animals, and, as used within the meaning of this definition:

(1) a "virus" is interpreted to be a product containing the minute living cause of an infectious disease and includes filterable viruses, bacteria, rickettsia, fungi and

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protozoa;

(2) a "therapeutic serum" is a product obtained from blood by removing the clot or clot components and the blood cells;

(3) a "toxin" is a product containing a soluble substance poisonous to laboratory animals or humans in doses of one milliliter or less of the product and, following the injection of nonfatal doses into an animal, having the property of or causing to be produced therein another soluble substance that specifically neutralizes the poisonous substance and that is demonstrable in the serum of the animal thus immunized; and

(4) an "antitoxin" is a product containing the soluble substance in serum or other body fluid of an immunized animal that specifically neutralizes the toxin against which the animal is immune;

D. "controlled substance" means a drug, substance or immediate precursor enumerated in Schedules I through V of the Controlled Substances Act;

E. "drug" means articles:

(1) recognized in an official compendium;

(2) intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in humans or other animals and includes the domestic animal biological products regulated under the federal Virus-Serum-Toxin Act, 37 Stat 832-833, 21 U.S.C. 151-158, and the biological products

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applicable to humans regulated under Federal 58 Stat 690, as amended, 42 U.S.C. 216, Section 351, 58 Stat 702, as amended, and 42 U.S.C. 262;

(3) other than food, that affect the structure or any function of the human body or the bodies of other animals; and

(4) intended for use as a component of Paragraph (1), (2) or (3) of this subsection, but "drug" does not include devices or their component parts or accessories;

F. "dangerous drug" means a drug, other than a controlled substance enumerated in Schedule I of the Controlled Substances Act, that because of a potentiality for harmful effect or the method of its use or the collateral measures necessary to its use is not safe except under the supervision of a practitioner licensed by law to direct the use of such drug and hence for which adequate directions for use cannot be prepared. "Adequate directions for use" means directions under which the layperson can use a drug or device safely and for the purposes for which it is intended. A drug shall be dispensed only upon the prescription or drug order of a practitioner licensed by law to administer or prescribe the drug if it:

(1) is a habit-forming drug and contains any quantity of a narcotic or hypnotic substance or a chemical derivative of such substance that has been found under the federal act and the board to be habit forming;

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(2) because of its toxicity or other potential for harmful effect or the method of its use or the collateral measures necessary to its use is not safe for use except under the supervision of a practitioner licensed by law to administer or prescribe the drug;

(3) is limited by an approved application by Section 505 of the federal act to the use under the professional supervision of a practitioner licensed by law to administer or prescribe the drug;

(4) bears the legend: "Caution: federal law prohibits dispensing without prescription.";

(5) bears the legend: "Caution: federal law restricts this drug to use by or on the order of a licensed veterinarian."; or

(6) bears the legend "RX only";

G. "counterfeit drug" means a drug that is deliberately and fraudulently mislabeled with respect to its identity, ingredients or sources. Types of such pharmaceutical counterfeits may include:

(1) "identical copies", which are counterfeits made with the same ingredients, formulas and packaging as the originals but not made by the original manufacturer;

(2) "look-alikes", which are products that feature high-quality packaging and convincing appearances but contain little or no active ingredients and may contain harmful

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substances;

(3) "rejects", which are drugs that have been rejected by the manufacturer for not meeting quality standards; and

(4) "relabels", which are drugs that have passed their expiration dates or have been distributed by unauthorized foreign sources and may include placebos created for late-phase clinical trials;

H. "device", except when used in Subsection P of this section and in Subsection G of Section 26-1-3, Subsection L and Paragraph (4) of Subsection A of Section 26-1-11 and Subsection C of Section 26-1-24 NMSA 1978, means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component, part or accessory, that is:

(1) recognized in an official compendium;

(2) intended for use in the diagnosis of disease or other conditions or in the cure, mitigation, treatment or prevention of disease in humans or other animals; or

(3) intended to affect the structure or a function of the human body or the bodies of other animals and that does not achieve any of its principal intended purposes through chemical action within or on the human body or the bodies of other animals and that is not dependent on being metabolized for achievement of any of its principal intended

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purposes;

I. "prescription" means an order given individually for the person for whom prescribed, either directly from a licensed practitioner or the practitioner's agent to the pharmacist, including by means of electronic transmission, or indirectly by means of a written order signed by the prescriber, and bearing the name and address of the prescriber, the prescriber's license classification, the name and address of the patient, the name and quantity of the drug prescribed, directions for use and the date of issue;

J. "practitioner" means a certified advanced practice chiropractic physician, physician, doctor of oriental medicine, dentist, veterinarian, euthanasia technician, certified nurse practitioner, clinical nurse specialist, pharmacist, pharmacist clinician, certified nurse-midwife, physician assistant, prescribing psychologist, dental therapist, dental hygienist or other person licensed or certified to prescribe and administer drugs that are subject to the New Mexico Drug, Device and Cosmetic Act;

K. "cosmetic" means:

(1) articles intended to be rubbed, poured, sprinkled or sprayed on, introduced into or otherwise applied to the human body or any part thereof for cleansing, beautifying, promoting attractiveness or altering the appearance; and

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(2) articles intended for use as a component of any articles enumerated in Paragraph (1) of this subsection, except that the term shall not include soap;

L. "official compendium" means the official United States pharmacopoeia national formulary or the official homeopathic pharmacopoeia of the United States or any supplement to either of them;

M. "label" means a display of written, printed or graphic matter upon the immediate container of an article. A requirement made by or under the authority of the New Mexico Drug, Device and Cosmetic Act that any word, statement or other information appear on the label shall not be considered to be complied with unless the word, statement or other information also appears on the outside container or wrapper, if any, of the retail package of the article or is easily legible through the outside container or wrapper;

N. "immediate container" does not include package liners;

O. "labeling" means all labels and other written, printed or graphic matter:

(1) on an article or its containers or wrappers; or

(2) accompanying an article;

P. "misbranded" means a label to an article that is misleading. In determining whether the label is misleading,

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there shall be taken into account, among other things, not only representations made or suggested by statement, word, design, device or any combination of the foregoing, but also the extent to which the label fails to reveal facts material in the light of such representations or material with respect to consequences that may result from the use of the article to which the label relates under the conditions of use prescribed in the label or under such conditions of use as are customary or usual;

Q. "advertisement" means all representations disseminated in any manner or by any means, other than by labeling, for the purpose of inducing, or that are likely to induce, directly or indirectly, the purchase of drugs, devices or cosmetics;

R. "antiseptic", when used in the labeling or advertisement of an antiseptic, shall be considered to be a representation that it is a germicide, except in the case of a drug purporting to be or represented as an antiseptic for inhibitory use as a wet dressing, ointment, dusting powder or such other use as involves prolonged contact with the body;

S. "new drug" means a drug:

(1) the composition of which is such that the drug is not generally recognized, among experts qualified by scientific training and experience to evaluate the safety and efficacy of drugs, as safe and effective for use under the

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conditions prescribed, recommended or suggested in the labeling thereof; or

(2) the composition of which is such that the drug, as a result of investigation to determine its safety and efficacy for use under such conditions, has become so recognized, but that has not, otherwise than in such investigations, been used to a material extent or for a material time under such conditions;

T. "contaminated with filth" applies to a drug, device or cosmetic not securely protected from dirt, dust and, as far as may be necessary by all reasonable means, from all foreign or injurious contaminations, or a drug, device or cosmetic found to contain dirt, dust, foreign or injurious contamination or infestation;

U. "selling of drugs, devices or cosmetics" shall be considered to include the manufacture, production, processing, packing, exposure, offer, possession and holding of any such article for sale and the sale and the supplying or applying of any such article in the conduct of a drug or cosmetic establishment;

V. "color additive" means a material that:

(1) is a dye, pigment or other substance made by a process of synthesis or similar artifice or extracted, isolated or otherwise derived, with or without intermediate or final change of identity, from a vegetable, mineral, animal or

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other source; or

(2) when added or applied to a drug or cosmetic or to the human body or a part thereof, is capable, alone or through reaction with other substances, of imparting color thereto; except that such term does not include any material that has been or hereafter is exempted under the federal act;

W. "federal act" means the Federal Food, Drug and Cosmetic Act;

X. "restricted device" means a device for which the sale, distribution or use is lawful only upon the written or oral authorization of a practitioner licensed by law to administer, prescribe or use the device and for which the federal food and drug administration requires special training or skills of the practitioner to use or prescribe. This definition does not include custom devices defined in the federal act and exempt from performance standards or premarket approval requirements under Section 520(b) of the federal act;

Y. "prescription device" means a device that, because of its potential for harm, the method of its use or the collateral measures necessary to its use, is not safe except under the supervision of a practitioner licensed in this state to direct the use of such device and for which "adequate directions for use" cannot be prepared, but that bears the label: "Caution: federal law restricts this device to sale by or on the order of a _____", the blank to be filled with

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the word "physician", "physician assistant", "certified advanced practice chiropractic physician", "doctor of oriental medicine", "dentist", "veterinarian", "euthanasia technician", "certified nurse practitioner", "clinical nurse specialist", "pharmacist", "pharmacist clinician", "certified nurse-midwife", "dental therapist" or "dental hygienist" or with the descriptive designation of any other practitioner licensed in this state to use or order the use of the device;

Z. "valid practitioner-patient relationship" means a professional relationship, as defined by the practitioner's licensing board, between the practitioner and the patient;

AA. "pedigree" means the recorded history of a drug; and

BB. "drug order" means an order either directly from a licensed practitioner or the practitioner's agent to the pharmacist, including by means of electronic transmission or indirectly by means of a written order signed by the licensed practitioner or the practitioner's agent, and bearing the name and address of the practitioner and the practitioner's license classification and the name and quantity of the drug or device ordered for use at an inpatient or outpatient facility."

SECTION 16. Section 27-2-12 NMSA 1978 (being Laws 1973, Chapter 376, Section 16, as amended) is amended to read:

"27-2-12. MEDICAL ASSISTANCE PROGRAMS.--

A. Consistent with the federal act and subject to

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the appropriation and availability of federal and state funds, the medical assistance division of the department may by rule provide medical assistance, including the services of licensed doctors of oriental medicine, licensed chiropractic physicians, licensed dental therapists and licensed dental hygienists in collaborating practice, to persons eligible for public assistance programs under the federal act.

B. Subject to appropriation and availability of federal, state or other funds received by the state from public or private grants or donations, the medical assistance division of the department may by rule provide medical assistance, including assistance in the payment of premiums for medical or long-term care insurance, to children up to the age of twelve if not part of a sibling group; children up to the age of eighteen if part of a sibling group that includes a child up to the age of twelve; and pregnant women who are residents of the state of New Mexico and who are ineligible for public assistance under the federal act. The department, in implementing the provisions of this subsection, shall:

(1) establish rules that encourage pregnant women to participate in prenatal care; and

(2) not provide a benefit package that exceeds the benefit package provided to state employees."

SECTION 17. Section 59A-22-32 NMSA 1978 (being Laws 1984, Chapter 127, Section 454, as amended) is amended to read:

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"59A-22-32. FREEDOM OF CHOICE OF HOSPITAL AND PRACTITIONER.--

A. Within the area and limits of coverage offered an insured and selected by the insured in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife, dental hygienist, dental therapist or registered nurse in expanded practice, as defined in Subsection B of this section, for treatment of an illness or injury within that person's scope of practice shall not be restricted under any new policy of health insurance, contract or health care plan issued after June 30, 1967 in this state or in the processing of a claim thereunder. A person insured or claiming benefits under any such health insurance policy, contract or health care plan providing within its coverage for payment of service benefits or indemnity for hospital care or treatment of persons for the cure or correction of any physical or mental condition shall be deemed to have complied with the requirements of the policy, contract or health care plan as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health or any practitioner of the healing arts or optometrist, psychologist, podiatrist, physician

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assistant, certified nurse-midwife, registered lay midwife, dental hygienist, dental therapist or registered nurse in expanded practice.

B. As used in this section:

(1) "hospital care" means hospital service provided through a hospital that is maintained by the state or a political subdivision of the state or a place that is currently licensed as a hospital by the department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but "hospital care" does not include a convalescent or nursing or rest home;

(2) "practitioner of the healing arts" means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

(a) the Chiropractic Physician Practice Act;

(b) the Dental Health Care Act;

(c) the Medical Practice Act;

(d) Chapter 61, Article 10 NMSA 1978; and

(e) the Acupuncture and Oriental

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Medicine Practice Act;

(3) "optometrist" means a person holding a license provided for in the Optometry Act;

(4) "podiatrist" means a person holding a license provided for in the Podiatry Act;

(5) "psychologist" means a person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology;

(6) "physician assistant" means a person who is licensed by the New Mexico medical board to practice as a physician assistant and who provides services to patients under the supervision and direction of a licensed physician;

(7) "certified nurse-midwife" means a person licensed by the board of nursing as a registered nurse and who is registered with the public health division of the department of health as a certified nurse-midwife;

(8) "registered lay midwife" means a person who practices lay midwifery and is registered as a registered lay midwife by the public health division of the department of health; [~~and~~]

(9) "registered nurse in expanded practice" means a person licensed by the board of nursing as a registered

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nurse approved for expanded practice pursuant to the Nursing Practice Act as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing [~~speciality~~] specialty and is certified by a national nursing organization;

(10) "dental hygienist" means an individual licensed to practice dental hygiene pursuant to the Dental Health Care Act; and

(11) "dental therapist" means an individual licensed to practice dental therapy pursuant to the Dental Health Care Act.

C. This section shall apply to any such policy that is delivered or issued for delivery in this state on or after July 1, 1979 and to any existing group policy or plan on its anniversary or renewal date after June 30, 1979 or at expiration of the applicable collective bargaining contract, if any, whichever is later."

SECTION 18. Section 59A-47-28.4 NMSA 1978 (being Laws 2003, Chapter 343, Section 4) is amended to read:

"59A-47-28.4. COVERAGE FOR DENTAL THERAPISTS AND COLLABORATIVE PRACTICE DENTAL HYGIENISTS.--An individual or group subscriber contract delivered or issued for delivery in New Mexico that, on a prepaid, service or indemnity basis,

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provides for treatment of persons for the prevention, cure or correction of any illness or physical or mental condition shall include coverage for the services of a dental therapist and of a dental hygienist in a collaborative practice pursuant to the Dental Health Care Act."

SECTION 19. Section 61-5B-1 NMSA 1978 (being Laws 1994, Chapter 55, Section 30) is amended to read:

"61-5B-1. SHORT TITLE.--[~~Sections 31 through 41 of this act~~] Chapter 61, Article 5B NMSA 1978 shall be cited as the "Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act"."

SECTION 20. Section 61-5B-2 NMSA 1978 (being Laws 1994, Chapter 55, Section 31, as amended) is amended to read:

"61-5B-2. DEFINITIONS.--As used in the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act:

A. "board" means the New Mexico board of dental health care;

B. "dental hygienists committee" means the New Mexico dental hygienists committee;

C. "dental therapy representative" means an individual who:

(1) publicly supports or recommends the practice of dental therapy in the state;

(2) has knowledge of the practice of dental therapy or of the educational or licensing requirements for the

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practice of dental therapy; and

(3) has been nominated by a representative of:

(a) New Mexico health resources, inc.;

(b) health action New Mexico;

(c) a state or regional dental therapists' association; or

(d) an institution of higher education located in New Mexico that has a dental therapist education program;

[~~C.~~] D. "dentistry, dental therapy or dental hygiene" means the practice of dentistry, dental therapy or dental hygiene; [~~and~~]

E. "joint committee" means the New Mexico dental therapist joint committee that makes recommendations to the board relating to the regulation of the practice of dental therapy and licensure of dental therapists; and

[~~D.~~] F. "licensee" means a dentist, dental therapist or dental hygienist licensed by the board."

SECTION 21. Section 61-5B-3 NMSA 1978 (being Laws 1994, Chapter 55, Section 32) is amended to read:

"61-5B-3. GROUNDS FOR RESTRICTION, SUSPENSION, REVOCATION, STIPULATION OR OTHER LIMITATION OF LICENSE OR CERTIFICATE.--The license of any [~~dentist or dental hygienist~~] licensee to practice dentistry, dental therapy or dental hygiene, or the certificate of a dental assistant to

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practice dental assisting, in this state shall be subject to restriction, suspension, revocation or stipulation or may otherwise be limited in case of inability of the licensee or certificate holder to practice with reasonable skill and safety to patients by reason of one or more of the following:

A. mental illness;

B. physical illness, including but not limited to deterioration through the aging process or loss of motor skills;

C. habitual or excessive use or abuse of drugs, as defined in the Controlled Substances Act; or

D. habitual or excessive use or abuse of alcohol."

SECTION 22. Section 61-5B-4 NMSA 1978 (being Laws 1994, Chapter 55, Section 33) is amended to read:

"61-5B-4. BOARD, JOINT COMMITTEE OR DENTAL HYGIENISTS COMMITTEE--ADDITIONAL POWERS AND DUTIES AS RELATED TO THE IMPAIRED [~~DENTISTS AND~~] DENTAL [~~HYGIENISTS~~] PROFESSIONALS ACT.--

A. If the board, joint committee or dental hygienists committee has reasonable cause to believe that a [~~person licensed to practice dentistry or dental hygiene~~] licensee is unable to practice with reasonable skill and safety to patients because of a condition described in the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals

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Act, the board shall cause an examination of [~~such~~] the licensee to be made and shall, following the examination, take appropriate action within the provisions of the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act.

B. Examination of a licensee pursuant to an order of the board shall be conducted by an examining committee designated by the board. [~~Each examining committee shall be composed of two duly licensed dentists, or two duly licensed dental hygienists if the licensee is a dental hygienist, and two duly licensed physicians, one of whom shall be a psychiatrist who is knowledgeable and experienced in the field of chemical dependency if a question of mental illness or dependency is involved. Whenever possible, examining committee members shall be selected for their knowledge or experience in the areas of alcoholism, chemical dependency, mental health and geriatrics and may be rehabilitated impaired dentists, dental hygienists or physicians. In designating the members of such examining committee, the board may consider nominations from the New Mexico dental association for the dentist member, the New Mexico dental hygienists' association for dental hygiene members thereof and nomination from the New Mexico medical society for the physician members thereof. No current members of the board, dental hygienists committee or New Mexico board of medical examiners shall be designated as a member of an examining~~

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~~committee.~~] An examining committee shall be composed of two licensed physicians, one of whom shall be a psychiatrist who is knowledgeable and experienced in the field of chemical dependency if a question of mental illness or dependency is involved. An examining committee shall also include additional members in the following manner:

(1) if the licensee is a dentist, the examining committee shall include two licensed dentists;

(2) if the licensee is a dental therapist, the examining committee shall include two licensed dental therapists or two dental therapy representatives; and

(3) if the licensee is a dental hygienist, the examining committee shall include two licensed dental hygienists.

C. Whenever possible, examining committee members shall be selected for their knowledge of or experience in the areas of alcoholism, chemical dependency, mental health and geriatrics. Members of the examining committee may be rehabilitated impaired dentists, dental therapists, dental hygienists or physicians.

D. In designating the members of an examining committee, the licensing authority may consider nominations from the New Mexico medical society for physician members and nominations from the following entities:

(1) for dentist members, from the New Mexico

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dental association;

(2) for dental therapist members, a state or regional dental therapists' association, if available, or a dental therapy education program located in the state; and

(3) for dental hygienist members, the New Mexico dental hygienists' association.

E. A current member of the board, the joint committee, the dental hygienists committee or the New Mexico board of medical examiners shall not be designated as a member of an examining committee."

SECTION 23. Section 61-5B-5 NMSA 1978 (being Laws 1994, Chapter 55, Section 34) is amended to read:

"61-5B-5. EXAMINATION BY COMMITTEE.--

A. The examining committee assigned to examine a licensee pursuant to referral by the board shall conduct an examination of the licensee for the purpose of determining the fitness of the licensee to practice dentistry, dental therapy or dental hygiene with reasonable skill and safety to patients, either on a restricted or unrestricted basis, and shall report its findings and recommendations to the board. The findings and recommendations shall be based on findings by the examining committee that the licensee examined possesses one or more of the impairments set forth in the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act and [~~such~~] the impairment does, in fact, affect the ability

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of the licensee to skillfully and safely practice dentistry, dental therapy or dental hygiene. The examining committee shall order the licensee to appear before it for a hearing and give the licensee fifteen days' notice of the time and place of the hearing, together with a statement of the cause for [~~such examination~~] the hearing. The notice shall be served upon the licensee either personally or by registered or certified mail with return receipt requested.

B. If the examining committee, in its discretion, deems a mental or physical examination of the licensee necessary to its determination of the fitness of the licensee to practice, the examining committee shall order the licensee to submit to [~~such~~] the examination. Any [~~person licensed to practice dentistry or dental hygiene~~] licensee in this state shall, by so practicing or by making or filing an annual registration to practice dentistry, dental therapy or dental hygiene in this state, be deemed to have:

(1) given consent to submit to mental or physical examination when so directed by the examining committee; and

(2) waived all objections to the admissibility of the report of the examining committee to the board, the joint committee or the dental hygienists committee on the grounds of privileged communication.

C. Any licensee who submits to a diagnostic

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mental or physical examination as ordered by the examining committee shall have a right to designate an accompanying individual to be present at the examination and make an independent report to the board.

D. Failure of a licensee to comply with an examining committee order under Subsection B of this section to appear before it for hearing or to submit to mental or physical examination under this section shall be reported by the examining committee to the board, the joint committee or the dental hygienists committee and, unless due to circumstances beyond the control of the licensee, shall be grounds for the immediate and summary suspension by the board [~~of the licensee~~] to practice dentistry, dental therapy or dental hygiene in this state until further order of the board."

SECTION 24. Section 61-5B-6 NMSA 1978 (being Laws 1994, Chapter 55, Section 35) is amended to read:

"61-5B-6. VOLUNTARY RESTRICTION OF LICENSURE.--

A. A licensee may request in writing to the board a restriction to practice under [~~his~~] the licensee's existing license, and the board [~~and the dental hygienists committee~~] shall have authority, if [~~it deems~~] deemed appropriate, to attach stipulations to the licensure of the licensee to practice dentistry, dental therapy or dental hygiene within specified limitations and waive the commencement of [~~any~~] a

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proceeding. Removal of a voluntary restriction on licensure to practice dentistry, dental therapy or dental hygiene shall be subject to the procedure for reinstatement of license. As a condition for accepting such voluntary limitation of practice, the board may require [~~each~~] the licensee to:

(1) agree to and accept care, counseling or treatment of physicians or other appropriate health care providers acceptable to the board;

(2) participate in a program of education prescribed by the board; or

(3) practice under the direction of a dentist acceptable to the board for a specified period of time.

B. Subject to the provisions of the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act, a violation of any of the conditions of the voluntary limitation of practice statement by [~~such~~] the licensee shall be due cause for the refusal of renewal, or the suspension or revocation, of the license by the board."

SECTION 25. Section 61-5B-7 NMSA 1978 (being Laws 1994, Chapter 55, Section 36) is amended to read:

"61-5B-7. REPORT TO THE BOARD, JOINT COMMITTEE OR DENTAL HYGIENISTS COMMITTEE--ACTION.--

A. The examining committee shall report to the board, joint committee or the dental hygienists committee its findings on the examination of the licensee, the

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determination of the examining committee as to the fitness of the licensee to engage in the practice of dentistry, dental therapy or dental hygiene with reasonable skill and safety to patients, either on a restricted or unrestricted basis, and any intervention that the examining committee may recommend. Such recommendation by the examining committee shall be advisory only and shall not be binding on the board.

B. The board, joint committee or dental hygienists committee may accept or reject the recommendation of the examining committee to permit a licensee to continue to practice with or without any restriction on [~~his~~] the licensee's licensure to practice dentistry, dental therapy or dental hygiene or may refer the matter back to the examining committee for further examination [~~and report thereon~~].

C. In the absence of a voluntary agreement by a licensee for restriction of the licensure of the dentist, dental therapist or the dental hygienist to practice dentistry or dental hygiene, [~~any~~] the licensee shall be entitled to a hearing before the board under and in accordance with the procedure contained in the Uniform Licensing Act and a determination on the evidence as to whether [~~or not~~] restriction, suspension or revocation of licensure shall be imposed."

SECTION 26. Section 61-5B-8 NMSA 1978 (being Laws 1994, Chapter 55, Section 37) is amended to read:

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"61-5B-8. PROCEEDINGS.--

A. The board may formally proceed against a licensee under the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act in accordance with the procedures contained in the Uniform Licensing Act.

B. When the licensee being considered for action is a dental hygienist, the board shall act upon recommendation of the dental hygienists committee on all aspects of procedures in the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act.

C. When the licensee being considered for action is a dental therapist, the board shall act upon recommendation of the joint committee on all aspects of procedures pursuant to the Impaired Dental Professionals Act.

[~~C.~~] D. At the conclusion of [~~the~~] a hearing conducted pursuant to the Impaired Dental Professionals Act, the board [~~or the dental hygienists committee~~] shall make the following findings:

(1) whether [~~or not~~] the licensee is impaired by one of the grounds for restriction, suspension or revocation listed [~~herein~~] in Section 61-5B-3 NMSA 1978;

(2) whether [~~or not such~~] the impairment does in fact limit the ability of the licensee to practice dentistry, dental therapy or dental hygiene skillfully and safely; and

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(3) to what extent [~~such~~] the impairment limits the ability of the licensee to practice dentistry, dental therapy or dental hygiene skillfully and safely and whether the board [~~or dental hygienists committee~~] finds that [~~such~~] the impairment is such that the license should be suspended, revoked or restricted in the licensee's practice of dentistry, dental therapy or dental hygiene. [~~and;~~

~~(4)~~] D. If the finding recommends suspension or restriction of the ability of the licensee to practice dentistry, dental therapy or dental hygiene, [~~then~~] the board shall make specific recommendations as to the length and nature of the suspension or restriction and shall recommend how [~~such~~] the suspension or restriction shall be carried out and supervised.

[~~D.~~] E. At the conclusion of the hearing, the board [~~or the dental hygienists committee~~] shall make a determination of the merits and may order one or more of the following:

(1) placement of the licensee on probation on such terms and conditions as it deems proper for the protection of the public;

(2) suspension or restriction of the license of the licensee to practice dentistry, dental therapy or dental hygiene for the duration of the licensee's impairment;

(3) revocation of the license of the licensee

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to practice dentistry, dental therapy or dental hygiene; or

(4) reinstatement of the license of the licensee to practice dentistry, dental therapy or dental hygiene without restriction.

[~~E.~~] F. The board may temporarily suspend the license of any licensee without a hearing, simultaneously with the institution of proceedings under the Uniform Licensing Act, if it finds that the evidence in support of the determination of the examining committee is clear and convincing and that continuation in practice would constitute an imminent danger to public health and safety.

[~~F.~~] G. Neither the record of the proceeding nor any order entered against a licensee may be used against the licensee in any other legal proceeding except upon judicial review."

SECTION 27. Section 61-5B-9 NMSA 1978 (being Laws 1994, Chapter 55, Section 38) is amended to read:

"61-5B-9. REINSTATEMENT OF LICENSE.--

A. A licensee whose licensure has been restricted, suspended or revoked under the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act, voluntarily or by action of the board, shall have a right at reasonable intervals to petition for reinstatement of the license and to demonstrate that the licensee can resume the competent practice of dentistry, dental therapy or dental hygiene with

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reasonable skill and safety to patients.

B. The petition shall be made in writing. If the licensee is a dental hygienist, the dental hygienists committee shall be advised and given all information [~~so that their~~] that the dental hygienists committee requests to inform its decision. The dental hygienists committee shall provide its recommendation [~~can be given~~] to the board for ratification.

C. If the licensee is a dental therapist, the joint committee shall be advised and given all information that the joint committee requests to inform its decision. The joint committee shall provide its recommendation to the board for ratification in accordance with the provisions of Section 61-5A-11 NMSA 1978.

[~~C.~~] D. Action of the board on [~~the~~] a petition for reinstatement shall be initiated by referral to and examination by [~~the~~] an examining committee.

[~~D.~~] E. The board may, in its discretion, upon written recommendation of the examining committee, restore the licensure of the licensee on a general or limited basis."

SECTION 28. Section 61-5B-10 NMSA 1978 (being Laws 1994, Chapter 55, Section 39) is amended to read:

"61-5B-10. IMPAIRED DENTISTS, DENTAL THERAPISTS AND DENTAL HYGIENISTS TREATMENT PROGRAM.--

A. The board has the authority to enter into an

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agreement with a nonprofit corporation to implement an impaired dentists, dental therapists and dental hygienists treatment program.

B. For the purposes of this section:

(1) "dental therapist" means an individual licensed to perform dental therapy pursuant to the provisions of the Dental Health Care Act; and

(2) "impaired dentists, dental therapists and dental hygienists treatment program" means a program of care and rehabilitation services provided by those organizations authorized by the board to provide for the [~~detention~~] detection, intervention and monitoring of an impaired [~~dentist or dental hygienist~~] licensee."

SECTION 29. Section 61-5B-11 NMSA 1978 (being Laws 1994, Chapter 55, Section 40) is amended to read:

"61-5B-11. IMPAIRED [~~DENTISTS AND~~] DENTAL [~~HYGIENISTS~~] PROFESSIONALS FUND CREATED.--

A. There is created an "impaired [~~dentists and~~] dental [~~hygienist~~] professionals fund".

B. The fund shall be initially established by an assessment to all licensees as determined by the board, the joint committee and the dental hygienists committee.

C. All [~~funds~~] money received by the board for an impaired assessment, either special or at time of relicensure, shall be deposited with the state treasurer.

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The state treasurer shall credit this money to the [~~impaired dentists and dental hygienists~~] fund.

D. Payments out of the fund shall be [~~on~~] made pursuant to vouchers issued and signed by the secretary-treasurer of the board upon warrants drawn by the department of finance and administration [~~in accordance with the responsibilities of the board~~] as approved by that department.

E. All amounts paid into the fund are subject to the order of the board and are to be used only for meeting necessary expenses incurred in executing the provisions and duties of the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act. All money unused at the end of any fiscal year shall remain in the fund for use in accordance with provisions of the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act.

F. Licensees shall be assessed an impaired fee at the time of renewal. The amount of the impaired fee shall be determined by the board, the joint committee and the dental hygienists committee and shall be established to meet the need for enforcing the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act.

G. The fund shall be used for the purpose of administration, testing, monitoring, hearings and consultation fees by the board, the joint committee or the

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dental hygienists committee or [~~their~~] its agent, which are necessary to enforce the Impaired [~~Dentists and~~] Dental [~~Hygienists~~] Professionals Act. It is not the purpose of the fund to pay for treatment of impaired dentists, [~~and~~] dental therapists or dental hygienists."

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE COURTS, CORRECTIONS AND JUSTICE COMMITTEE AND THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC HEALTH; AMENDING THE MEDICAID PROVIDER ACT; DEFINING "CREDIBLE ALLEGATION OF FRAUD" AND "OVERPAYMENT"; ESTABLISHING RIGHTS AND REMEDIES OF MEDICAID PROVIDERS AND SUBCONTRACTORS FOR ALLEGED OVERPAYMENTS OR CREDIBLE ALLEGATION OF FRAUD BASED ON AUDIT FINDINGS AND SAMPLING; PROHIBITING EXTRAPOLATION; PROVIDING FOR JUDICIAL REVIEW, INJUNCTIVE RELIEF, ATTORNEY FEES AND WITNESS FEES; AMENDING THE MEDICAID FRAUD ACT TO CLARIFY THAT MERE ERRORS FOUND DURING THE COURSE OF AN AUDIT, BILLING ERRORS THAT ARE ATTRIBUTABLE TO HUMAN ERROR, INADVERTENT BILLING AND PROCESSING ERRORS AND FAILURE TO COMPLY WITH A REGULATORY STANDARD THAT IS NOT A CONDITION OF PAYMENT DO NOT CONSTITUTE MEDICAID FRAUD AND TO PROVIDE FOR INVESTIGATION AND LIMITATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 27-11-1 NMSA 1978 (being Laws 1998, Chapter 30, Section 1) is amended to read:

"27-11-1. SHORT TITLE.--[~~This act~~] Chapter 27, Article 11 NMSA 1978 may be cited as the "Medicaid Provider Act"."

SECTION 2. Section 27-11-2 NMSA 1978 (being Laws 1998, Chapter 30, Section 2) is amended to read:

"27-11-2. DEFINITIONS.--As used in the Medicaid Provider Act:

A. "credible allegation of fraud" means an allegation of medicaid fraud, as defined in Subsection A of Section 30-44-7 NMSA 1978, that has been verified as credible by the department:

(1) considering the totality of the facts and circumstances surrounding any particular allegation or set of allegations;

(2) based upon a careful review of all allegations, facts and evidence; and

(3) accompanied by sufficient indicia of reliability to justify a decision by the department to refer a medicaid provider or other person to the attorney general for further investigation;

[~~A.~~] B. "department" means the human services department;

[~~B.~~] C. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements

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with the department to provide health care and related services;

[~~C.~~] D. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

[~~D.~~] E. "medicaid provider" means a person, including a managed care organization, operating under contract with the department to provide medicaid-related services to recipients;

F. "overpayment" means an amount paid to a medicaid provider or subcontractor in excess of the medicaid allowable amount, including payment for any claim to which a medicaid provider or subcontractor is not entitled;

[~~E.~~] G. "person" means an individual or other legal entity;

[~~F.~~] H. "recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

[~~G.~~] I. "secretary" means the secretary of human services; and

[~~H.~~] J. "subcontractor" means a person who contracts with a medicaid provider to provide medicaid-related services to recipients."

SECTION 3. A new section of the Medicaid Provider Act is enacted to read:

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"[NEW MATERIAL] DETERMINATION OF OVERPAYMENTS OR CREDIBLE ALLEGATION OF FRAUD BASED UPON AUDIT FINDINGS--SAMPLING--EXTRAPOLATION PROHIBITED--RIGHTS OF MEDICAID PROVIDER OR SUBCONTRACTOR.--

A. The department:

(1) may audit a medicaid provider or subcontractor for overpayment, using sampling for the time period audited;

(2) shall not extrapolate audit findings; and

(3) shall require each person reviewing audited claims for the department to be licensed, certified, registered or otherwise credentialed in New Mexico as to the matters such person audits, including coding or specific clinical practice.

B. Prior to reaching a final determination of overpayment or final determination of credible allegation of fraud based in whole or in part upon overpayment, the department shall provide written notice of a tentative finding of overpayment to the medicaid provider or subcontractor.

C. The notice of a tentative finding of overpayment shall:

(1) state with specificity the factual and legal basis for each finding of an alleged overpayment; and

(2) notify the medicaid provider or subcontractor that is the subject of a tentative finding of overpayment of the medicaid provider's or subcontractor's right

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to request, within thirty days of receipt of the notice of a tentative finding of overpayment:

(a) an informal conference with a representative of the department to address, resolve or dispute the department's overpayment allegations; and

(b) an administrative hearing to challenge the department's overpayment allegations.

D. Upon receipt of a request for an informal conference, the department shall set a date for the conference to occur no later than seven days following receipt of the request.

E. The medicaid provider or subcontractor shall have no less than thirty days following receipt of the department's notice of a tentative finding of overpayment to provide additional documentation to the department to attempt to informally address or resolve a disputed tentative finding of overpayment.

F. Upon receipt of a request for an administrative hearing, the department shall set a date for the hearing no later than thirty days, or as stipulated by the parties or upon a showing of good cause, no later than ninety days following receipt of the request.

G. The department shall allow a medicaid provider or subcontractor to correct clerical, typographical, scrivener's and computer errors or to provide misplaced

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credentialing, licensure or training records prior to making a final determination of overpayment or final determination of credible allegation of fraud based in whole or in part upon overpayment and may impose corrective action upon the medicaid provider or subcontractor to address systemic conditions contributing to errors in the submission of claims for payment to which a medicaid provider or subcontractor is not entitled.

H. A medicaid provider or subcontractor shall be permitted to challenge the accuracy of the department's audit, the statistical methodology of the department's original sample, the credentials of the persons who participated in the audit or the good faith of a prepayment review of claims and to present evidence to dispute any factual findings of the department as to any matter.

I. The department shall not require a medicaid provider or subcontractor to conduct its own audit or sampling as a condition precedent to challenging the department's tentative or final audit determinations.

J. A medicaid provider or subcontractor shall have a right of appeal to district court from a final determination of overpayment pursuant to Section 39-3-1.1 NMSA 1978."

SECTION 4. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] SUSPENSION OF PAYMENTS--PREPAYMENT REVIEW--REMEDIAL TRAINING AND EDUCATION--RETURN OF SUSPENDED

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PAYMENTS--DISPOSITION OF RECOVERED OVERPAYMENTS.--

A. The department shall not suspend payment to a medicaid provider or subcontractor:

(1) before a final determination of overpayment is made and until all administrative and civil remedies and appeals have been exhausted by the medicaid provider or subcontractor; or

(2) after the posting of a bond or other surety by the medicaid provider or subcontractor in the amount of the suspended payment, which shall be deemed good cause not to suspend payment.

B. The provisions of this section shall not prevent the department from:

(1) conducting a good-faith prepayment review of subsequent claims by a medicaid provider or subcontractor that is the subject of a tentative overpayment determination; or

(2) requiring a medicaid provider or subcontractor that is the subject of a tentative overpayment determination or its employees to complete remedial training or education to prevent the submission of claims for payment to which a medicaid provider or subcontractor is not entitled.

C. The department shall release suspended payments no later than seven days following the earlier of:

(1) the posting of a bond or other surety by the medicaid provider or subcontractor in the amount of the

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suspended payment;

(2) notice from the attorney general that the attorney general will not pursue legal action arising out of the referral of the medicaid provider or subcontractor;

(3) the date on which an administrative decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final; or

(4) the date on which a judicial decision as to the basis for suspending such payments, or portion of such payments, in favor of the medicaid provider or subcontractor becomes final and not subject to further appeal.

D. The department shall not pay any portion of overpayments recovered by the state from a medicaid provider or subcontractor to any other person unless expressly authorized or required to do so by state or federal statute."

SECTION 5. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] CREDIBLE ALLEGATION OF FRAUD--JUDICIAL REVIEW.--

A. A credible allegation of fraud determination by the department shall be deemed a final decision as defined in Section 39-3-1.1 NMSA 1978.

B. A medicaid provider or subcontractor who is the subject of a referral to the attorney general for further

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investigation based upon a credible allegation of fraud may seek judicial review of the department's credible allegation of fraud determination pursuant to Section 39-3-1.1 NMSA 1978."

SECTION 6. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] INJUNCTIVE RELIEF.--A medicaid provider or subcontractor appealing a final determination of overpayment or seeking judicial review of the department's credible allegation of fraud determination shall be entitled to:

A. injunctive relief during the pendency of any investigation of alleged fraud, waste or abuse based upon a credible allegation of fraud and of related court proceedings, including:

(1) enjoining the department from suspending payments, subject to the requirement that the medicaid provider or subcontractor post a bond or other surety; and

(2) requiring the department to pay for ongoing services rendered by the medicaid provider or subcontractor, subject to a good-faith prepayment review of claims; and

B. such other relief as the court deems appropriate to protect the professional and property interests of the medicaid provider or subcontractor and of its officers, directors and employees during the pendency of any investigation of alleged fraud, waste or abuse based upon a credible allegation of fraud and of related court proceedings."

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SECTION 7. A new section of the Medicaid Provider Act is enacted to read:

"[NEW MATERIAL] ATTORNEY FEES--WITNESS FEES.--Reasonable attorney fees and witness fees may be assessed against the department upon a finding by an administrative law judge or district court judge that the department has substantially prejudiced the medicaid provider's or subcontractor's rights and has acted arbitrarily or capriciously in its determination of credible allegation of fraud or overpayment under the Medicaid Provider Act."

SECTION 8. Section 30-44-7 NMSA 1978 (being Laws 1989, Chapter 286, Section 7, as amended) is amended to read:

"30-44-7. MEDICAID FRAUD--DEFINED--[~~INVESTIGATION~~] PENALTIES.--

A. Medicaid fraud consists of:

(1) paying, soliciting, offering or receiving:

(a) a kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the program, including an offer or promise to, or a solicitation or acceptance by, a health care official of anything of value with intent to influence a decision or commit a fraud affecting a state or federally funded or mandated managed health care plan;

(b) a rebate of a fee or charge made to a provider for referring a recipient to a provider;

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(c) anything of value, intending to retain it and knowing it to be in excess of amounts authorized under the program, as a precondition of providing treatment, care, services or goods or as a requirement for continued provision of treatment, care, services or goods; or

(d) anything of value, intending to retain it and knowing it to be in excess of the rates established under the program for the provision of treatment, services or goods;

(2) providing with intent that a claim be relied upon for the expenditure of public money:

(a) treatment, services or goods that have not been ordered by a [~~treating physician~~] provider;

(b) treatment that is substantially inadequate when compared to generally recognized standards within the discipline or industry; or

(c) merchandise that has been adulterated, debased or mislabeled or is outdated;

(3) presenting or causing to be presented for allowance or payment with intent that a claim be relied upon for the expenditure of public money any false, fraudulent or excessive [~~multiple or incomplete~~] claim for furnishing treatment, services or goods; or

(4) executing or conspiring to execute a plan or action to:

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(a) defraud a state or federally funded or mandated managed health care plan in connection with the delivery of or payment for health care benefits, including engaging in any intentionally deceptive marketing practice in connection with proposing, offering, selling, soliciting or providing any health care service in a state or federally funded or mandated managed health care plan; or

(b) obtain by means of false or fraudulent representation or promise anything of value in connection with the delivery of or payment for health care benefits that are in whole or in part paid for or reimbursed or subsidized by a state or federally funded or mandated managed health care plan. This includes representations or statements of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered and the qualifications of persons rendering health care or ancillary services.

B. The following do not constitute medicaid fraud:

(1) mere errors found during the course of an audit;

(2) billing errors that are attributable to human error;

(3) inadvertent billing and processing errors;

(4) inadvertent failure to maintain complete credentialing, licensure or training records; and

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(5) failure to comply with a regulatory standard that is not a condition of payment.

[~~B.~~] C. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (1) or (3) of Subsection A of this section is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~C.~~] D. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud as described in Paragraph (2) or (4) of Subsection A of this section when the value of the benefit, treatment, services or goods improperly provided is:

(1) not more than one hundred dollars ($100) is guilty of a petty misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(2) more than one hundred dollars ($100) but not more than two hundred fifty dollars ($250) is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978;

(3) more than two hundred fifty dollars ($250) but not more than two thousand five hundred dollars ($2,500) is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978;

(4) more than two thousand five hundred dollars

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($2,500) but not more than twenty thousand dollars ($20,000) [~~shall be~~] is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978; and

(5) more than twenty thousand dollars ($20,000) [~~shall be~~] is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~D.~~] E. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in physical harm or psychological harm to a recipient is guilty of a fourth degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~E.~~] F. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in great physical harm or great psychological harm to a recipient is guilty of a third degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

[~~F.~~] G. Except as otherwise provided for in this section regarding the payment of fines by an entity, whoever commits medicaid fraud when the fraud results in death to a recipient is guilty of a second degree felony and shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA

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[~~G.~~] H. If the person who commits medicaid fraud is an entity rather than an individual, the entity shall be subject to a fine of not more than fifty thousand dollars ($50,000) for each misdemeanor and not more than two hundred fifty thousand dollars ($250,000) for each felony.

[~~H. The unit shall coordinate with the human services department, department of health and children, youth and families department to develop a joint protocol establishing responsibilities and procedures, including prompt and appropriate referrals and necessary action regarding allegations of program fraud, to ensure prompt investigation of suspected fraud upon the medicaid program by any provider. These departments shall participate in the joint protocol and enter into a memorandum of understanding defining procedures for coordination of investigations of fraud by medicaid providers to eliminate duplication and fragmentation of resources. The memorandum of understanding shall further provide procedures for reporting to the legislative finance committee the results of all investigations every calendar quarter. The unit shall report to the legislative finance committee a detailed disposition of recoveries and distribution of proceeds every calendar quarter.~~]"

SECTION 9. Section 30-44-8 NMSA 1978 (being Laws 1989, Chapter 286, Section 8, as amended) is amended to read:

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"30-44-8. CIVIL PENALTIES--CREATED--ENUMERATED--PRESUMPTION [~~LIMITATION OF ACTION~~].--

A. Any person who receives payment for furnishing treatment, services or goods under the program, which payment the person is not entitled to receive by reason of a violation of the Medicaid Fraud Act, shall, in addition to any other penalties or amounts provided by law, be liable for:

(1) payment of interest on the amount of the excess payments at the maximum legal rate in effect on the date the payment was made, for the period from the date payment was made to the date of repayment to the state;

(2) a civil penalty in an amount of up to three times the amount of excess payments;

(3) payment of a civil penalty of up to ten thousand dollars ($10,000) for each false or fraudulent claim submitted or representation made for providing treatment, services or goods; and

(4) payment of legal fees and costs of investigation and enforcement of civil remedies.

B. Interest amounts, legal fees and costs of enforcement of civil remedies assessed under this section shall be remitted to the state treasurer for deposit in the general fund.

C. Any penalties and costs of investigation recovered on behalf of the state shall be remitted to the state

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treasurer for deposit in the general fund except an amount not to exceed two hundred fifty thousand dollars ($250,000) in fiscal year 2004, one hundred twenty-five thousand dollars ($125,000) in fiscal year 2005 and seventy-five thousand dollars ($75,000) in fiscal year 2006 may be retained by the unit and expended, consistent with federal regulations and state law, for the purpose of carrying out the unit's duties.

D. A criminal action need not be brought against a person as a condition precedent to enforcement of civil liability under the Medicaid Fraud Act.

E. The remedies under this section are separate from and cumulative to any other administrative and civil remedies available under federal or state law or regulation.

F. The department may adopt regulations for the administration of the civil penalties contained in this section.

[~~G. No action under this section shall be brought after the expiration of five years from the date the action accrues.~~]"

SECTION 10. A new section of the Medicaid Fraud Act is enacted to read:

"[NEW MATERIAL] INVESTIGATION--LIMITATION OF ACTIONS.--

A. The unit shall coordinate with the human services department, department of health and children, youth and families department to develop a joint protocol

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establishing responsibilities and procedures, including prompt and appropriate referrals and necessary action regarding allegations of program fraud, to ensure prompt investigation of suspected fraud upon the medicaid program by any provider. These departments shall participate in the joint protocol and enter into a memorandum of understanding defining procedures for coordination of investigations of fraud by medicaid providers to eliminate duplication and fragmentation of resources. The memorandum of understanding shall further provide procedures for reporting to the legislative finance committee the results of all investigations every calendar quarter. The unit shall report to the legislative finance committee a detailed disposition of recoveries and distribution of proceeds every calendar quarter.

B. No action under the Medicaid Fraud Act shall be brought after the expiration of four years from the date the action accrues."

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO THE LEGISLATURE; AMENDING SECTIONS OF CHAPTER 2, ARTICLE 13 NMSA 1978 TO ASSIGN MONITORING AND OVERSIGHT DUTIES AND TO PROVIDE YEAR-ROUND, PERMANENT STAFF TO THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE; ENACTING A NEW SECTION OF CHAPTER 2, ARTICLE 13 NMSA 1978 TO REQUIRE COMPLIANCE WITH THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE'S AND ITS SUBCOMMITTEES' REQUESTS FOR INFORMATION AND TO PROVIDE THE COMMITTEE AND ITS SUBCOMMITTEES WITH THE POWER TO ADMINISTER OATHS AND ISSUE SUBPOENAS; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 2-13-2 NMSA 1978 (being Laws 1989, Chapter 349, Section 2) is amended to read:

"2-13-2. DUTIES OF THE COMMITTEE.--The legislative health and human services committee shall [~~conduct a continuing study~~

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~~of~~] monitor and oversee the programs, agencies, policies, issues and needs relating to health and human services, including [~~review and study~~] monitoring and oversight of the statutes, constitutional provisions, regulations and court decisions governing such programs, agencies, policies and issues. The committee shall also [~~study~~] monitor and oversee the full continuum of programs and services available and needed for children and families and the aging population. The committee shall make an annual report of its findings and recommendations and recommend any necessary legislation to each session of the legislature."

SECTION 2. Section 2-13-5 NMSA 1978 (being Laws 1989, Chapter 349, Section 5) is amended to read:

"2-13-5. STAFF.--The [~~staff for the~~] legislative health and human services committee shall [~~be provided by the legislative council service~~] have a permanent, year-round staff assigned exclusively to carrying out the duties of the committee. The legislative council service shall provide the staff for the legislative health and human services committee, which shall include individuals with expertise in law, policy or finance related to health care delivery or finance or to human services matters."

SECTION 3. A new section of Chapter 2, Article 13 NMSA 1978 is enacted to read:

"[NEW MATERIAL] COMPLIANCE WITH REQUESTS FOR INFORMATION--

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POWER TO CONDUCT HEARINGS AND ADMINISTER OATHS--SUBPOENA POWER.--

A. The human services department, the department of health, the aging and long-term services department, the corrections department, the children, youth and families department, the workforce solutions department, the interagency behavioral health purchasing collaborative and every other state agency and political subdivision of the state shall, upon request, furnish and make available to the legislative health and human services committee, or any subcommittee of the legislative health and human services committee consisting of three members or more, documents, material or information requested by the committee or any subcommittee of the committee consisting of three members or more or the staff of the committee or subcommittee.

B. The legislative health and human services committee may conduct hearings and administer oaths. The legislative health and human services committee or any subcommittee of the legislative health and human services committee consisting of three members or more may subpoena, which may be enforced through any district court of the state. Process of the legislative health and human services committee or any of its subcommittees shall be served by any sheriff or any member of the New Mexico state police and shall be served without cost to the legislative health and human services

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committee or its subcommittees."

SECTION 4. APPROPRIATION.--Two hundred thousand dollars ($200,000) is appropriated from the general fund to the legislative council service for expenditure in fiscal year 2016 to fund staffing for and the activities of the legislative health and human services committee pursuant to Section 1 of this act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE BOARD OF REGENTS OF THE UNIVERSITY OF NEW MEXICO TO SUPPORT THE PAIN MANAGEMENT CENTER AT THE UNIVERSITY OF NEW MEXICO.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--One million one hundred thousand dollars ($1,100,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal year 2016 to support the pain management center at the university of New Mexico. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE HIGHER EDUCATION DEPARTMENT FOR DENTAL STUDENTS PARTICIPATING IN THE WESTERN INTERSTATE COMMISSION FOR HIGHER EDUCATION PROGRAM.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Four hundred thousand dollars ($400,000) is appropriated from the general fund to the higher education department for expenditure in fiscal year 2016 to increase the number of dental students who may participate in the western interstate commission for higher education program. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE BOARD OF REGENTS OF THE UNIVERSITY OF NEW MEXICO FOR OCULOPHARYNGEAL MUSCULAR DYSTROPHY RESEARCH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Two hundred fifty thousand dollars ($250,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal year 2016 to fund oculopharyngeal muscular dystrophy research conducted by the university of New Mexico health sciences center. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE CRIME VICTIMS REPARATION COMMISSION FOR SUPPORT, ADVOCACY AND SERVICES FOR VICTIMS OF HUMAN TRAFFICKING PURSUANT TO CHAPTER 30, ARTICLE 52 NMSA 1978.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to the crime victims reparation commission for expenditure in fiscal year 2016 to fund support, advocacy and services for adult and child victims of human trafficking statewide pursuant to Chapter 30, Article 52 NMSA 1978. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE CHILDREN, YOUTH AND FAMILIES DEPARTMENT TO FUND A SUPPORTIVE HOUSING PILOT PROJECT TO PROVIDE PERMANENT HOUSING AND SUPPORTIVE SERVICES FOR AT-RISK FAMILIES AND CHILDREN.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--

A. Nine hundred thousand dollars ($900,000) is appropriated from the general fund to the children, youth and families department for expenditure in fiscal year 2016 to fund a supportive housing pilot project to provide permanent housing and supportive services for families that:

(1) have children who have been identified as victims of child abuse or neglect;

(2) lack adequate housing; and

(3) struggle with substance abuse or mental health issues.

B. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC HEALTH; ENACTING THE VACCINE PURCHASING ACT; ESTABLISHING A UNIVERSAL VACCINE PURCHASING PROGRAM; CREATING THE VACCINE PURCHASING FUND; REQUIRING REPORTING OF THE NUMBER OF INSURED CHILDREN; AUTHORIZING ASSESSMENTS TO BE LEVIED ON HEALTH INSURERS FOR COSTS OF VACCINES FOR INSURED CHILDREN; PROVIDING FOR PENALTIES FOR FAILURE TO REPORT NUMBER OF INSURED CHILDREN; MAKING AN APPROPRIATION; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Vaccine Purchasing Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the Vaccine Purchasing Act:

A. "advisory committee on immunization practices" means the group of medical and public health experts that

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develops recommendations on how to use vaccines to control diseases in the United States, established under Section 222 of the federal Public Health Service Act;

B. "department" means the department of health;

C. "fund" means the vaccine purchasing fund;

D. "health insurer" means any entity subject to regulation by the office of superintendent of insurance that:

(1) provides or is authorized to provide health insurance or health benefit plans;

(2) administers health insurance or health benefit coverage; or

(3) otherwise provides a plan of health insurance or health benefits;

E. "insured child" means a child under the age of nineteen who is eligible to receive benefits from a health insurer;

F. "office of superintendent" means the office of superintendent of insurance;

G. "policy" means any contract of health insurance between a health insurer and the insured, including all clauses, riders, endorsements and parts thereof; and

H. "vaccines for children program" means the federally funded program that provides vaccines at no cost to eligible children pursuant to Section 1928 of the federal Social Security Act.

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SECTION 3. [NEW MATERIAL] UNIVERSAL VACCINE PURCHASING PROGRAM.--The department shall establish and administer a statewide universal vaccine purchasing program to:

A. expand access to childhood immunizations recommended by the advisory committee on immunization practices;

B. maintain and improve immunization rates;

C. facilitate the acquisition by health care providers of vaccines for childhood immunizations recommended by the advisory committee on immunization practices; and

D. leverage public and private funding and resources for the purchase, storage and distribution of vaccines for childhood immunizations recommended by the advisory committee on immunization practices.

SECTION 4. [NEW MATERIAL] VACCINE PURCHASING FUND.--

A. The "vaccine purchasing fund" is created in the state treasury. The fund consists of assessments paid by health insurers pursuant to the Vaccine Purchasing Act and appropriations and transfers made to the fund. Money in the fund shall be expended only for the purposes specified in the Vaccine Purchasing Act, by warrant issued by the secretary of finance and administration pursuant to vouchers approved by the secretary of health.

B. Money from the fund may be appropriated to the department to be expended only as authorized in Section 5 of

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the Vaccine Purchasing Act.

C. The fund shall be audited in the same manner as other state funds are audited, and all records of payments made from the fund shall be open to the public.

D. Any balance remaining in the fund shall not revert or be transferred to any other fund at the end of a fiscal year, and that balance shall be taken into consideration in the determination of the department's succeeding fiscal year's budget.

E. Money in the fund shall be invested by the state investment officer in accordance with the limitations in Article 12, Section 7 of the constitution of New Mexico. Income from investment of the fund shall be credited to the fund.

SECTION 5. [NEW MATERIAL] AUTHORIZED USES OF THE VACCINE PURCHASING FUND.--

A. The fund shall be used for the purchase, storage and distribution of vaccines, as recommended by the advisory committee on immunization practices, for insured children who are not eligible for the vaccines for children program.

B. The fund shall not be used for:

(1) the purchase, storage and distribution of vaccines for children who are eligible for the vaccines for children program; or

(2) administrative expenses associated with the

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statewide universal vaccine purchasing program.

SECTION 6. [NEW MATERIAL] REPORTING--ASSESSMENTS.--

A. The office of superintendent shall require each health insurer to annually reimburse the state for the cost of vaccines for childhood immunizations for each insured child according to each health insurer's policy obligations and in accordance with state and federal laws.

B. No later than July 1, 2015 and on May 1 of each year thereafter, each health insurer shall:

(1) report the number of children it insures who will be under the age of nineteen as of the following December 31 to the department and to the office of superintendent; and

(2) exclude from such report children who are:

(a) enrolled in medicaid or in any medical assistance program administered by the department or the human services department; and

(b) American Indian or Alaska Natives.

C. No later than August 1, 2015 and June 1 of each year thereafter, the department shall determine the amount to be expended by the department in the current calendar year to purchase, store and distribute vaccines recommended by the advisory committee on immunization practices to all insured children in the state and report the amount to the office of superintendent.

D. No later than September 1, 2015 and July 1 of

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each year thereafter, the office of superintendent shall determine the amount each health insurer must pay into the fund determined by a fraction, the denominator of which is the total number of insured children reported by all health insurers pursuant to Subsection B of this section and the numerator of which is the number of insured children reported by such health insurers pursuant to Subsection B of this section multiplied by the amount reported to be expended by the department pursuant to Subsection C of this section.

E. No later than October 1, 2015 and August 1 of each year thereafter, the office of superintendent shall submit a statement to each health insurer that includes the proposed assessment for such insurer for the current calendar year.

F. Each health insurer shall pay the assessment to the office of superintendent not later than November 1, 2015 and September 1 of each year thereafter for deposit into the vaccine purchasing fund.

G. The payment of an assessment pursuant to the Vaccine Purchasing Act shall be deemed payment for clinical services and activities to promote health care quality for the purpose of calculating a health insurer's medical loss ratio.

SECTION 7. [NEW MATERIAL] APPEAL--PENALTIES.--

A. A health insurer aggrieved by an assessment levied under Section 6 of the Vaccine Purchasing Act may appeal as provided in Section 59A-4-20 NMSA 1978.

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B. A health insurer that fails to file the report required under Subsection B of Section 6 of the Vaccine Purchasing Act shall pay a late filing fee of five hundred dollars ($500) per day for each day from the date the report was due.

C. The office of superintendent may require a health insurer subject to the Vaccine Purchasing Act to produce records that were used to prepare the report required under Subsection B of Section 6 of the Vaccine Purchasing Act. If the office of superintendent determines that there is other than a good faith discrepancy between the number of insured children reported and the number of insured children that should have been reported, the health insurer shall pay a civil penalty of five hundred dollars ($500) for each report filed for which the office of superintendent determines there is such a discrepancy.

D. The department and the office of superintendent shall cooperate to verify the accuracy of health insurer reports required under Subsection B of Section 6 of the Vaccine Purchasing Act.

E. Failure of a health insurer to make timely payment of an assessment levied under Section 6 of the Vaccine Purchasing Act shall subject the health insurer to a civil penalty of five hundred dollars ($500) for each day from the date the payment is due.

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SECTION 8. [NEW MATERIAL] POWERS AND AUTHORITY.--The department and the office of superintendent shall promulgate and enforce such rules as may be necessary to carry out the provisions of the Vaccine Purchasing Act.

SECTION 9. [NEW MATERIAL] APPLICABILITY.--The provisions of the Vaccine Purchasing Act:

A. do not apply to an entity that only issues policies, certificates or subscriber contracts within New Mexico that are limited to a specific disease; hospital confinement; indemnity; accident-only; credit; dental; vision; medicare supplement; long-term care; disability income insurance; student health benefits-only coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; nonrenewable short-term coverage issued for a period of twelve months or less; medicaid; or any medical assistance program administered by the department or the human services department; and

B. apply to policies, plans, contracts and certificates delivered or issued for delivery or renewed, extended or amended in this state on or after January 1, 2015.

SECTION 10. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

SENATE JOINT MEMORIAL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A JOINT MEMORIAL

REQUESTING THE SUPERINTENDENT OF INSURANCE TO CONVENE AN INNOVATION WAIVER WORKING GROUP TO MAKE RECOMMENDATIONS TO THE GOVERNOR AND THE LEGISLATURE ON THE VALUE OF APPLYING FOR AN INNOVATION WAIVER UNDER THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT AND TO CREATE A COMPREHENSIVE, SUSTAINABLE HEALTH CARE SYSTEM TO ADDRESS THE HEALTH CARE NEEDS OF NEW MEXICANS.

WHEREAS, New Mexico ranks among the states with the highest uninsured rates for health coverage in the United States; and

WHEREAS, the Kaiser family foundation reports that at least one-third of uninsured adults went without needed medical care due to cost in 2013; and

WHEREAS, the Kaiser family foundation reports that people

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without health coverage often face costly medical debt whenever they do seek care, with nearly forty percent of uninsured adults reporting outstanding medical bills, even when their incomes are as high as one hundred thousand dollars ($100,000) per year; and

WHEREAS, the human services department reports that New Mexico's expansion of medicaid eligibility has resulted in the enrollment of one hundred seventy-one thousand adults; and

WHEREAS, to offer health coverage that is more affordable to Americans with modest incomes, the federal Patient Protection and Affordable Care Act, also known as the Affordable Care Act, provides for premium tax credits and cost-sharing subsidies through health insurance exchanges to offset the high cost of health coverage; and

WHEREAS, as of September 2014, the New Mexico health insurance exchange reported that it had enrolled approximately seventeen thousand one hundred individuals, although only half of that number were newly insured; and

WHEREAS, the New Mexico health insurance exchange reports that, as of September 2014, the rate of New Mexicans lacking any health coverage had fallen from twenty-one and six-tenths percent to fourteen and five-tenths percent; and

WHEREAS, the New Mexico health insurance exchange reports that it projects that another eighty-five thousand individuals will be enrolled through medicaid or through the New Mexico

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health insurance exchange by February 2015, dropping the rate of people living without health coverage to one hundred ninety-seven thousand individuals, or nine and six-tenths percent; and

WHEREAS, eighty percent of New Mexico health insurance exchange enrollees received financial assistance for qualified health plan coverage in 2014, but sixty-six percent of New Mexicans do not know that tax credits are also available to pay for health coverage, according to the New Mexico health insurance exchange; and

WHEREAS, even with federal premium tax credits and cost-sharing subsidies, the New Mexico health insurance exchange reports that fifty-six percent of New Mexicans have cited affordability as the primary reason why they do not have health insurance; and

WHEREAS, a recent Harvard school of public health study has found that many Americans experience fluctuations in income that mean that eligibility will shift between public coverage programs such as medicaid and private insurance, creating a "churn" between programs that can result in one- or two-month periods without coverage; and

WHEREAS, in addition to increasing access to needed care and reducing personal medical debt, maintaining health coverage and reducing the rate of uninsurance is of benefit to health care providers and reduces uncompensated care costs; and

WHEREAS, the "National Health Expenditure Projections,

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2012 to 2022" report by the federal centers for medicare and medicaid services states that health spending will be twenty percent of the United States' gross domestic product by the year 2020; and

WHEREAS, health care expenditure projections show an unsustainable course for New Mexico; and

WHEREAS, health care spending in January 2014 represented seventeen and seven-tenths percent of the United States' gross domestic product, which represents an all-time high; and

WHEREAS, the center for economic and policy research reports that the United States' health care system is "possibly the most inefficient in the world", spending double per capita on health care compared to other industrialized countries yet having worse health outcomes, including a lower life expectancy than other industrialized countries; and

WHEREAS, the center for economic and policy research reports that if the United States can get health care costs under control, budget deficits will not rise uncontrollably in the future, but if health care costs continue to skyrocket, it will be almost impossible to prevent exploding future budget deficits; and

WHEREAS, access to timely and quality health care is hindered in New Mexico by large health disparities that exist among people of differing ethnicities and races, between rural and urban residents and among individuals of varying incomes

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and employment status; and

WHEREAS, targeting certain health risks and addressing sets of health needs is hindered in New Mexico by the fact that there is no comprehensive data collection system to allow for a system-wide review of health care utilization in New Mexico; and

WHEREAS, access to timely and quality health care is further hindered by New Mexico's chronic and serious lack of health care professionals in thirty-one of New Mexico's thirty-three counties; and

WHEREAS, New Mexico lacks a comprehensive strategy for addressing the effects of the lack of health insurance, unaffordable health coverage, disparities in access to quality health care, health professional shortages, utilization patterns and health care costs; and

WHEREAS, New Mexico's unique population and high rates of poverty, "churning" between public and private health coverage, geographic barriers and the lack of health insurance mean that many New Mexicans will continue to struggle to access affordable health coverage for the near future; and

WHEREAS, Section 1332 of the Affordable Care Act allows states to apply for an "innovation waiver" to implement in the year 2017 a health care coverage system that overhauls the current state health system to provide coverage that:

A. is as comprehensive as the coverage available

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through the New Mexico health insurance exchange;

B. is no less affordable than coverage available through the New Mexico health insurance exchange;

C. will cover as many New Mexicans as the New Mexico health insurance exchange; and

D. will not increase the federal deficit; and

WHEREAS, New Mexico has an opportunity to tailor the provisions of the innovation waiver to the needs of the state without losing federal subsidies;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the superintendent of insurance be requested to convene an innovation waiver working group composed of experts in health care delivery, policy and finance as well as related areas; and

BE IT FURTHER RESOLVED that the innovation waiver working group be requested to analyze the potential, under the auspices of a federal innovation waiver, for designing a comprehensive, sustainable health care system that:

A. addresses the effects of the lack of health insurance, unaffordable health coverage, disparities in access to health care and uncompensated care on New Mexicans;

B. provides for the collection of data and the examination of variations in health care utilization; and

C. bends the health care cost curve in the state; and

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BE IT FURTHER RESOLVED that the innovation waiver working group be requested to meet at least monthly from April through December 2015; and

BE IT FURTHER RESOLVED that the legislative council service and the legislative finance committee be requested to provide staff and administrative support to the innovation waiver working group; and

BE IT FURTHER RESOLVED that the innovation waiver working group be requested to examine the following:

A. the federal legal requirements for implementing the waiver, including the provisions of Section 1332 of the Affordable Care Act and related regulations and guidance;

B. the type of state legal action required to implement the innovation waiver;

C. information about coverage, quality and health care costs to ensure future sustainability;

D. potential changes in health care enrollment, such as automatic enrollment for eligible medicaid recipients and "no wrong door" for applying for enrollment among myriad coverage options;

E. the cost of a transition to a comprehensive, sustainable health care system under an innovation waiver as well as the availability of funds to cover the transition;

F. the potential impact of the innovation waiver's implementation on the state's current health coverage systems,

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including the state medicaid program and the New Mexico health insurance exchange; and

G. the potential impact of the innovation waiver on the health care delivery sector; and

BE IT FURTHER RESOLVED that the innovation waiver working group be requested to develop recommendations for any state legislation that may be required to apply for and implement an innovation waiver; and

BE IT FURTHER RESOLVED that the superintendent of insurance be requested to prepare and present the findings of the innovation waiver working group to the legislative health and human services committee and the legislative finance committee by December 1, 2015; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the governor, the superintendent of insurance, the director of the legislative council service and the director of the legislative finance committee.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO TRAUMATIC INJURIES; REQUIRING THE USE OF MOTORCYCLE SAFETY HELMETS; PROVIDING EXCEPTIONS; CREATING A DISTINCTIVE MOTORCYCLE VALIDATING STICKER ALLOWING CERTAIN OPERATORS AND PASSENGERS TO REFRAIN FROM WEARING A SAFETY HELMET; CREATING THE FATAL-INJURY DIAGNOSIS AND REPORTING FUND; PRESCRIBING PENALTIES; MAKING APPROPRIATIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 66-3-14 NMSA 1978 (being Laws 1978, Chapter 35, Section 34, as amended) is amended to read:

"66-3-14. REGISTRATION PLATES OR VALIDATING STICKERS TO BE FURNISHED BY DEPARTMENT--REFLECTIVE MATERIAL.--

A. The department upon registering a vehicle shall issue a registration plate or a validating sticker to the owner of the vehicle. The validating sticker may be designed and

required to be placed on the registration plate or elsewhere on the vehicle as prescribed by the department.

B. Each registration plate shall have a background of reflective material such that the registration number assigned to the vehicle is plainly legible from a distance of one hundred feet at night. The colors shall include those of the state flag, except prestige and special plates.

C. Each registration plate shall have displayed upon it:

(1) the registration number assigned to the person to whom it was issued; and

(2) the name of this state.

D. The department shall issue no registration plates for privately owned vehicles that contain the words "staff officer" or any other title except as otherwise provided by law.

E. All registration plates for private vehicles shall be alike in form except for the owner's registration number. The department shall adopt registration number systems for registration plates.

F. In lieu of or in addition to a registration plate or sticker for commercial motor vehicles, the department may issue an electronic identifying device.

G. The department shall determine the design of and make available distinctive motorcycle validating stickers that

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signify that any person age eighteen or older who operates a motorcycle on which the sticker is affixed and any of that operator's passengers age eighteen or older are not required by law to wear a safety helmet while operating or riding on the motorcycle. The department shall issue a distinctive motorcycle validating sticker when a qualifying person pays the fee as provided in Paragraph (2) of Subsection A of Section 66-6-1 NMSA 1978."

SECTION 2. Section 66-6-1 NMSA 1978 (being Laws 1978, Chapter 35, Section 336, as amended) is amended to read:

"66-6-1. MOTORCYCLES--REGISTRATION FEES--VALIDATING STICKERS.--

A. For the registration of [~~motorcycles~~] a motorcycle, the department shall collect one of the following fees for a twelve-month registration period:

[~~(1) for a motorcycle having not more than two wheels in contact with the ground, fifteen dollars ($15.00); and~~

~~(2) for a motorcycle having three wheels in contact with the ground or having a sidecar, fifteen dollars ($15.00)~~]

(1) fifteen dollars ($15.00) for a standard validating sticker; or

(2) six hundred ninety-two dollars ($692) for a distinctive motorcycle validating sticker that signifies that

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any person age eighteen or older who operates the motorcycle on which it is affixed and any of that operator's passengers age eighteen or older are not required by law to wear a safety helmet.

B. The revenue from the fee imposed by Paragraph (2) of Subsection A of this section shall be distributed as follows:

(1) four hundred seventy-three dollars ninety cents ($473.90) to the trauma system fund;

(2) one hundred thirty-five dollars forty cents ($135.40) to the brain injury services fund;

(3) sixty-seven dollars seventy cents ($67.70) to the fatal-injury diagnosis and reporting fund; and

(4) fifteen dollars ($15.00) as otherwise provided by law.

[~~B.~~] C. In addition to other fees required by this section, the department shall collect for each motorcycle an annual tire recycling fee of one dollar ($1.00) for a twelve-month registration period."

SECTION 3. [NEW MATERIAL] FATAL-INJURY DIAGNOSIS AND REPORTING FUND--CREATED.--The "fatal-injury diagnosis and reporting fund" is created in the state treasury. The fund consists of appropriations, gifts, grants, donations and income from investment of the fund. The university of New Mexico school of medicine shall administer the fund on behalf of the

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state medical investigator, and money in the fund is appropriated to the university of New Mexico school of medicine for the diagnosis and reporting of fatal injuries. Money in the fund shall be disbursed on warrants signed by the secretary of finance and administration pursuant to vouchers signed by the dean of the school of medicine or the dean's authorized representative. Money in the fund shall not revert at the end of any fiscal year.

SECTION 4. Section 66-7-356 NMSA 1978 (being Laws 1978, Chapter 35, Section 460, as amended) is amended to read:

"66-7-356. MANDATORY USE OF PROTECTIVE HELMETS.--

A. [~~No~~] A person under the age of eighteen [~~shall operate~~] who operates a motorcycle [~~unless he is wearing~~] and any operator and passenger age eighteen or older on a motorcycle whose registration plate is affixed with a standard validating sticker shall wear a safety helmet that is securely fastened on [~~his~~] the person's head in a normal manner as headgear and [~~meeting~~] that meets the standards specified by the director. A person age eighteen or older who operates a motorcycle on which a valid, distinctive motorcycle validating sticker, as described in Paragraph (2) of Subsection A of Section 66-6-1 NMSA 1978, is affixed and any of that person's passengers age eighteen or older are not required to wear a safety helmet. The director shall adopt rules and regulations establishing standards [~~covering the types of~~] and

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specifications for acceptable helmets [~~and the specifications therefor~~] and shall establish and maintain a list of approved helmets meeting [~~the~~] those standards and specifications [~~of the director. No~~]. A dealer or person who leases or rents motorcycles shall not lease or rent a motorcycle to a person under the age of eighteen unless the lessee or renter shows such person a valid driver's license or permit and possesses the safety equipment required of an operator who is under the age of eighteen. [~~No~~] A person shall not carry any passenger under the age of eighteen on any motorcycle unless the passenger is wearing a securely fastened safety helmet, as specified in this section, meeting the standards specified by the director.

B. Failure to wear a safety helmet as required in this section shall not constitute contributory negligence."

SECTION 5. Section 66-8-116 NMSA 1978 (being Laws 1978, Chapter 35, Section 524, as amended) is amended to read:

"66-8-116. PENALTY ASSESSMENT MISDEMEANORS--DEFINITION--SCHEDULE OF ASSESSMENTS.--

A. As used in the Motor Vehicle Code, "penalty assessment misdemeanor" means violation of any of the following listed sections of the NMSA 1978 for which, except as provided in Subsections D and E of this section, the listed penalty assessment is established:

COMMON NAME OF OFFENSE	SECTION VIOLATED	PENALTY

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		ASSESSMENT
Improper display of registration plate	66-3-18	$ 25.00
Failure to notify of change of name or address	66-3-23	25.00
Lost or damaged registration, plate or title	66-3-24	20.00
Permitting unauthorized minor to drive	66-5-40	50.00
Permitting unauthorized person to drive	66-5-41	25.00
Failure to obey sign	66-7-104	10.00
Failure to obey signal	66-7-105	10.00
Speeding	66-7-301	
(1) up to and including ten miles an hour over the speed limit		15.00
(2) from eleven up to and including fifteen miles an hour over the speed limit		30.00
(3) from sixteen up to and including twenty miles an hour over the speed limit		65.00

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(4) from twenty-one up to and including twenty-five miles an hour over the speed limit		100.00
(5) from twenty-six up to and including thirty miles an hour over the speed limit		125.00
(6) from thirty-one up to and including thirty-five miles an hour over the speed limit		150.00
(7) more than thirty-five miles an hour over the speed limit		200.00
Unfastened safety belt	66-7-372	25.00
Child not in restraint device or seat belt	66-7-369	25.00
Minimum speed	66-7-305	10.00
Speeding	66-7-306	15.00
Improper starting	66-7-324	10.00
Improper backing	66-7-354	10.00
Improper lane	66-7-308	10.00
Improper lane	66-7-313	10.00
Improper lane	66-7-316	10.00

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Improper lane	66-7-317	10.00
Improper lane	66-7-319	10.00
Improper passing	66-7-309 through 66-7-312	10.00
Improper passing	66-7-315	10.00
Controlled access violation	66-7-320	10.00
Controlled access violation	66-7-321	10.00
Improper turning	66-7-322	10.00
Improper turning	66-7-323	10.00
Improper turning	66-7-325	10.00
Following too closely	66-7-318	10.00
Failure to yield	66-7-328 through 66-7-331	10.00
Failure to yield	66-7-332	50.00
Failure to yield	66-7-332.1	25.00
Pedestrian violation	66-7-333	10.00
Pedestrian violation	66-7-340	10.00
Failure to stop	66-7-342 and 66-7-344 through 66-7-346	10.00
Railroad-highway grade crossing violation	66-7-341 and 66-7-343	150.00
Passing school bus	66-7-347	100.00
Failure to signal	66-7-325 through 66-7-327	10.00
Failure to secure load	66-7-407	100.00
Operation without oversize-		

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overweight permit	66-7-413	50.00
Transport of reducible load with special permit more than six miles from a border crossing	66-7-413	100.00
Improper equipment	66-3-801 through 66-3-851	25.00
Improper equipment	66-3-901	20.00
Improper emergency signal	66-3-853 through 66-3-857	10.00
[~~Minor on motorcycle without helmet~~] Failure to wear a motorcycle safety helmet - first violation	66-7-356	300.00
Failure to wear a motorcycle safety helmet - subsequent violation	66-7-356	600.00
Operation interference	66-7-357	50.00
Littering	66-7-364	300.00
Improper parking	66-7-349 through 66-7-352 and 66-7-353	5.00
Improper parking	66-3-852	5.00
Failure to dim lights	66-3-831	10.00

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Riding in or towing		
occupied house trailer	66-7-366	5.00
Improper opening of doors	66-7-367	5.00
No slow-moving vehicle emblem or flashing amber light	66-3-887	5.00
Open container - first violation	66-8-138	25.00
Texting while driving - first violation	[~~Section 1 of this 2014 act~~] 66-7-374	25.00
Texting while driving - subsequent violation	[~~Section 1 of this 2014 act~~] 66-7-374	50.00.

B. The term "penalty assessment misdemeanor" does not include a violation that has caused or contributed to the cause of an accident resulting in injury or death to a person.

C. When an alleged violator of a penalty assessment misdemeanor elects to accept a notice to appear in lieu of a notice of penalty assessment, a fine imposed upon later conviction shall not exceed the penalty assessment established for the particular penalty assessment misdemeanor and probation imposed upon a suspended or deferred sentence shall not exceed ninety days.

D. The penalty assessment for speeding in violation of Paragraph (4) of Subsection A of Section 66-7-301 NMSA 1978 is twice the penalty assessment established in Subsection A of

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this section for the equivalent miles per hour over the speed limit.

E. Upon a second conviction for operation without a permit for excessive size or weight pursuant to Section 66-7-413 NMSA 1978, the penalty assessment shall be two hundred fifty dollars ($250). Upon a third or subsequent conviction, the penalty assessment shall be five hundred dollars ($500).

F. Upon a second conviction for transport of a reducible load with a permit for excessive size or weight pursuant to Subsection N of Section 66-7-413 NMSA 1978 more than six miles from a port-of-entry facility on the border with Mexico, the penalty assessment shall be five hundred dollars ($500). Upon a third or subsequent conviction, the penalty assessment shall be one thousand dollars ($1,000)."

SECTION 6. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2015.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH CARE; AMENDING THE ADOLESCENT TREATMENT HOSPITAL ACT TO TRANSFER THE ADMINISTRATION OF THE ADOLESCENT TREATMENT HOSPITAL AND THE ADOLESCENT RESIDENTIAL TREATMENT FACILITY TO THE BOARD OF REGENTS OF THE UNIVERSITY OF NEW MEXICO; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 23-9-2 NMSA 1978 (being Laws 1992, Chapter 60, Section 2, as amended) is amended to read:

"23-9-2. DEFINITIONS.--As used in the Adolescent Treatment Hospital Act:

A. "adolescent" means a person aged thirteen through twenty;

B. "adolescent treatment hospital" means the hospital created pursuant to the Adolescent Treatment Hospital

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Act;

C. "board" means the adolescent treatment hospital governing board;

D. "adolescent residential treatment facility" means the facility created pursuant to the Adolescent Treatment Hospital Act; and

E. "coordinated treatment panel" means the group made up of trained health and mental health professionals who review and approve psychosocial treatment recommendations, develop psychosocial treatment alternatives, track costs and cost-effectiveness and evaluate outcomes [~~and~~

~~F. "secretary" means the secretary of health~~]."

SECTION 2. Section 23-9-5 NMSA 1978 (being Laws 1992, Chapter 60, Section 5) is amended to read:

"23-9-5. ADOLESCENT TREATMENT HOSPITAL GOVERNING BOARD--CREATION--ORGANIZATION--DUTIES.--

A. There is created the "adolescent treatment hospital governing board" consisting of five members appointed by the [~~secretary~~] board of regents of the university of New Mexico. The members shall serve at the pleasure of the [~~secretary~~] board of regents of the university of New Mexico and shall be familiar with the treatment and care of violent adolescents who are mentally disordered.

B. The board shall advise the [~~secretary~~] board of regents of the university of New Mexico on professional

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practices, community concerns and policies and procedures related to the treatment of adolescents admitted to the adolescent treatment hospital.

C. The board, in consultation with the [~~secretary~~] board of regents of the university of New Mexico, shall make and adopt such reasonable rules and regulations as may be necessary or convenient to carry out its duties and to administer the provisions of the Adolescent Treatment Hospital Act."

SECTION 3. Section 23-9-6 NMSA 1978 (being Laws 1992, Chapter 60, Section 6, as amended) is amended to read:

"23-9-6. HOSPITAL ADMISSIONS--TREATMENT.--

A. Adolescents shall be admitted to the adolescent treatment hospital and adolescent residential treatment facility only in accordance with the provisions of the Mental Health and Developmental Disabilities Code or the Children's Mental Health and Developmental Disabilities Act. The coordinated treatment panel may make recommendations on admissions.

B. The [~~secretary~~] board of regents of the university of New Mexico shall, in consultation with the board, define admittance criteria; provided that the criteria [~~may~~] shall not exclude adolescents in the custody of [~~other agencies~~] any state agency who might otherwise meet the criteria for services provided through the adolescent treatment

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hospital.

C. The Mental [~~Heath~~] Health and Developmental Disabilities Code or the Children's Mental Health and Developmental Disabilities Act shall apply to inpatient treatment."

SECTION 4. Section 23-9-7 NMSA 1978 (being Laws 1992, Chapter 60, Section 7) is amended to read:

"23-9-7. ADOLESCENT TREATMENT HOSPITAL AND ADOLESCENT RESIDENTIAL TREATMENT FACILITY ADMINISTRATION.--

A. The adolescent treatment hospital and adolescent residential treatment facility shall be under the administration [~~and control~~] of the [~~department of health~~] board of regents of the university of New Mexico. The [~~secretary of health~~] board of regents of the university of New Mexico shall ensure that the adolescent treatment hospital becomes accredited by an appropriate hospital accreditation organization within the limits of its appropriations and, notwithstanding that accreditation, shall also seek and maintain licensure under the appropriate state standards.

B. The adolescent treatment hospital and adolescent residential treatment facility may establish and maintain administrative units and services for administration, medical and mental health care treatment, nursing, dietetics, education, recreation, social work and related services as may be necessary to carry out the purposes for which the adolescent

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treatment hospital and adolescent residential treatment facility are established.

C. Employees of the adolescent treatment hospital and adolescent residential treatment facility shall be subject to the [~~State~~] Personnel Act.

D. The adolescent treatment hospital and adolescent residential treatment facility may develop and implement a reasonable schedule of fees for adolescents not in the custody of the state and not otherwise eligible for services paid for or supported by the state. All fee payments shall be [~~deposited with the state treasurer and credited to the general fund~~] paid over to the board of regents of the university of New Mexico to be used for the purpose of operating the adolescent treatment hospital and the adolescent residential treatment facility.

E. The adolescent treatment hospital and adolescent residential treatment facility may accept donations, gifts or bequests of land, money or things of value for the establishment, maintenance and advancement of the adolescent treatment hospital and adolescent residential treatment facility. Title to lands acquired shall be vested in the state. Donations, gifts and bequests of money shall be deposited to the credit of the adolescent treatment hospital and adolescent residential treatment facility if required as a condition of the donation, gift or bequest."

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SECTION 5. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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HOUSE MEMORIAL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A MEMORIAL

REQUESTING THE UNIVERSITY OF NEW MEXICO'S BUREAU OF BUSINESS AND ECONOMIC RESEARCH TO CONVENE A PARENTAL PAID-LEAVE WORKING GROUP TO MAKE FINDINGS AND DEVELOP RECOMMENDATIONS FOR THE ESTABLISHMENT OF A PUBLICLY MANAGED PARENTING WORKERS' LEAVE FUND.

WHEREAS, the first months of life have a lifelong impact on the development of human beings; and

WHEREAS, an essential factor in healthy development of a baby's cognitive, social and emotional development is the amount of focused attention that the baby's caregiver provides in the first months of the baby's life; and

WHEREAS, increased parental attention during a child's first few months can reduce childhood illnesses and infant mortality, which in turn lowers the health and human service

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expenditures in the wider society; and

WHEREAS, experts advise that babies at risk for developmental difficulties such as illness, birth defects, low birth weight or premature birth are especially in need of adequate time with their parents; and

WHEREAS, parents with well-nurtured children miss less time from work to care for sick or disabled children; and

WHEREAS, for over a decade, the state of California has implemented a parental-leave program that pays parents benefits through the state's social disability insurance program; and

WHEREAS, the state of California has seen an increase in low-wage job retention for workers who have made use of the state's parental paid-leave program; and

WHEREAS, eighty-seven percent of businesses in California have seen no increased costs as a result of that state's parental paid-leave policy; and

WHEREAS, New Jersey employers report that businesses have experienced no increase in administrative costs associated with the state's parental paid-leave program; and

WHEREAS, the *Harvard Business Review* reports that most companies with parental paid-leave policies experience stronger employee loyalty and morale; and

WHEREAS, a state-sponsored parental paid-leave policy allows smaller businesses to compete with larger businesses that might otherwise attract the best employees with parental

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paid leave; and

WHEREAS, the state of New Mexico has a strong interest in supporting strong, healthy families where young New Mexicans may develop into peaceful, productive and law-abiding residents;

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE STATE OF NEW MEXICO that the university of New Mexico's bureau of business and economic research be requested to convene a parental paid-leave working group of experts in child and family development, business, law and public finance and administration, including:

A. the state investment council;

B. the children, youth and families department;

C. the workforce solutions department;

D. the taxation and revenue department;

E. New Mexico voices for children;

F. New Mexico chambers of commerce;

G. the southwest women's law center;

H. the New Mexico pediatric society;

I. New Mexico women's agenda;

J. the New Mexico center on law and poverty; and

K. collective action strategies, incorporated; and

BE IT FURTHER RESOLVED that the parental paid-leave working group be requested to develop recommendations for the establishment of a parental paid-leave program to provide paid

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leave to parents for childbirth and to care for newborn or newly adopted children or for newly acquired foster children; and

BE IT FURTHER RESOLVED that the parental paid-leave working group be requested to make findings and develop recommendations for the establishment of a publicly managed parenting workers' leave fund to allow private and public employees and employers to make contributions to the fund to enable employees to earn up to eighty percent of their regular pay for a period of up to twelve consecutive weeks; and

BE IT FURTHER RESOLVED that the parental paid-leave working group develop recommendations as to choosing a state agency to manage the parental paid-leave program and the parenting workers' leave fund; and

BE IT FURTHER RESOLVED that the parental paid-leave working group be requested to present its findings and recommendations to the legislative health and human services committee and the legislative finance committee by October 1, 2016; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to:

A. the governor;

B. the secretary of children, youth and families;

C. the secretary of workforce solutions;

D. the secretary of taxation and revenue;

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E. the state investment officer;

F. the president of the university of New Mexico;

G. the director of the bureau of business and economic research at the university of New Mexico;

H. legislative health and human services committee staff;

I. legislative finance committee staff; and

J. the executive directors of:

(1) New Mexico voices for children;

(2) New Mexico chambers of commerce;

(3) the southwest women's law center;

(4) the New Mexico pediatric society;

(5) New Mexico women's agenda;

(6) the New Mexico center on law and poverty; and

(7) collective action strategies, incorporated.

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE CORRECTIONS DEPARTMENT TO FUND PRISON RAPE ELIMINATION ACT SERVICES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Five hundred thousand dollars ($500,000) is appropriated from the general fund to the corrections department for expenditure in fiscal year 2016 to fund services offered through contracts with rape crisis centers pursuant to the federal Prison Rape Elimination Act of 2003. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO EMPLOYMENT; ENACTING THE PREGNANT WORKER ACCOMMODATION ACT; PROHIBITING DISCRIMINATION IN EMPLOYMENT ON THE BASIS OF PREGNANCY, CHILDBIRTH OR A RELATED CONDITION; REQUIRING THAT EMPLOYERS MAKE REASONABLE ACCOMMODATION OF AN EMPLOYEE'S OR JOB APPLICANT'S PREGNANCY, CHILDBIRTH OR RELATED CONDITION; PROHIBITING RETALIATION FOR AN EMPLOYEE'S OR JOB APPLICANT'S ASSERTION OF A CLAIM PURSUANT TO THE PREGNANT WORKER ACCOMMODATION ACT; PROVIDING FOR GRIEVANCE PROCEDURE AND PENALTIES.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] SHORT TITLE.--This act may be cited as the "Pregnant Worker Accommodation Act"."

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SECTION 2. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] DEFINITIONS.--As used in the Pregnant Worker Accommodation Act:

A. "employer" means a person or entity, including a partnership, association, corporation, business trust, unassociated group or agency employing one or more employees or a person or entity acting on behalf of or as an agent of an employer;

B. "reasonable accommodation" means an accommodation for as long as necessary to enable an employee to continue working despite limitations due to pregnancy, childbirth or a related condition that does not present an undue hardship on the employee's employer; and

C. "undue hardship" means an action requiring significant difficulty or expense when considered in light of the following factors:

(1) the nature and cost of the accommodation;

(2) the financial resources of the employer involved in the provision of the reasonable accommodation;

(3) the number of persons the employer employs;

(4) the effect on expenses and resources;

(5) the impact otherwise of the accommodation upon the employer's business;

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(6) the overall financial resources of the employer;

(7) the overall size of the business of an employer with respect to the number, type and location of its facilities;

(8) the type of operation of the employer, including the composition, structure and functions of the work force of the employer; and

(9) the geographic separateness or administrative or fiscal relationship to the employer of the employer's facilities."

SECTION 3. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] EMPLOYMENT DISCRIMINATION--PROHIBITION.--

A. It is an unlawful discriminatory practice for an employer to:

(1) refuse to allow a female employee disabled by pregnancy, childbirth or a related condition to take a leave for a reasonable period of time not to exceed three months and thereafter return to work in the same or a similar position in the workplace. The employee shall be entitled to utilize any accrued vacation leave during this period of time. An employer may require an employee who plans to take a leave pursuant to this section to give the employer reasonable notice of the date the leave shall commence and the estimated duration of the

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leave;

(2) refuse to maintain coverage for an eligible female employee who takes leave under a group health plan that the employer offers, as defined in Section 5000(b)(1) of the federal Internal Revenue Code of 1986, for the duration of leave that the employee takes pursuant to this section, not to exceed three months over the course of a twelve-month period, at the level and the conditions under which the employee would have been covered by the group health plan coverage if the employee had continued in employment continuously for the duration of the leave; provided that:

(a) nothing in this paragraph shall preclude an employer from maintaining and paying for coverage under a group health plan for an employee for leave that extends beyond three months;

(b) an employer may recover from the employee the premium that the employer paid as required under this paragraph for maintaining coverage for the employee under the group plan if the employee fails to return from leave after the period of leave to which the employee is entitled has expired, unless the employee fails to return from leave for a reason other than the continuation, recurrence or onset of a health condition or other circumstance beyond the control of the employee; and

(c) if the employer is a state agency,

the collective bargaining agreement shall govern with respect to the continued receipt by an eligible female employee of group health plan coverage pursuant to the provisions of this paragraph;

(3) refuse a request for reasonable accommodation or fail to make reasonable accommodation of an employee or job applicant disabled by pregnancy, childbirth or a related condition, unless the employer demonstrates that the accommodation constitutes an undue hardship;

(4) refuse to hire, discharge, refuse to promote, demote or discriminate in matters of compensation or leave or terms, conditions or privileges of employment against any person otherwise qualified for employment on the basis of that person's pregnancy, childbirth or related condition unless based on a bona fide occupational qualification;

(5) print or circulate or cause to be printed or circulated any statement, advertisement or publication; use any form of application for employment; or make any inquiry regarding prospective employment that expresses directly or indirectly any limitation, specification or discrimination as to pregnancy, childbirth or a related condition; and

(6) require an employee to take leave under any leave law or policy of the employer if another reasonable accommodation can be provided to the known limitations related to the employee's pregnancy, childbirth or related condition.

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B. It is an unlawful discriminatory practice for an employer to refuse to list or properly classify for employment or to refuse to refer a person for employment in a known available job for which the person is otherwise qualified on the basis of the person's pregnancy, childbirth or related condition, unless based on a bona fide occupational qualification.

C. It is an unlawful discriminatory practice for an employer's agent to comply with a request from an employer for referral of applicants for employment if the request indicates either directly or indirectly that the employer discriminates in employment on the basis of pregnancy, childbirth or related condition, unless that discrimination is based on a bona fide occupational qualification."

SECTION 4. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] PREGNANCY ACCOMMODATION NOTICE.--

A. An employer shall provide written notice of an employee's rights pursuant to the Pregnant Worker Accommodation Act to be free from discrimination in relation to pregnancy, childbirth or a related condition, including the right to reasonable accommodations for conditions related to pregnancy, childbirth or a related condition, to:

(1) job applicants;

(2) new employees at the commencement of

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employment;

(3) existing employees within one hundred twenty days after the effective date of the Pregnant Worker Accommodation Act; and

(4) within ten days of her notification, any employee who notifies the employer of her pregnancy.

B. The notice provided pursuant to this section shall also be conspicuously posted at an employer's place of business in an area accessible to employees."

SECTION 5. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ADMINISTRATIVE REVIEW--JUDICIAL REVIEW.--

A. A person claiming to be aggrieved by an unlawful discriminatory practice in violation of the Pregnant Worker Accommodation Act may:

(1) maintain an action to establish liability and recover damages and injunctive relief in any court of competent jurisdiction by an employee or job applicant on behalf of the employee or job applicant or on behalf of other employees or job applicants similarly situated; or

(2) seek relief under the Human Rights Act pursuant to the process set out in Sections 28-1-10 through 28-1-13 NMSA 1978.

B. The court in any action brought pursuant to this section shall, in addition to any judgment awarded to the

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plaintiff, allow costs of the action and reasonable attorney fees to be paid by the defendant. In any proceedings brought pursuant to the provisions of this section, the employee or job applicant shall not be required to pay any filing fee or other court costs necessarily incurred in such proceedings.

C. The court in any action brought under this section may order appropriate injunctive relief, including requiring an employer to post in the place of business a notice describing violations by the employer, as determined by the court or a copy of a cease and desist order applicable to the employer.

D. An action arising pursuant to the Pregnant Worker Accommodation Act shall be initiated within one year from the date of discovery of the violation.

E. A person claiming to be aggrieved by an unlawful discriminatory practice in violation of the Pregnant Worker Accommodation Act need not exhaust state administrative remedies before filing an action in court.

F. The initiation of an administrative process under the Human Rights Act pursuant to the process set out in Sections 28-1-10 through 28-1-13 NMSA 1978 shall toll the statute of limitations for initiating a claim under the Pregnant Worker Accommodation Act."

SECTION 6. A new section of Chapter 28 NMSA 1978 is enacted to read:

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"[NEW MATERIAL] RETALIATION PROHIBITED.--It is a violation of the Pregnant Worker Accommodation Act for an employer or any other person to discharge, demote, deny promotion to or in any other way discriminate against an employee in the terms or conditions of employment in retaliation for the person asserting a claim or right pursuant to the Pregnant Worker Accommodation Act, for assisting another person to assert a claim or right pursuant to the Pregnant Worker Accommodation Act or for informing another person about employment rights or other rights provided by law."

SECTION 7. A new section of Chapter 28 NMSA 1978 is enacted to read:

"[NEW MATERIAL] ENFORCEMENT--PENALTIES--REMEDIES.--

A. An employer that violates a provision of the Pregnant Worker Accommodation Act shall be liable to the affected employee or job applicant for damages and equitable relief, including employment, reinstatement and promotion. Damages shall be calculated on the basis of:

(1) an affected employee's unpaid wages and the damages from retaliation;

(2) all other actual damages; and

(3) treble damages.

B. The court may, in its discretion, not award treble damages or award any amount thereof not to exceed the amount specified in this section if the employer found to have

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violated the Pregnant Worker Accommodation Act shows to the satisfaction of the court that the act or omission giving rise to such action was in good faith and that the employer had reasonable grounds for believing that the employer's act or omission was not a violation of the Pregnant Worker Accommodation Act.

C. An employer that violates a provision of the Pregnant Worker Accommodation Act may be liable to an employee or job applicant for punitive damages."

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SENATE JOINT MEMORIAL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A JOINT MEMORIAL

REQUESTING THE SECRETARY OF HEALTH TO CONVENE A LESBIAN, GAY, BISEXUAL, TRANSGENDER AND QUEER HEALTH DISPARITIES TASK FORCE TO ANALYZE HEALTH DISPARITIES AND MAKE RECOMMENDATIONS FOR ADDRESSING THOSE HEALTH DISPARITIES.

WHEREAS, the United States department of health and human services has made improving the health, safety and well-being of lesbian, gay, bisexual and transgender individuals, known by the acronym "LGBT", a new topic of its nationwide public health campaign, "Healthy People 2020"; and

WHEREAS, the "Healthy People 2020" recommendations include an increase in the number of population-based data systems used to monitor "Healthy People 2020" objectives, which includes in its core objectives a standardized set of questions that identify LGBT populations; and

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WHEREAS, there has been growing research and recognition of the roles that social stigma and discrimination play in the health of sexual and gender minorities and that the discussion has expanded beyond sexual behavior; and

WHEREAS, LGBT individuals also appear to be at higher risk than their straight counterparts for some chronic conditions such as asthma, disability and arthritis; and

WHEREAS, studies by the federal institute of medicine and the board on the health of select populations have found that lesbians and bisexual women have higher rates of breast cancer than heterosexual women; and

WHEREAS, the *American Journal of Preventive Medicine* reports that lesbians and bisexual women get less routine health care than other women, including colon, breast and cervical cancer screening; and

WHEREAS, research suggests that LGBT individuals face health disparities linked to societal stigma, discrimination and denial of their civil and human rights; and

WHEREAS, according to a survey entitled "Injustice at Every Turn, A Report of the National Transgender Discrimination Survey", nineteen percent of transgender individuals surveyed report being refused medical care due to their transgender status or gender-nonconforming status, with people of color reporting even higher rates of medical care discrimination; and

WHEREAS, over one-fourth, twenty-eight percent, of

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participants in the transgender survey report that they postponed medical care due to their experiences of discrimination in the medical care sector; and

WHEREAS, the transgender population surveyed live in extreme poverty and are nearly four times more likely than the non-transgender population to have a household income of less than ten thousand dollars ($10,000) a year; and

WHEREAS, a staggering forty-one percent of respondents in the transgender survey report having attempted suicide, compared to one and six-tenths percent of the general population, with reported rates even higher for the following respondents:

A. fifty-five percent among individuals who lost a job due to bias;

B. fifty-one percent for individuals who were harassed or bullied in school;

C. sixty-one percent for individuals who were victims of physical assault; and

D. sixty-four percent for individuals who were victims of sexual assault; and

WHEREAS, at least forty-seven thousand adults and twelve thousand five hundred adolescents in New Mexico identify as a sexual minority, a classification that includes lesbians, gays and bisexuals and is known by the acronym "LGB"; and

WHEREAS, LGB adults are more likely to report having

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depression and anxiety and are more likely to have ever attempted suicide than their heterosexual or "straight" counterparts; and

WHEREAS, LGB adults smoke cigarettes at twice the rate of straight adults, putting them at increased risk for tobacco-related diseases and death; and

WHEREAS, smoking rates decreased significantly in the straight adult population between 2005 and 2010, but smoking rates increased in lesbian and gay populations and remained high in the bisexual population; and

WHEREAS, LGB youths are twice as likely to be bullied at school than straight youths; and

WHEREAS, LGB youths are three times more likely to skip school because of safety issues than straight youths; and

WHEREAS, LGB youths are twice as likely to binge drink than straight youths; and

WHEREAS, LGB youths are almost three times as likely to smoke cigarettes than straight youths; and

WHEREAS, LGB youths are more likely to use marijuana or other drugs than straight youths; and

WHEREAS, the department of health reports that gay and bisexual men and other men who have sex with men comprise the majority of human immunodeficiency virus cases since the beginning of the epidemic in New Mexico, accounting for two thousand one hundred ninety-eight cases or seventy and three

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one-hundredths percent of all cumulative diagnoses;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the secretary of health be requested to convene an "LGBTQ health disparities task force" to examine the current state of health and wellness among New Mexicans who identify as lesbian, gay, bisexual, transgender or queer and to perform a gap analysis of the needs that exist and remain unaddressed; and

BE IT FURTHER RESOLVED that the LGBTQ health disparities task force examine the disparities in physical and behavioral health outcomes that exist between New Mexicans who identify as lesbian, gay, bisexual, transgender or queer and New Mexicans who identify as heterosexual or straight, including, among the latter, those whose assigned gender matches their gender identity or orientation; and

BE IT FURTHER RESOLVED that the LGBTQ health disparities task force be requested to employ a "health in all policies model" that examines the environmental, socioeconomic, cultural and other social determinants of health alongside areas such as epidemiology, population health, health care service utilization and health care finance and delivery systems; and

BE IT FURTHER RESOLVED that the secretary of health be requested to invite to participate in the LGBTQ health disparities task force representatives with expertise relating to the following:

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A. New Mexico's diverse LGBTQ communities;

B. health;

C. the well-being of children and families;

D. public benefits programs;

E. law;

F. education;

G. aging;

H. disability; and

I. public administration; and

BE IT FURTHER RESOLVED that the secretary of health be requested to invite to participate in the LGBTQ health disparities task force representatives from the department of health, the children, youth and families department, the human services department, the aging and long-term services department, the Indian affairs department, the public education department, the higher education department, equality New Mexico and the transgender resource center; and

BE IT FURTHER RESOLVED that the LGBTQ health disparities task force be requested to compile and publish a report that includes the task force's recommendations for addressing the health disparities it has identified and to present the task force's report to the legislative health and human services committee and other appropriate legislative committees by November 1, 2015; and

BE IT FURTHER RESOLVED that copies of this memorial be

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transmitted to the governor; the secretaries of health, children, youth and families, human services, aging and long-term services, Indian affairs, public education and higher education; and to the executive directors of equality New Mexico and the transgender resource center.

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH COVERAGE; ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROVIDE THAT HEALTH COVERAGE CARRIERS SHALL NOT DISCRIMINATE AGAINST HEALTH CARE PROVIDERS WORKING WITHIN THEIR LEGAL SCOPES OF PRACTICE; AMENDING A SECTION OF CHAPTER 59A, ARTICLE 22 NMSA 1978; REPEALING SECTIONS OF THE NMSA 1978.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--NONDISCRIMINATION.--

A. Group health coverage, including any form of self-insurance, offered, issued or renewed under the Health

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Care Purchasing Act shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license, certification or other legal authority to practice in the state.

B. This section shall not require that a group health plan contract with any health care provider willing to abide by the terms and conditions for participation established by the group health plan.

C. Nothing in this section shall be construed as preventing a group health plan from establishing varying reimbursement rates based on quality or performance measures.

D. As used in this section, "health care provider" means a person that is licensed, certified or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in the state."

SECTION 2. Section 59A-22-32 NMSA 1978 (being Laws 1984, Chapter 127, Section 454, as amended) is amended to read:

"59A-22-32. FREEDOM OF CHOICE OF HOSPITAL [~~AND PRACTITIONER~~].--

A. Within the area and limits of coverage offered an insured and selected by the insured in the application for insurance, the right of a person to exercise full freedom of choice in the selection of a hospital for hospital care [~~or of~~

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~~a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice, as defined in Subsection B of this section~~] for treatment of an illness or injury [~~within that person's scope of practice~~] shall not be restricted under any [~~new~~] policy of health insurance, contract or health care plan [~~issued after June 30, 1967~~] in this state or in the processing of a claim thereunder. A person insured or claiming benefits under any [~~such~~] health insurance policy, contract or health care plan providing within its coverage for payment of service benefits or indemnity for hospital care [~~or treatment of persons for the cure or correction of any physical or mental condition~~] shall be deemed to have complied with the requirements of the policy, contract or health care plan as to submission of proof of loss upon submitting written proof supported by the certificate of any hospital currently licensed by the department of health [~~or any practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife or registered nurse in expanded practice~~].

B. As used in this section, [~~(1)~~] "hospital care" means hospital service provided through a hospital that is maintained by the state or a political subdivision of the state or a place that is currently licensed as a hospital by the

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department of health and has accommodations for resident bed patients, a licensed professional registered nurse always on duty or call, a laboratory and an operating room where surgical operations are performed, but "hospital care" does not include a convalescent or nursing or rest home

[~~(2) "practitioner of the healing arts" means a person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:~~

~~(a) the Chiropractic Physician Practice Act;~~

~~(b) the Dental Health Care Act;~~

~~(c) the Medical Practice Act;~~

~~(d) Chapter 61, Article 10 NMSA 1978;~~ ~~and~~

~~(e) the Acupuncture and Oriental Medicine Practice Act;~~

~~(3) "optometrist" means a person holding a license provided for in the Optometry Act;~~

~~(4) "podiatrist" means a person holding a license provided for in the Podiatry Act;~~

~~(5) "psychologist" means a person who is duly licensed or certified in the state where the service is rendered and has a doctoral degree in psychology and has had at~~

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~~least two years of clinical experience in a recognized health setting or has met the standards of the national register of health service providers in psychology;~~

~~(6) "physician assistant" means a person who is licensed by the New Mexico medical board to practice as a physician assistant and who provides services to patients under the supervision and direction of a licensed physician;~~

~~(7) "certified nurse-midwife" means a person licensed by the board of nursing as a registered nurse and who is registered with the public health division of the department of health as a certified nurse-midwife;~~

~~(8) "registered lay midwife" means a person who practices lay midwifery and is registered as a registered lay midwife by the public health division of the department of health; and~~

~~(9) "registered nurse in expanded practice" means a person licensed by the board of nursing as a registered nurse approved for expanded practice pursuant to the Nursing Practice Act as a certified nurse practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing speciality and is certified by a national nursing organization.~~

~~C. This section shall apply to any such policy that~~

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~~is delivered or issued for delivery in this state on or after July 1, 1979 and to any existing group policy or plan on its anniversary or renewal date after June 30, 1979 or at expiration of the applicable collective bargaining contract, if any, whichever is later~~]."

SECTION 3. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--NONDISCRIMINATION.--

A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall not discriminate with respect to participation under the policy, plan or certificate against any health care provider who is acting within the scope of that provider's license, certification or other legal authority to practice in the state.

B. This section shall not require that a health insurer contract with any health care provider willing to abide by the terms and conditions for participation established by the health insurance policy, health care plan or certificate of health insurance.

C. Nothing in this section shall be construed as preventing a health insurer from establishing varying reimbursement rates based on quality or performance measures.

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D. As used in this section, "health care provider" means a person that is licensed, certified or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in the state."

SECTION 4. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--NONDISCRIMINATION.--

A. A group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in the state shall not discriminate with respect to participation under the policy, plan or certificate against any health care provider who is acting within the scope of that provider's license, certification or other legal authority to practice in the state.

B. This section shall not require that a health insurer contract with any health care provider willing to abide by the terms and conditions for participation established by the health insurance policy, health care plan or certificate of health insurance.

C. Nothing in this section shall be construed as preventing a health insurer from establishing varying reimbursement rates based on quality or performance measures.

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D. As used in this section, "health care provider" means a person that is licensed, certified or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in the state."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--NONDISCRIMINATION.--

A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in the state shall not discriminate with respect to participation pursuant to that contract against any health care provider who is acting within the scope of that provider's license, certification or other legal authority to practice in the state.

B. This section shall not require that a health maintenance organization contract with any health care provider willing to abide by the terms and conditions for participation established by the health maintenance contract.

C. Nothing in this section shall be construed as preventing a health maintenance organization from establishing varying reimbursement rates based on quality or performance measures.

D. As used in this section, "health care provider"

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means a person that is licensed, certified or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in the state."

SECTION 6. A new section of the Nonprofit Health Plan Law is enacted to read:

"[NEW MATERIAL] HEALTH CARE PROVIDERS--NONDISCRIMINATION.--

A. An individual or group health care plan that is delivered, issued for delivery or renewed in the state shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license, certification or other legal authority to practice in the state.

B. This section shall not require that a health plan contract with any health care provider willing to abide by the terms and conditions for participation established by the health plan.

C. Nothing in this section shall be construed as preventing a health insurer from establishing varying reimbursement rates based on quality or performance measures.

D. As used in this section, "health care provider" means a person that is licensed, certified or otherwise authorized to provide services relating to physical or behavioral health care in the ordinary course of business in

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the state."

SECTION 7. REPEAL.--Sections 59A-46-35, 59A-46-36, 59A-47-28.2 and 59A-47-28.3 NMSA 1978 (being Laws 1987, Chapter 335, Section 1, Laws 1989, Chapter 96, Section 2, Laws 1991, Chapter 145, Section 1 and Laws 1998, Chapter 39, Section 2, as amended) are repealed.

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HOUSE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; ENACTING SECTIONS OF THE HEALTH CARE PURCHASING ACT, THE NEW MEXICO INSURANCE CODE, THE HEALTH MAINTENANCE ORGANIZATION LAW AND THE NONPROFIT HEALTH CARE PLAN LAW TO PROVIDE FOR PARITY BETWEEN BEHAVIORAL HEALTH BENEFITS AND OTHER BENEFITS; AMENDING A SECTION OF THE HEALTH INSURANCE PORTABILITY ACT TO ADD CERTAIN BEHAVIORAL HEALTH BENEFITS TO THE PROVISIONS OF THAT ACT; REPEALING SECTIONS OF CHAPTER 59A, ARTICLE 23 NMSA 1978 AND THE NONPROFIT HEALTH CARE PLAN LAW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. Group health coverage, including any form of

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self-insurance, offered, issued or renewed under the Health Care Purchasing Act, or group health coverage offered, issued or renewed in connection with the group health coverage, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. Group health coverage may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the group health coverage plan to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

SECTION 2. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual health insurance policy, health care plan or certificate of health insurance that is delivered,

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issued for delivery or renewed in this state, or an individual health insurance policy, plan or certificate offered, issued or renewed in connection with a health insurance policy, plan or certificate of health insurance, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health insurer may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the health insurance policy, plan or certificate to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

SECTION 3. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. A group health insurance policy, health care

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plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state, or a group health insurance policy, plan or certificate offered, issued or renewed in connection with a health insurance policy, plan or certificate of health insurance, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health insurer may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the group health insurance policy, plan or certificate to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

SECTION 4. Section 59A-23E-18 NMSA 1978 (being Laws 2000, Chapter 6, Section 1) is amended to read:

"59A-23E-18. REQUIREMENT FOR [~~MENTAL~~] BEHAVIORAL HEALTH BENEFITS IN A GROUP HEALTH PLAN, OR GROUP HEALTH INSURANCE

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OFFERED IN CONNECTION WITH THE PLAN, FOR A PLAN YEAR OF AN EMPLOYER.--

A. A group health plan for a plan year of an employer beginning or renewed on or after October 1, 2000, or group health insurance offered in connection with that plan, shall provide both medical and surgical benefits and [~~mental~~] behavioral health benefits. The plan shall not impose treatment limitations or financial requirements on the provision of [~~mental~~] behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A group health plan for a plan year of an employer beginning on or after October 1, 2000, or group health insurance offered in connection with that plan, may:

(1) require pre-admission screening prior to the authorization of [~~mental~~] behavioral health benefits whether inpatient or outpatient; or

(2) apply limitations that restrict [~~mental~~] behavioral health benefits provided under the plan to those that are medically necessary.

[~~C. A group health plan for a plan year of an employer beginning or renewed on or after January 1, 2000, or group health insurance offered in connection with that plan, may not be changed through amendment or on renewal to exclude or decrease the mental health benefits existing as of that~~

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~~date.~~

~~D. An employer, having at least two but not more than forty-nine employees, that is required by the provisions of Subsection A of this section to provide mental health benefits coverage in a group health plan, or group health insurance offered in connection with that plan on renewal of an existing plan, may, if a premium increase of more than one and one-half percent in the plan year results from the change in coverage:~~

~~(1) pay the premium increase;~~

~~(2) reach agreement with the employees to cost-share that amount of the premium above one and one-half percent;~~

~~(3) negotiate a reduction in coverage, but not below the coverage existing before the renewal, to reduce the premium increase to no more than one and one-half percent; or~~

~~(4) after demonstrating to the satisfaction of the insurance division that the amount of the premium increase above one and one-half percent is due exclusively to the additional coverage required by the provisions of Subsection A of this section, receive written permission from the division to not increase coverage.~~

~~E. An employer, having at least fifty employees, that is required by the provisions of Subsection A of this section to provide mental health benefits coverage in a group~~

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~~health plan, or group health insurance offered in connection with that plan on renewal of an existing plan, may, if a premium increase of more than two and one-half percent in the plan year results from the change in coverage:~~

~~(1) pay the premium increase;~~

~~(2) reach agreement with the employees to cost-share that amount of the premium above two and one-half percent;~~

~~(3) negotiate a reduction in coverage, but not below the coverage existing before applying parity requirements, to reduce the premium increase to no more than two and one-half percent; or~~

~~(4) after demonstrating to the satisfaction of the insurance division that the amount of the premium increase above two and one-half percent is due exclusively to the additional coverage provided because of the provisions of Subsection A of this section, receive written permission from the division to not increase coverage.~~

~~F.~~] C. If an organization offering group health benefits to its members makes more than one health insurance policy or nonprofit health care plan available to its members on a member option basis, the organization shall not require behavioral health benefits coverage from one health insurer or health care plan without requiring the same level of behavioral health benefits coverage for all other health insurance

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policies or health care plans that the organization makes available to its members.

D. As used in this section, "[~~mental~~] behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, [~~as described in the group health plan or group health insurance offered in connection with the plan, but does not include benefits with respect to treatment of substance abuse, chemical dependency or gambling addiction~~] including but not limited to services provided to an adult or a child at a residential treatment center."

SECTION 5. A new section of the Health Maintenance Organization Law is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual or group health maintenance organization contract that is delivered, issued for delivery or renewed in this state, or coverage that is offered, issued or renewed in connection with a health maintenance organization contract, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health maintenance organization may:

(1) require pre-admission screening prior to

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the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

(2) apply limitations that restrict benefits provided under the health maintenance contract to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

SECTION 6. A new section of the Nonprofit Health Care Plan Law is enacted to read:

"[NEW MATERIAL] BEHAVIORAL HEALTH BENEFITS--PARITY WITH OTHER BENEFITS.--

A. An individual or group nonprofit health care plan that is delivered, issued for delivery or renewed in this state, or coverage that is issued or renewed in connection with a health care plan, shall not impose treatment limitations or financial requirements on the provision of behavioral health benefits if identical limitations or requirements are not imposed on coverage of benefits for other conditions.

B. A health care plan may:

(1) require pre-admission screening prior to the authorization of behavioral health benefits, whether for inpatient, outpatient or residential treatment; or

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(2) apply limitations that restrict benefits provided under the health care plan to those that are medically necessary.

C. As used in this section, "behavioral health benefits" means all medically necessary mental health and substance use disorder treatment benefits, including but not limited to services provided to an adult or a child at a residential treatment facility."

SECTION 7. REPEAL.--Sections 59A-23-6 and 59A-47-35 NMSA 1978 (being Laws 1983, Chapter 64, Section 1 and Laws 1984, Chapter 127, Section 879.34, as amended) are repealed.

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BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH INSURANCE; ENACTING A NEW SECTION OF THE SMALL GROUP RATE AND RENEWABILITY ACT TO PROVIDE FOR TRANSPARENCY MEASURES RELATING TO HEALTH BENEFIT PLANS COVERING SMALL EMPLOYERS' EMPLOYEES AND THEIR DEPENDENTS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Small Group Rate and Renewability Act is enacted to read:

"[NEW MATERIAL] HEALTH BENEFIT PLAN QUOTE--DISCLOSURES REQUIRED.--

A. The superintendent shall adopt and promulgate rules to require that a carrier that provides a quote for a health benefit plan to a small employer make the following disclosures to the small employer:

(1) any commission or other compensation that

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a broker or agent is to receive contingent upon issuance of the health benefit plan for which the quote is provided; and

(2) the history of rate changes over the preceding five years for the type of health benefit plan being considered.

B. As used in this section, "quote" means an estimate of a health benefit plan's cost for a potential purchaser of the health benefit plan."

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER TO PLAN A BACHELOR OF ARTS AND DOCTOR OF DENTAL SCIENCE PROGRAM.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Four hundred thousand dollars ($400,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal year 2016 to fund planning for a bachelor of arts and doctor of dental science program by the health sciences center. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE
AND THE COURTS, CORRECTIONS AND JUSTICE COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; REQUIRING THE HUMAN SERVICES DEPARTMENT TO PROVIDE FOR CONTINUED MEDICAID ENROLLMENT FOR ELIGIBLE INCARCERATED INDIVIDUALS WHO WERE ENROLLED IN MEDICAID UPON INCARCERATION AND NEW ENROLLMENT IN MEDICAID FOR INDIVIDUALS RELEASED FROM INCARCERATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] INCARCERATED INDIVIDUALS--MEDICAID ENROLLMENT--ENROLLMENT ASSISTANCE.--

A. The secretary of human services shall adopt and promulgate rules to provide that an incarcerated individual who was enrolled in medicaid until the date of incarceration shall remain enrolled in medicaid and shall not be terminated from enrollment in medicaid upon incarceration and that:

(1) during the time the incarcerated

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individual is incarcerated, reimbursement shall not be made for a claim submitted for payment on behalf of the incarcerated individual, except a claim for which federal medical assistance percentage reimbursement is available, including inpatient services furnished at a health care facility outside the premises of incarceration; and

(2) upon release from incarceration, the formerly incarcerated individual shall remain enrolled in medicaid until the individual is determined to be ineligible for medicaid as provided by federal law on grounds other than incarceration.

B. The secretary of human services shall adopt and promulgate rules to provide that an incarcerated individual who was not enrolled in medicaid upon the date that the individual became incarcerated shall be permitted to submit an application for medicaid enrollment during the incarcerated individual's period of incarceration. To execute the provisions of this subsection, the human services department shall create a process for assisting incarcerated individuals with applying to enroll in medicaid in a manner consistent with federal requirements. The human services department shall:

(1) ensure that every incarcerated individual is informed of the individual's right to apply to enroll in medicaid and, upon the individual's request, is provided with an application to enroll in medicaid;

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(2) provide assistance to incarcerated individuals who apply to enroll in medicaid and who request assistance. This assistance shall include:

(a) providing incarcerated individuals with application forms;

(b) obtaining medical information, proof of eligibility and other information required to support an application for enrollment in medicaid; and

(c) completing and submitting medicaid applications;

(3) provide assistance to incarcerated individuals in completing periodic verification of eligibility for enrollment in medicaid. This assistance shall include:

(a) providing incarcerated individuals with the forms necessary for eligibility verification;

(b) obtaining medical information, proof of eligibility and other information required to support a periodic verification of eligibility for enrollment in medicaid; and

(c) completing and submitting a periodic verification of eligibility for enrollment in medicaid;

(4) ensure that an incarcerated individual who wishes to receive an assessment of eligibility for enrollment in medicaid receives that assessment before the incarcerated individual is released from custody. This process shall be

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initiated:

(a) immediately after the release date becomes known to the incarceration facility when the incarcerated individual's period of incarceration is projected upon incarceration to be at least thirty days; or

(b) immediately upon incarceration when the incarcerated individual's period of incarceration is projected upon incarceration to be less than thirty days;

(5) ascertain upon the incarceration of an individual whether the incarcerated individual was enrolled in medicaid until the date of incarceration and, if so, assist that individual in notifying the human services department to ensure that the individual receives all correspondence that the human services department transmits to the incarcerated individual during the individual's incarceration; and

(6) ensure that any incarcerated individual assisted pursuant to this section receives any notification or correspondence that the human services department transmits to the incarcerated individual during the individual's incarceration.

C. The fact that an individual who submits an application for enrollment in medicaid is incarcerated shall not be grounds for the human services department to refuse to process an application for medicaid enrollment that the incarcerated individual submits in a manner otherwise in

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accordance with state law and the rules of the human services department.

D. The provisions of this section shall not be construed to abrogate:

(1) any deadline that governs the processing of applications for enrollment in medicaid pursuant to existing federal or state law; or

(2) requirements under federal or state law that the human services department be notified of changes in income or residency.

E. The secretary of human services shall collaborate and cooperate with the corrections department, the children, youth and families department and the administrators of each of the correctional facilities in the state to carry out the provisions of this act.

F. As used in this section:

(1) "incarcerated individual" means an individual, the legal guardian or conservator of an individual or, for an individual who is an unemancipated minor, the parent or guardian of the individual, who is confined in any of the following correctional facilities:

(a) a state correctional facility;

(b) a privately operated correctional facility;

(c) a county jail;

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(d) a municipal jail;

(e) a privately operated jail;

(f) a detention facility that is operated under the authority of the children, youth and families department and that holds the individual pending a court hearing; or

(g) a facility that is operated under the authority of the children, youth and families department and that provides for the care and rehabilitation of an individual who is under eighteen years of age and who has committed an act that would be designated as a crime under the law if committed by an individual who is eighteen years of age or older;

(2) "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal Social Security Act and rules promulgated pursuant to that act; and

(3) "unemancipated minor" means an individual who is under eighteen years of age and who:

(a) is not on active duty in the armed forces; and

(b) has not been declared by court order to be emancipated.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH SECURITY ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE COSTS; CREATING A COMMISSION; PROVIDING FOR ITS POWERS AND DUTIES; PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL COUNCILS; DIRECTING AND AUTHORIZING THE DEVELOPMENT OF A STATE HEALTH SECURITY PLAN; PROVIDING FOR TRANSFER OF HEALTH INSURANCE EXCHANGE PERSONAL PROPERTY TO THE COMMISSION; PROVIDING PENALTIES; AMENDING A SECTION OF THE TORT CLAIMS ACT; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 45 of this act may be cited as the "Health Security Act".

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SECTION 2. [NEW MATERIAL] PURPOSES OF ACT.--The purposes of the Health Security Act are to:

A. create a program that ensures health care coverage to all New Mexicans through a combination of public and private financing;

B. control escalating health care costs; and

C. improve the health care of all New Mexicans.

SECTION 3. [NEW MATERIAL] DEFINITIONS.--As used in the Health Security Act:

A. "beneficiary" means a person eligible for health care and benefits pursuant to the health security plan;

B. "budget" means the total of all categories of dollar amounts of expenditures for a stated period authorized for an entity or a program;

C. "capital budget" means that portion of a budget that establishes expenditures for:

(1) acquisition or addition of substantial improvements to real property; or

(2) acquisition of tangible personal property;

D. "case management" means a comprehensive program designed to meet an individual's need for care by coordinating and linking the components of health care;

E. "commission" means the health care commission;

F. "consumer price index for medical care prices" means that index as published by the bureau of labor statistics

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of the federal department of labor;

G. "controlling interest" means:

(1) a five percent or greater ownership interest, direct or indirect, in the person controlled; or

(2) a financial interest, direct or indirect, that, because of business or personal relationships, has the power to influence important decisions of the person controlled;

H. "essential community provider" means an entity that is designated in federal law as serving a health care provider that serves predominately low-income or medically underserved populations and that includes any of the following health care facilities:

(1) a federally qualified health center, or "look alike" community health center;

(2) a health facility that receives federal funds to treat individuals living with human immunodeficiency virus or acquired immunodeficiency syndrome;

(3) a safety net care pool hospital;

(4) a family planning clinic that receives federal funding pursuant to Title X of the federal Public Health Service Act;

(5) a hemophilia treatment center;

(6) a medical care program operated by the federal Indian Health Service or an Indian nation, tribe or

pueblo; or

(7) a hospital defined under federal law as a disproportionate share hospital or a hospital eligible for disproportionate share payments; a children's hospital; a rural referral center; a free-standing cancer center; or a critical-access hospital;

I. "financial interest" means an ownership interest of any amount, direct or indirect;

J. "group practice" means an association of health care providers that provides one or more specialized health care services or a tribal or urban Indian coalition in partnership or under contract with the federal Indian health service that is authorized under federal law to provide health care to Native American populations in the state;

K. "health care" means health care provider services and health facility services;

L. "health care provider" means:

(1) a person or network of persons licensed or certified and authorized to provide health care in New Mexico;

(2) an individual licensed or certified by a nationally recognized professional organization and designated as a health care provider by the commission; or

(3) a person that is a group practice of licensed providers or a transportation service;

M. "health facility" means a school-based clinic,

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an Indian health service facility, a tribally operated health care facility, a state-operated health care facility, a general hospital, a special hospital, an outpatient facility, a psychiatric hospital, a primary clinic pursuant to the Rural Primary Health Care Act, a laboratory, a skilled nursing facility or a nursing facility; provided that the health facility is authorized to receive state or federal reimbursement;

N. "health security plan" means the program that is created and administered by the commission for provision of health care pursuant to the Health Security Act;

O. "major capital expenditure" means construction or renovation of facilities or the acquisition of diagnostic, treatment or transportation equipment by a health care provider or health facility that costs more than an amount recommended and established by the commission;

P. "medicare offset" means a reimbursement that the federal government makes pursuant to the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

Q. "operating budget" means the budget of a health facility exclusive of the facility's capital budget;

R. "person" means an individual or any other legal entity;

S. "primary care provider" means a health care

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provider who is a physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other health care provider certified by the commission to provide the first level of basic health care, including diagnostic and treatment services; services delivered at a primary clinic, telehealth site or a school-based health center; and behavioral health services if those services are integrated into the provider's service array;

T. "provider budget" means the authorized expenditures pursuant to payment mechanisms established by the commission to pay for health care furnished by health care providers participating in the health security plan;

U. "superintendent" means the superintendent of insurance; and

V. "transportation service" means a person providing the services of an ambulance, helicopter or other conveyance that is equipped with health care supplies and equipment and that is used to transport patients to health care providers or health facilities.

SECTION 4. [NEW MATERIAL] HEALTH CARE COMMISSION CREATED--GOVERNMENTAL INSTRUMENTALITY.--As of December 1, 2016, the "health care commission" is created as a public body, politic and corporate, constituting a governmental instrumentality. The commission consists of fifteen members.

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SECTION 5. [NEW MATERIAL] CREATION OF HEALTH CARE COMMISSION MEMBERSHIP NOMINATING COMMITTEE--MEMBERSHIP, TERMS AND DUTIES OF COMMITTEE.--

A. As of April 15, 2016, the "health care commission membership nominating committee" is created, consisting of ten members, to reflect the geographic diversity of the state, as follows:

(1) three members appointed by the speaker of the house of representatives;

(2) three members appointed by the president pro tempore of the senate;

(3) two members appointed by the minority floor leader of the house of representatives; and

(4) two members appointed by the minority floor leader of the senate.

B. By March 1, 2016, the legislative council service shall provide the public with public notice to allow members of the public to request consideration of appointment to the nominating committee. The notice shall be advertised and reported on a publicly accessible web site, in media outlets throughout the state and through publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks preceding June 1, 2016.

C. At the first meeting of the nominating

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committee, it shall elect a chair and any other officers it deems necessary from its membership. The chair shall vote only in the case of a tie vote.

D. Members shall serve two-year terms.

E. A member shall serve until the member's successor is appointed and qualified. Successor members shall be appointed by the appointing authority that made the initial appointment to the nominating committee. A state employee who is exempt from the Personnel Act is not eligible to serve on the nominating committee. A member shall be eligible for or enrolled in the health security plan. An elected official shall not serve on the nominating committee.

F. Appointed members of the nominating committee shall have substantial knowledge of the health care system as demonstrated by education or experience. A person shall not be appointed to the nominating committee if, currently or within the previous thirty-six months, the person or a member of the person's household is employed by, is an agent or officer of or has a controlling interest in:

(1) a health facility;

(2) a person that provides health care services in the regular course of business; or

(3) a person that is licensed to provide health insurance.

G. The nominating committee shall take appropriate

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action to ensure that adequate prior notice of its meetings is advertised and reported at least seventy-two hours before each meeting on a publicly accessible web site, in media outlets throughout the state and through the publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks immediately preceding the date of a meeting. Meetings of the nominating committee shall be open to the public, and public comment shall be allowed.

H. A majority of the nominating committee constitutes a quorum. The nominating committee may allow members' participation in meetings by telephone or other electronic media that allow full participation. Meetings may be closed only for discussion of candidates prior to selection. Final selection of candidates shall be by vote of the members and shall be conducted in a public meeting.

I. The New Mexico legislative council shall convene the first meeting of the nominating committee on or before May 16, 2016. The nominating committee shall actively solicit, accept and evaluate applications from qualified persons for membership on the commission subject to the requirements for commission membership qualifications pursuant to Section 6 of the Health Security Act.

J. No later than October 1, 2016, the nominating committee shall submit to the governor the names of persons

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recommended for appointment to the commission by a majority of the nominating committee. Immediately after receiving the nominating committee's nominations, the governor may make one request of the nominating committee for submission of additional names. If a majority of the nominating committee finds that additional persons would be qualified, the nominating committee shall promptly submit additional names and recommend those persons for appointment to the commission. The nominating committee shall submit no more than three names for a membership position for each initial or additional appointment.

K. Appointed nominating committee members may be reimbursed pursuant to the Per Diem and Mileage Act for expenses incurred in fulfilling their duties.

L. Staff to assist the nominating committee in its duties until a commission is appointed shall be furnished by the legislative council service.

SECTION 6. [NEW MATERIAL] APPOINTMENT OF COMMISSION MEMBERS--MEETINGS--QUALIFICATIONS--TERMS.--

A. From the nominees submitted by the health care commission membership nominating committee, the governor shall appoint fifteen members to the commission, and the initial commission shall be in place by December 1, 2016. In the event that the governor does not appoint a member to a commission membership slot by December 1, 2016, the nominating committee

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shall make that appointment.

B. The New Mexico legislative council shall convene a first meeting of the commission by January 4, 2017. At the first meeting of the commission, the members shall elect from their membership a chair and a vice chair and any other officers they deem necessary. The chair, vice chair and any other officers shall serve for terms of two years.

C. After the first meeting of the commission, the commission shall meet at the call of the chair as the chair deems necessary and at least once each month.

D. The terms of the initial commission members appointed shall be chosen by lot: five members shall be appointed for terms of four years; five members shall be appointed for terms of three years; and five members shall be appointed for terms of two years. Thereafter, all members shall be appointed for terms of four years. After initial terms are served, no member shall serve more than two consecutive four-year terms. A member may serve until a successor is appointed.

E. A person who served on the health care commission membership nominating committee shall not be nominated for or serve on the commission within thirty-six months from the time served on the committee. A state employee who is exempt from the Personnel Act is not eligible to serve on the commission. An elected official shall not serve on the

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commission. A commission member shall be eligible for or enrolled in the health security plan.

F. When a vacancy occurs in the membership of the commission, the health care commission membership nominating committee shall meet and act within thirty days of the occurrence of the vacancy. From the nominees submitted, the governor shall fill the vacancy within thirty days after receiving final nominations. In the event that the governor does not appoint a member to the vacancy within thirty days, the nominating committee shall appoint a member to fill the vacancy.

G. The fifteen members of the commission shall include:

(1) five persons who represent either health care providers or health facilities;

(2) six persons who represent consumer interests; and

(3) four persons who represent employer interests.

H. Except for persons appointed to represent health facilities or health care providers, a person shall be disqualified for appointment to the commission if:

(1) the person has served on the health care commission membership nominating committee within the past thirty-six months; or

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(2) currently or within the previous thirty-six months, the person or a member of the person's household is employed by, is an agent or officer of or has a controlling interest in:

(a) a health facility;

(b) a person that provides health care services in the regular course of business; or

(c) a person that is licensed to provide health insurance.

I. Persons appointed who do not represent health care providers or health facilities must have a knowledge of the health care system as demonstrated by experience or education. To ensure fair representation of all areas of the state, members shall be appointed from each of the public education commission districts as follows:

(1) two from public education commission district 1;

(2) one from public education commission district 2;

(3) one from public education commission district 3;

(4) two from public education commission district 4;

(5) two from public education commission district 5;

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(6) one from public education commission district 6;

(7) two from public education commission district 7;

(8) two from public education commission district 8;

(9) one from public education commission district 9; and

(10) one from public education commission district 10.

J. The presence of a majority of the commission's members constitutes a quorum for the transaction of business. The commission may allow members' participation in meetings by telephone or other electronic media that allow full participation.

K. A member may receive per diem and mileage at a rate equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act for expenses incurred in fulfilling their duties. Additionally, members shall be compensated at the rate of two hundred dollars ($200) for each day of a meeting or training event actually attended not to exceed compensation for one hundred twenty meetings for a two-year period occurring in a term.

L. The commission shall establish an electronic

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mail or "email" system for use by members in the conduct of commission business. Commission business shall be exclusively conducted on the commission's email system.

SECTION 7. [NEW MATERIAL] CONFLICT OF INTEREST--DISCLOSURE BY MEMBERS AND DISQUALIFICATION FROM VOTING ON CERTAIN MATTERS.--

A. The commission shall adopt a conflict-of-interest disclosure statement for use by all members that requires disclosure of a financial interest, whether or not a controlling interest, of the member or a member of the member's household in a person providing health care or health insurance.

B. A member representing health facilities or health care providers may vote on matters that pertain generally to health facilities or health care providers.

C. If there is a question about a conflict of interest of a commission member, the other members shall vote on whether to allow the member to vote.

SECTION 8. [NEW MATERIAL] COMMISSION CODE OF CONDUCT--MEMBER DISCIPLINE--REMOVAL.--The commission shall adopt and promulgate a code of conduct and procedures to be observed by members in the execution of their duties. The commission may remove a member for a violation of the commission code of conduct or a violation of the Health Security Act by a two-thirds' majority vote of all of the members at a meeting where

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a quorum is duly constituted. A member shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with procedures the commission has adopted and promulgated.

SECTION 9. [NEW MATERIAL] APPLICATION OF CERTAIN STATE LAWS TO COMMISSION.--The commission and regional councils created pursuant to the Health Security Act:

A. shall be subject to and shall comply with the provisions of the:

(1) Open Meetings Act;

(2) State Rules Act;

(3) Inspection of Public Records Act;

(4) Public Records Act;

(5) Financial Disclosure Act;

(6) Accountability in Government Act;

(7) Gift Act; and

(8) Tort Claims Act; and

B. shall not be subject to the provisions of the Procurement Code or the Personnel Act.

SECTION 10. [NEW MATERIAL] CHIEF EXECUTIVE OFFICER--STAFF--CONTRACTS--BUDGETS.--

A. The commission shall appoint and set the salary of a "chief executive officer". The chief executive officer shall serve at the pleasure of the commission and has authority

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to carry on the day-to-day operations of the commission and the health security plan.

B. The chief executive officer shall employ those persons necessary to administer and implement the provisions of the Health Security Act.

C. The chief executive officer and the chief executive officer's staff shall implement the Health Security Act in accordance with that act and the rules adopted by the commission. The chief executive officer may delegate authority to employees and may organize the staff into units to facilitate its work.

D. If the chief executive officer determines that the commission staff or a state agency does not have the resources or expertise to perform a necessary task, the chief executive officer may contract for performance from a person who has a demonstrated capability to perform the task. The commission shall establish the standards and requirements by which a contract is executed by the commission or the chief executive officer. A contract shall be reviewed by the commission or the chief executive officer to ensure that it meets the criteria, performance standards, expectations and needs of the commission.

E. The chief executive officer shall prepare and submit an annual budget request and plan of operation to the commission for its approval. The chief executive officer shall

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provide at least quarterly status reports on the budget and advise of a potential shortfall as soon as practically possible.

SECTION 11. [NEW MATERIAL] COMMISSION--GENERAL DUTIES.--The commission shall:

A. adopt a transition plan to ensure the seamless transition of health security plan beneficiaries from other sources of coverage, public and private. The transition plan shall ensure the proper assignment and payment of claims incurred on behalf of beneficiaries before the implementation of the health security plan;

B. by February 15, 2017, obtain legal counsel to advise the commission in the execution of its duties;

C. by April 1, 2017, adopt and promulgate rules for the procurement of goods and services. With the exception of audit-related services, rules relating to the procurement of goods and services shall provide for a preference for New Mexico vendors;

D. pursuant to federal law, apply for any federal waiver that the commission deems necessary to implement the health security plan;

E. design the health security plan to fulfill the purposes of and conform with the provisions of the Health Security Act;

F. provide a program to educate the public, health

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care providers and health facilities about the health security plan and the persons eligible to receive its benefits;

G. study and adopt as provisions of the health security plan cost-effective methods of providing quality health care to all beneficiaries, according high priority to increased reliance on:

(1) preventive and primary care that includes immunization and screening examinations;

(2) providing health care in rural or underserved areas of the state;

(3) in-home and community-based alternatives to institutional health care; and

(4) case management services when appropriate;

H. establish compensation methods for health care providers and health facilities and adopt standards and procedures for negotiating and entering into contracts with participating health care providers and health facilities;

I. establish annual health security plan budgets and budgets for those projected future periods that the commission believes appropriate;

J. establish capital budgets for health facilities, limited to capital expenditures subject to the Health Security Act, and include and adopt in establishing those budgets:

(1) standards and procedures for determining the budgets; and

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(2) a requirement for prior approval by the commission for major capital expenditures by a health facility;

K. negotiate and enter into health care reciprocity agreements with out-of-state health care providers and negotiate and enter into other health care agreements with out-of-state health care providers and health facilities;

L. develop claims and payment procedures for health care providers, health facilities and claims administrators and include provisions to ensure timely payments and provide for payment of interest when reimbursable claims are not paid within a reasonable time;

M. establish, in conjunction with state agencies similarly charged, a comprehensive system to collect and analyze health care data, including claims data and other data, necessary to improve the quality, efficiency and effectiveness of health care and to control costs of health care in New Mexico, which system shall include data on:

(1) mortality, including accidental causes of death, and natality;

(2) morbidity;

(3) health behavior;

(4) physical and psychological impairment and disability;

(5) health care system costs and health care availability, utilization and revenues;

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(6) environmental factors;

(7) availability, adequacy and training of health care personnel;

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

N. standardize data collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for reporting health information;

O. foster a health care delivery system that is efficient to administer and that eliminates unnecessary administrative costs;

P. adopt rules necessary to implement and monitor a preferred drug list, bulk purchasing or other mechanism to provide prescription drugs and a pricing procedure for nonprescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids and oxygen;

Q. establish a pharmacy and therapeutics committee to:

(1) research federal and state incentives and discount programs for the purchase, manufacture or supply of drugs, biologics and medical equipment and supplies to maximize the health security plan's savings potential through these

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incentives and programs;

(2) conduct research and analysis to establish a formulary of drugs and biologics that is in accordance with clinical best practices for safety, efficacy and effectiveness while, in strict observance of those best practices, maximizing fiscal soundness;

(3) conduct concurrent, prospective and retrospective drug utilization review;

(4) consult with specialists in appropriate fields of medicine for therapeutic classes of drugs;

(5) recommend therapeutic classes of drugs, including specific drugs within each class to be included in the preferred drug list;

(6) identify appropriate exclusions from the preferred drug list; and

(7) conduct periodic clinical reviews of preferred, nonpreferred and new drugs;

R. study and evaluate the adequacy and quality of health care furnished pursuant to the Health Security Act, the cost of each type of service and the effectiveness of cost-containment measures in the health security plan;

S. in conjunction with the human services department, apply to the United States department of health and human services for all waivers of requirements under health care programs established pursuant to the federal Social

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Security Act that are necessary to enable the health security plan to receive federal payments for services rendered to medicaid or medicare beneficiaries;

T. except for those programs designated in Subsection B of Section 21 of the Health Security Act, identify other federal programs that provide federal funds for payment of health care services to individuals and apply for any waivers or enter into any agreements that are necessary for services covered by the health security plan; provided, however, that agreements negotiated with the federal Indian health service or tribal governments shall not impair treaty obligations of the United States government and that other agreements negotiated shall not impair portability or other aspects of the health care coverage;

U. seek an amendment to the federal Employee Retirement Income Security Act of 1974 to exempt New Mexico from the provisions of that act that relate to health care services or health insurance, or apply to the appropriate federal agency for waivers of any requirements of that act if congress provides for waivers to enable the commission to extend coverage through the Health Security Act to as many New Mexicans as possible; provided, however, that the amendment or waiver requested shall not impair portability or other aspects of the health care coverage;

V. analyze developments in federal law and

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regulation relevant to the health security plan, and provide updates and any legislative recommendations to the legislature that the commission deems necessary pursuant to those developments;

W. work with the counties to determine the expenditure of funds generated pursuant to the Indigent Hospital and County Health Care Act and the Statewide Health Care Act;

X. seek to maximize federal contributions and payments for health care services provided in New Mexico and ensure that the contributions of the federal government for health care services in New Mexico will not decrease in relation to other states as a result of any waivers, exemptions or agreements;

Y. study and monitor the migration of persons to New Mexico to determine if persons with costly health care needs are moving to New Mexico to receive health care and, if migration appears to threaten the financial stability of the health security plan, recommend to the legislature changes in eligibility requirements, premiums or other changes that may be necessary to maintain the financial integrity of the health security plan;

Z. collaborate with state agencies and experts to study and evaluate health care work force data and research, and information solicited from health care providers and health

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care work force experts, on the effect of the health security plan on the state's provider community. This shall include the study and evaluation of the supply of health care providers in the state and providers' ability to provide high-quality health care under the health security plan;

AA. study and evaluate the cost of health care provider professional liability insurance and its impact on the price of health care services and recommend changes to the legislature as necessary;

BB. establish and approve changes in coverage benefits and benefit standards in the health security plan in compliance with federal and state law;

CC. conduct necessary investigations and inquiries;

DD. adopt rules necessary to implement, administer and monitor the operation of the health security plan;

EE. designate a Native American liaison who shall assist the commission in developing and ensuring implementation of communication and collaboration between the commission and Native Americans in the state. The Native American liaison shall serve as a contact person between the commission and New Mexico Indian nations, tribes and pueblos and shall ensure that training is provided to the staff of the commission, which may include training in:

(1) cultural competency;

(2) state and federal law relating to Indian

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health; and

(3) other matters relating to the functions of the health security plan with respect to Native Americans in the state;

FF. report annually to the legislature and the governor on the commission's activities and the operation of the health security plan and include in the annual report:

(1) a summary of information about health care needs, health care services, health care expenditures, revenues received and projected revenues and other relevant issues relating to the health security plan, the initial five-year plan and future updates of that plan and other long- and short-range plans; and

(2) recommendations on methods to control health care costs and improve access to and the quality of health care for state residents, as well as recommendations for legislative action; and

GG. provide at least one annual training for its members on health care coverage, policy and financing.

SECTION 12. [NEW MATERIAL] COMMISSION--AUTHORITY.--The commission has the authority necessary to carry out the powers and duties pursuant to the Health Security Act. The commission retains responsibility for its duties but may delegate authority to the chief executive officer; provided, however, that only the commission may:

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A. approve the commission's budget and plan of operation;

B. approve the health security plan and make changes in the health security plan, but only after legislative approval of those changes specified in Section 30 of the Health Security Act;

C. make rules and conduct both rulemaking and adjudicatory hearings in person or by use of a hearing officer;

D. issue subpoenas to persons to appear and testify before the commission and to produce documents and other information relevant to the commission's inquiry and enforce this subpoena power through an action in a state district court;

E. make reports and recommendations to the legislature;

F. subject to the prohibitions and restrictions of Section 21 of the Health Security Act, apply for program waivers from any governmental entity if the commission determines that the waivers are necessary to ensure the participation by the greatest possible number of beneficiaries;

G. apply for and accept grants, loans and donations;

H. acquire or lease real property and make improvements on it and acquire by lease or by purchase tangible and intangible personal property;

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I. dispose of and transfer personal property, but only at public sale after adequate notice;

J. appoint and prescribe the duties of employees, fix their compensation, pay their expenses and provide an employee benefit program;

K. establish and maintain banking relationships, including establishment of checking and savings accounts;

L. participate as a qualified entity in the programs of the New Mexico finance authority; and

M. enter into agreements with an employer, group or other plan to provide health care services for the employer's employees or retirees; provided, however, that nothing in the Health Security Act shall be construed to reduce or eliminate benefits to which the employee or retiree is entitled.

SECTION 13. [NEW MATERIAL] ADVISORY BOARDS.--

A. The commission shall establish a "health care provider advisory board" and a "health facility advisory board". The commission may establish additional advisory boards to assist it in performing its duties. Advisory boards shall assist the commission in matters requiring the expertise and knowledge of the advisory boards' members.

B. The commission may appoint not more than two commission members and up to five additional persons to serve on an advisory board it creates. Advisory board members may be paid per diem and mileage equal to the rate at which state

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legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

C. Except for the health care provider advisory board and the health facility advisory board, no more than two advisory board members shall have a controlling interest, direct or indirect, in a person providing health care or a person duly authorized to transact the business of health insurance in the state pursuant to the New Mexico Insurance Code.

D. The commission shall establish an advisory committee made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, to make recommendations to the commission on:

(1) matters relating to Native American beneficiaries; and

(2) agreements between the commission and tribal governments.

E. Staff and technical assistance for an advisory board shall be provided by the commission as necessary.

SECTION 14. [NEW MATERIAL] HEALTH CARE DELIVERY REGIONS.--The commission shall establish health care delivery regions in the state, based on geography and health care resources. The regions may have differential fee schedules, budgets, capital expenditure allocations or other features to encourage the provision of health care in rural and other

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underserved areas or to tailor otherwise the delivery of health care to fit the needs of a region or a part of a region.

SECTION 15. [NEW MATERIAL] REGIONAL COUNCILS.--

A. The commission shall designate regional councils in the designated health care delivery regions. In selecting persons to serve as members of regional councils, the commission shall consider the comments and recommendations of persons in the region who are knowledgeable about health care and the economic and social factors affecting the region.

B. The regional councils shall be composed of the commission members who live in the region and five other members who live in the region and are appointed by the commission. No more than two noncommission council members shall have a controlling interest, direct or indirect, in a person providing health care. An individual who is, or whose household contains an individual who is, employed by or an officer of or who has a controlling interesting in a person providing health insurance, directly or as an agent of a health insurer, shall not be appointed to a regional council.

C. Members of a regional council may be paid per diem and mileage equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

D. The regional councils shall hold public hearings to receive comments, suggestions and recommendations from the

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public regarding regional health care needs. The councils shall report to the commission at times specified by the commission to ensure that regional concerns are considered in the development and update of the five-year plan, other short- and long-range plans and projections, fee schedules, budgets and capital expenditure allocations.

E. Staff technical assistance for the regional councils shall be provided by the commission.

SECTION 16. [NEW MATERIAL] RULEMAKING.--

A. The commission shall adopt rules necessary to carry out the duties of the commission and the provisions of the Health Security Act.

B. The commission shall not adopt, amend or repeal any rule affecting a person outside the commission without a public hearing on the proposed action before the commission or a hearing officer designated by the commission. The hearing officer may be a member of the commission's staff. The hearing shall be held in a county that the commission determines would be in the interest of those affected. Notice of the subject matter of the rule, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed rule or an amendment or repeal of an existing rule may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general

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circulation in the state and shall also be published in an informative nonlegal format in one newspaper published in each health care delivery region and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

C. All rules adopted by the commission shall be filed in accordance with the State Rules Act.

SECTION 17. [NEW MATERIAL] HEALTH SECURITY PLAN.--

A. The health security plan shall be designed to provide comprehensive, necessary and appropriate health care benefits, including minimum essential health benefits required under federal and state law as well as additional preventive health care and primary, secondary and tertiary health care for acute and chronic conditions. The health security plan shall include in its networks each essential community provider that is found in the health security plan's service area.

B. Covered health care services shall not include:

(1) surgery for cosmetic purposes other than for reconstructive purposes;

(2) medical examinations and medical reports prepared for purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recovery or settlement of damages; and

(3) orthodontic services and cosmetic dental services except those cosmetic dental services necessary for

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reconstructive purposes.

C. The health security plan shall specify the health care to be covered and the amount, scope and duration of services.

D. The health security plan shall contain provisions to control health care costs so that beneficiaries receive comprehensive, high-quality health care consistent with available revenue and budget constraints.

E. The health security plan shall phase in eligibility for beneficiaries as their participation becomes possible through contracts, waivers or federal legislation. The health security plan may provide for certain preventive health care to be offered to all New Mexicans regardless of a person's eligibility to participate as a beneficiary.

SECTION 18. [NEW MATERIAL] LONG-TERM CARE.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "long-term care committee" made up of representatives of health care consumers, providers and administrators to develop a plan for integrating long-term care into the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The long-term care component of the health

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security plan shall provide for case management and noninstitutional services when appropriate.

C. Nothing in this section affects long-term care services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 19. [NEW MATERIAL] MENTAL AND BEHAVIORAL HEALTH SERVICES--PARITY.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "mental and behavioral health services committee" made up of representatives of mental and behavioral health care consumers, providers and administrators to develop a plan for coordinating mental and behavioral health services within the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The commission shall ensure that the health security plan conforms to state and federal mental and behavioral health services parity laws.

C. The mental and behavioral health services component of the health security plan shall provide, where appropriate, for:

(1) inpatient residential substance abuse

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treatment services without a step therapy requirement; and

(2) case management and noninstitutional services.

D. Nothing in this section limits mental and behavioral health services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 20. [NEW MATERIAL] MEDICAID COVERAGE--AGREEMENTS.--The commission may enter into appropriate agreements with the human services department, another state agency or a federal agency for the purpose of furthering the goals of the Health Security Act. These agreements may provide for certain services provided pursuant to the medicaid program under Title 19 or Title 21 of the federal Social Security Act and any waiver or provision of that act to be administered by the commission to implement the health security plan.

SECTION 21. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE--CONDITIONS OF ELIGIBILITY FOR BENEFICIARIES--EXCLUSIONS.--

A. An individual is eligible as a beneficiary of the health security plan if the individual has been physically present in New Mexico for one year prior to the date of application for enrollment in the health security plan and if the individual has a current intention to remain in New Mexico and not to reside elsewhere. A dependent of an eligible

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individual is included as a beneficiary.

B. Individuals covered under the following governmental programs shall not be brought into coverage:

(1) federal retiree health plan beneficiaries;

(2) active duty and retired military personnel; and

(3) individuals covered by the federal active and retired military health programs.

C. Federal Indian health service or tribally operated health care program beneficiaries shall not be brought into coverage except through agreements with:

(1) Indian nations, tribes or pueblos;

(2) consortia of tribes or pueblos; or

(3) a federal Indian health service agency subject to the approval of the tribes or pueblos located in that agency.

D. If an individual is ineligible due to the residence requirement, the individual may become eligible by paying the premium required by the health security plan for coverage for the period of time up to the date the individual fulfills that requirement if the individual is an employee who physically resides and intends to reside in the state because of employment offered to the individual in New Mexico while the individual was residing elsewhere as demonstrated by furnishing that evidence of those facts required by rule adopted by the

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commission.

E. An employer, group or other plan that provides health care benefits for its employees after retirement, including coverage for payment of health care supplementary coverage if the retiree is eligible for medicare, may agree to participate in the health security plan, provided that there is no loss of benefits under the retiree health benefit coverage. An employer, group or other plan that participates in the health security plan shall contribute to the health security plan for the benefit of the retiree, and the agreement shall ensure that the health benefit coverage for the retiree shall be restored in the event of the retiree's ineligibility for health security plan coverage.

F. The commission shall prescribe by rule conditions under which other persons in the state may be eligible for coverage pursuant to the health security plan.

SECTION 22. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE OF NONRESIDENT STUDENTS.--

A. Except as provided in Subsection B of this section, an educational institution shall purchase coverage under the health security plan for its nonresident students through fees assessed to those students. The governing body of an educational institution shall set the fees at the amount determined by the commission.

B. A nonresident student at an educational

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institution may satisfy the requirement for health care coverage by proof of coverage under a policy or plan in another state that is acceptable to the commission. The student shall not be assessed a fee in that case.

C. The commission shall adopt rules to determine proof of an individual's eligibility for the health security plan or a student's proof of nonresident health care coverage.

SECTION 23. [NEW MATERIAL] REMOVING INELIGIBLE PERSONS.--The commission shall adopt rules to provide procedures for removing persons no longer eligible for coverage.

SECTION 24. [NEW MATERIAL] ELIGIBILITY CARD--USE--PENALTIES FOR MISUSE.--

A. A beneficiary shall receive a card as proof of eligibility. The card shall be electronically readable and shall contain a photograph or electronic image of the beneficiary, information that identifies the beneficiary for treatment and billing, payment and other information the commission deems necessary. The use of a beneficiary's social security number as an identification number is not permitted.

B. The eligibility card is not transferable. A beneficiary who lends the beneficiary's card to another and an individual who uses another's card shall be jointly and severally liable to the commission for the full cost of the health care provided to the user. The liability shall be paid in full within one year of final determination of liability.

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Liabilities created pursuant to this section shall be collected in a manner similar to that used for collection of delinquent taxes.

C. A beneficiary who lends the beneficiary's card to another or an individual who uses another's card after being determined liable pursuant to Subsection B of this section of a previous misuse is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978. A third or subsequent conviction is a fourth degree felony, and the offender shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

SECTION 25. [NEW MATERIAL] PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO SERVICES.--

A. Except as provided in the Workers' Compensation Act, a beneficiary has the right to choose a primary care provider.

B. The primary care provider is responsible for providing health care provider services to the patient except for:

(1) services in medical emergencies; and

(2) services for which a primary care provider determines that specialist services are required, in which case the primary care provider shall advise the patient of the need for and the type of specialist services.

C. Except as otherwise provided in this section,

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health care provider specialists shall be paid pursuant to the health security plan only if the patient has been referred by a primary care provider. Nothing in this subsection prevents a beneficiary from obtaining the services of a health care provider specialist and paying the specialist for services provided.

D. The commission shall by rule specify when and under what circumstances a beneficiary may self-refer, including self-referral to a chiropractic physician, a doctor of oriental medicine, mental and behavioral health service providers and other health care providers who are not primary care providers.

E. The commission shall by rule specify the conditions under which a beneficiary may select a specialist as a primary care provider.

SECTION 26. [NEW MATERIAL] DISCRIMINATION PROHIBITED.--A health care provider or health facility shall not discriminate against or refuse to furnish health care to a beneficiary on the basis of age, race, color, income level, national origin, religion, gender, sexual orientation, disabling condition or payment status. Nothing in this section shall require a health care provider or health facility to provide services to a beneficiary if the provider or facility is not qualified to provide the needed services or does not offer them to the general public.

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SECTION 27. [NEW MATERIAL] BENEFICIARY RIGHTS--GRIEVANCES--INTERNAL APPEALS--EXTERNAL APPEALS--UTILIZATION REVIEW.--

A. The commission shall adopt rules and shall monitor and oversee the health security plan to ensure that each beneficiary enrolled in the health security plan is treated fairly and in accordance with the requirements of the Health Security Act.

B. The rules that the commission adopts to protect beneficiary rights shall provide at a minimum that:

(1) before enrolling or at the time of enrolling in the health security plan, the plan shall provide a summary of benefits and exclusions, premium information and a provider listing;

(2) within a reasonable time after enrollment and at subsequent periodic times as appropriate, the health security plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the health security plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, beneficiary financial responsibility for payments, grievance procedures, appeal rights and the patients' rights available to all beneficiaries; and

(3) the health security plan shall provide

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notice to each beneficiary, in a culturally and linguistically appropriate manner, of:

(a) the availability of internal and external appeals processes for grievances and the time lines for hearing and decisions on internal and external appeals;

(b) the availability of expedited appeals, the grounds for expedited appeals and the time lines for hearing and decisions on expedited appeals;

(c) the availability of the office of ombudsman at the office of superintendent of insurance to assist beneficiaries with the appeals process;

(d) the beneficiary's right to review the beneficiary's file and to present evidence and testimony as part of the grievance and appeals process; and

(e) the beneficiary's right to receive continued coverage pending the outcome of the grievance and appeals process.

C. In providing reasonably accessible health care services that are available in a timely manner, the health security plan shall ensure that:

(1) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's beneficiaries;

(2) health care providers that are specialists

may act as primary care providers for patients with chronic medical conditions; provided that the specialists offer all basic health care services that are required of them by the health security plan;

(3) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(4) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(5) the plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its beneficiary population.

D. The commission shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the health security plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify beneficiaries of their rights to obtain review by the plan, their rights to

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obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Health Security Act.

E. The commission shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an affected beneficiary. The decision to approve or deny care to a beneficiary shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that each beneficiary has proper access to health care services, including referrals to necessary specialists. A decision made in the health security plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent.

F. The superintendent shall adopt and promulgate rules to establish an external appeals process for review of beneficiary grievances in accordance with the provisions of the Health Security Act.

G. The superintendent may appoint one or more qualified individuals to review external grievance appeals. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations. The

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commission shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

H. Upon completion of the external grievance appeal review, the superintendent shall prepare a detailed statement of compensation due each appointee and shall present the statement to the beneficiary and the commission.

I. The decision to approve or deny a claim based on a technicality shall be made in a timely manner and shall not exceed time limits established by rule of the commission. A final decision to deny payment for services based on medical necessity or utilization shall be based on a recommendation made by a health care professional having appropriate and adequate qualifications to make the recommendation. A denial of a claim for payment of a medical specialty service based on medical necessity or utilization shall be made only after a written recommendation for denial is made by a member of that medical specialty with credentials equivalent to those of the provider.

J. The fact of and the specific reasons for a denial of a health care claim shall be communicated promptly in writing to both the provider and the beneficiary involved.

SECTION 28. [NEW MATERIAL] QUALITY OF CARE--HEALTH CARE PROVIDER AND HEALTH FACILITIES--PRACTICE STANDARDS.--

A. The commission shall adopt rules to establish

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and implement a quality improvement program that monitors the quality and appropriateness of health care provided by the health security plan, including evidence-based medicine, best practices, outcome measurements, consumer education and patient safety. The commission shall set standards and review benefits to ensure that effective, cost-efficient, high-quality and appropriate health care is provided under the health security plan.

B. The commission shall establish a quality improvement program. The quality improvement program shall include an ongoing system for monitoring patterns of practice. Pursuant to the quality improvement program, the commission shall review and adopt professional practice guidelines developed by state and national medical and specialty organizations, federal agencies for health care policy and research and other organizations as it deems necessary to promote the quality and cost-effectiveness of health care provided through the health security plan.

C. The commission shall appoint a "health care practice advisory committee" consisting of health care providers, health facilities and other knowledgeable persons to advise the commission and staff on health care practice issues. The committee shall include both health care providers and health facilities from counties having fifty thousand or fewer inhabitants as of the most recent federal decennial census and

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health care providers and health facilities from counties having more than fifty thousand inhabitants as of the most recent federal decennial census. The committee may appoint subcommittees and task forces to address practice issues of a specific health care provider discipline or a specific kind of health facility, provided that the subcommittee or task force includes providers of substantially similar specialties or types of facilities. The advisory committee shall provide to the commission recommended standards and guidelines to be followed in making determinations on practice issues.

D. With the advice of the health care practice advisory committee, the commission shall establish a system of peer education for health care providers or health facilities determined to be engaging in aberrant patterns of practice pursuant to Subsection B of this section. If the commission determines that peer education efforts have failed, the commission may refer the matter to the appropriate licensing or certifying board.

E. The commission shall provide by rule the procedures for recouping payments or withholding payments for health care determined by the commission with the advice of the health care practice advisory committee or subcommittee to be medically unnecessary.

F. The commission may provide by rule for the assessment of administrative penalties for up to three times

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the amount of excess payments if it finds that excessive billings were part of an aberrant pattern of practice. Administrative penalties shall be deposited in the current school fund.

G. After consultation with the health care practice advisory committee, the commission may suspend or revoke a health care provider's or health facility's privilege to be paid for health care provided under the health security plan based upon evidence clearly supporting a determination by the commission that the provider or facility engages in aberrant patterns of practice, including inappropriate utilization, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Security Act or rules adopted pursuant to that act. As used in this subsection, "unbundle" means to divide a service into components in an attempt to increase, or with the effect of increasing, compensation from the health security plan.

H. The commission shall report a suspension or revocation of the privilege to be paid for health care pursuant to the Health Security Act to the appropriate licensing or certifying board.

I. The commission shall report cases of suspected fraud by a health care provider or a health facility to the attorney general for investigation and prosecution. The office of the attorney general has independent authority to

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investigate and prosecute suspected fraud without a prior commission report of fraud.

SECTION 29. [NEW MATERIAL] PROVIDER AND HEALTH FACILITY DISPUTE RESOLUTION.--

A. The health security plan shall not:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with a beneficiary even if the health security plan does not approve of the option;

(2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to a beneficiary; or

(3) require a health care provider to violate any recognized fiduciary duty of the health care provider's profession or place the health care provider's license in jeopardy.

B. If the health security plan proposes to terminate a health care provider from participation in the health security plan, it shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

C. The commission shall adopt and implement a process pursuant to which providers may raise with the health

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security plan concerns that they may have regarding operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network. The process shall include, at a minimum, the right of the provider to present to the commission any concerns that the provider has regarding operation of the health security plan. In addition, the commission shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation in the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

SECTION 30. [NEW MATERIAL] HEALTH SECURITY PLAN BUDGET--PREMIUM RATES.--

A. Annually, the commission shall develop and submit to the legislature a health security plan budget. The budget shall be the commission's recommendation for the total amount to be spent by the plan for covered health care services in the next fiscal year.

B. In establishing or changing premium rates or employer contribution rates, the commission shall comply with the provisions of Sections 59A-18-13 through 59A-18-14 NMSA 1978.

C. In developing the health security plan budget,

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the commission shall provide that credit be taken in the budget for all revenues produced for health care in the state pursuant to any law other than the Health Security Act.

D. The health security plan shall include a maximum amount or percentage for administrative costs, and this maximum, if a percentage, may change in relation to the total costs of services provided under the health security plan. For the sixth and subsequent calendar years of operation of the health security plan, administrative costs shall not exceed five percent of the health security plan budget.

SECTION 31. [NEW MATERIAL] PAYMENTS TO HEALTH CARE PROVIDERS--CO-PAYMENTS--OUT-OF-STATE SERVICES--SUBROGATION--PAYMENTS FROM THIRD PARTIES.--

A. The commission shall prepare a provider budget. Consistent with the provider budget, the health security plan shall provide payment for all covered health care rendered by health care providers. A variety of payment plans, including fee-for-service, may be adopted by the commission. Payment plans shall be negotiated with providers as provided by rule. In the event that negotiation fails to develop an acceptable payment plan, the disputing parties shall submit the dispute for resolution pursuant to Section 29 of the Health Security Act.

B. To the extent required to avoid violating federal antitrust law, the commission shall facilitate and

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supervise the participation of health care providers and health facilities in the planning and implementation of the health security plan. The commission shall ensure the establishment and operation of the health security plan in cooperation with the office of the attorney general to ensure compliance with federal antitrust law.

C. As it deems appropriate, the commission may create a shared incentive pool for health care providers and health facilities.

D. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care in rural and other underserved areas throughout the state.

E. An annual percentage increase in the amount allocated for provider payments in the budget shall be no greater than the annual percentage increase in the consumer price index for medical care prices published by the bureau of labor statistics of the federal department of labor using the year prior to the year in which the health security plan is implemented as the baseline year. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

F. Payment, or the offer of payment whether or not that offer is accepted, to a health care provider for services covered by the health security plan shall be payment in full

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for those services. A health care provider shall not charge a beneficiary an additional amount for services covered by the plan.

G. The commission may establish a co-payment schedule if a required co-payment is determined to be an effective cost-control measure. A co-payment shall not be required for preventive health care services, as the commission defines "preventive health care services" by rule in accordance with state and federal law. When a co-payment is required, the health care provider shall not waive it, and if it remains uncollected, the health care provider shall demonstrate a good-faith effort to have collected the co-payment.

H. A beneficiary may obtain health care services covered by the health security plan out of state; provided, however, that the services shall be reimbursed at:

(1) the same rate that would apply if those services had been received in New Mexico; or

(2) a rate higher than the reimbursement rate the health security plan would have paid if the services had been received in New Mexico if the commission negotiates a reimbursement agreement or other agreement with:

(a) the state in which the health care services were received; or

(b) the health care provider or health facility rendering the services.

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I. The health security plan shall make reasonable efforts to ascertain any legal liability of third-party persons that are or may be liable to pay all or part of the health care services costs of injury, disease or disability of a beneficiary.

J. When the health security plan makes payments on behalf of a beneficiary, the health security plan is subrogated to any right of the beneficiary against a third party for recovery of amounts paid by the health security plan.

K. By operation of law, an assignment to the health security plan of the rights of a beneficiary:

(1) is conclusively presumed to be made of:

(a) a payment for health care services from any person, including an insurance carrier; and

(b) a monetary recovery for damages for bodily injury, whether by judgment, contract for compromise or settlement;

(2) shall be effective to the extent of the amount of payments by the health security plan; and

(3) shall be effective as to the rights of any other beneficiary whose rights can legally be assigned by the beneficiary.

SECTION 32. [NEW MATERIAL] PAYMENTS TO HEALTH FACILITIES--CO-PAYMENTS.--

A. A health facility shall negotiate an annual

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operating budget with the commission. The operating budget shall be based on a base operating budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated annual operating budget is not agreed upon, a health facility shall submit the budget to dispute resolution pursuant to Section 29 of the Health Security Act. An annual percentage increase in the amount allocated for a health facility operating budget shall be no greater than the change in the annual consumer price index for medical care prices, published annually by the bureau of labor statistics of the federal department of labor. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

B. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state.

C. Each health care provider employed by a health facility shall be paid from the facility's operating budget in a manner determined by the health facility.

D. The commission may establish a co-payment schedule if a required co-payment is determined to be an effective cost-control measure. The commission shall not require a co-payment for preventive health care services, as

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the commission defines "preventive health care services" by rule in accordance with state and federal law. When a co-payment is required, the health facility shall not waive it, and if it remains uncollected, the health facility shall demonstrate a good-faith effort to have collected the co-payment.

SECTION 33. [NEW MATERIAL] STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The commission shall adopt standard claim forms and electronic formats that shall be used by all health care providers and health facilities that seek payment through the health security plan or from private persons, including private insurance companies, for health care services rendered in the state. Each claim form or electronic format may indicate whether a person is eligible for federal or other insurance programs for payment. To the extent practicable, the commission shall require the use of existing, nationally accepted standardized forms, formats and systems.

SECTION 34. [NEW MATERIAL] HEALTH RESOURCE CERTIFICATE--COMMISSION RULES--REQUIREMENT FOR REVIEW.--

A. The commission shall adopt rules stating when a health facility or health care provider participating in the health security plan shall apply for a health resource certificate, how the application will be reviewed, how the certificate will be granted, how an expedited review is conducted and other matters relating to health resource

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projects.

B. Except as provided in Subsection F of this section, a health facility or health care provider participating in the health security plan shall not make or obligate itself to make a major capital expenditure without first obtaining a health resource certificate.

C. A health facility or health care provider shall not acquire through rental, lease or comparable arrangement or through donation all or a part of a capital project that would have required review if the acquisition had been by purchase unless the project is granted a health resource certificate.

D. A health facility or health care provider shall not engage in component purchasing in order to avoid the provisions of this section.

E. The commission shall grant a health resource certificate for a major capital expenditure or a capital project undertaken pursuant to Subsection C of this section only when the project is determined to be needed.

F. This section does not apply to:

(1) the purchase, construction or renovation of office space for health care providers;

(2) expenditures incurred solely in preparation for a capital project, including architectural design, surveys, plans, working drawings and specifications and other related activities, but those expenditures shall be

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included in the cost of a project for the purpose of determining whether a health resource certificate is required;

(3) acquisition of an existing health facility, equipment or practice of a health care provider that does not result in a new service being provided or in increased bed capacity;

(4) major capital expenditures for nonclinical services when the nonclinical services are the primary purpose of the expenditure; and

(5) the replacement of equipment with equipment that has the same function and that does not result in the offering of new services.

G. No later than November 1, 2017, the commission shall report to the appropriate committees of the legislature on the capital needs of health facilities, including facilities of state and local governments, with a focus on underserved geographic areas with substantially below-average health facilities and investment per capita as compared to the state average. The report shall also describe geographic areas where the distance to health facilities imposes a barrier to care. The report shall include a section on health care transportation needs, including capital, personnel and training needs. The report shall make recommendations for legislation to amend the Health Security Act that the commission determines necessary and appropriate.

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SECTION 35. [NEW MATERIAL] FISCAL AND ACTUARIAL REVIEWS--AUDITS.--

A. The commission shall provide for annual independent fiscal and actuarial reviews of the health security plan and any funds of the commission or the plan.

B. The commission shall provide by rule requirements for independent financial audits of health care providers and health facilities.

C. The commission, through its staff or by contract, shall perform announced and unannounced reviews, including financial, operational, management and electronic data processing reviews of health care providers and health facilities. Review findings shall be reported directly to the commission. The commission may request the state auditor to review preliminary findings or to consult with review staff before the findings are reported to the commission.

D. Actuarial review, fiscal reviews, financial audits and internal audits are public documents after they have been released by the commission, provided that the reports protect private and confidential information of a patient or provider. Copies of reviews, audits and other reports shall be transmitted to the governor, the legislature, appropriate interim committees of the legislature and the office of the state auditor as well as made available via the internet.

SECTION 36. [NEW MATERIAL] INFORMATION TECHNOLOGY

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SYSTEM.--The commission shall establish guidelines for maximizing participation of health care providers and health facilities in the health security plan's information technology network that provides for electronic transfer of payments to health care providers and health facilities; transmittal of reports, including patient data and other statistical reports; billing data, with specificity as to procedures or services provided to individual patients; and any other information required or requested by the commission. To the extent practicable, the commission shall require the use of existing, nationally accepted standardized forms, formats and systems.

SECTION 37. [NEW MATERIAL] REPORTS REQUIRED--CONFIDENTIAL INFORMATION.--

A. The commission shall require reports by all health care providers and health facilities of information needed to allow the commission to evaluate the health security plan, cost-containment measures, utilization review, health facility operating budgets, health care provider fees and any other information the commission deems necessary to carry out its duties pursuant to the Health Security Act.

B. The commission shall establish uniform reporting requirements for health care providers and health facilities.

C. Information confidential pursuant to other provisions of law shall be confidential pursuant to the Health Security Act. Within the constraints of confidentiality,

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reports of the commission are public documents.

SECTION 38. [NEW MATERIAL] CONSUMER, PROVIDER AND HEALTH FACILITY ASSISTANCE PROGRAM.--

A. The commission shall establish a consumer, health care provider and health facility assistance program to take complaints and to provide timely and knowledgeable assistance to:

(1) eligible persons and applicants about their rights and responsibilities and the coverages provided in accordance with the Health Security Act; and

(2) health care providers and health facilities about the status of claims, payments and other pertinent information relevant to the claims payment process.

B. The commission shall establish a toll-free telephone line and publicly accessible web site for the consumer, health care provider and health facility assistance program and shall have persons available throughout the state to assist beneficiaries, applicants, health care providers and health facilities in person.

SECTION 39. [NEW MATERIAL] PRIVATE HEALTH INSURANCE COVERAGE LIMITED--VOLUNTARY PURCHASE OF OTHER INSURANCE.--

A. After the date on which the health security plan begins operating:

(1) a beneficiary may purchase supplemental health insurance benefits; and

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(2) a person shall not provide private health insurance to a beneficiary for a health care service that is covered by the health security plan, except as follows:

(a) transitional coverage as provided in Section 45 of the Health Security Act; and

(b) a retiree health insurance plan that does not enter into contract with the health security plan.

B. Nothing in this section affects insurance coverage pursuant to the federal Employee Retirement Income Security Act of 1974 unless the state obtains a congressional exemption or a waiver from the federal government. Health coverage plans that are covered by the provisions of that act may elect to participate in the health security plan.

C. Nothing in the Health Security Act shall be construed to prohibit the voluntary purchase of insurance coverage for health care services not covered by the health security plan or for individuals not eligible for coverage under the health security plan.

SECTION 40. [NEW MATERIAL] INSURANCE RATES--SUPERINTENDENT DUTIES.--

A. The superintendent shall work closely with the legislative finance committee pursuant to Section 41 of the Health Security Act to identify premium costs associated with health care coverage in workers' compensation and automobile medical coverage. The superintendent shall develop an estimate

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of expected reduction in those costs based upon assumptions of health care services coverage in the health security plan and shall report the findings to the legislative finance committee to determine the financing of the health security plan.

B. The superintendent shall ensure that workers' compensation and automobile insurance premiums on insurance policies written in New Mexico reflect a lower rate to account for the medical payment component to be assumed by the health security plan.

SECTION 41. [NEW MATERIAL] STUDY--FINANCING THE HEALTH SECURITY PLAN.--

A. The legislative finance committee shall undertake a fiscal analysis relating to the first five years of the health security plan's establishment and operation. The fiscal analysis shall include a review of financing options for the health security plan and a projection of costs to the plan.

B. In its fiscal analysis performed pursuant to Subsection A of this section, the legislative finance committee shall be guided by the following requirements and assumptions:

(1) health care services to be included and for which costs are to be projected in determining the financing options shall be no less than the health care services afforded to state employees pursuant to the Health Care Purchasing Act; and

(2) financing options may set minimum and

maximum levels of costs to a beneficiary based on the following factors, as they apply to a given beneficiary:

(a) the beneficiary's income;

(b) federal premium tax credits;

(c) federal cost-sharing subsidies;

(d) medicare offsets; and

(e) contributions from the beneficiary's employer or any other third-party payor; provided that an employer may cover all or part of a beneficiary's premium to the extent that a collective bargaining agreement is not violated.

C. The legislative finance committee shall:

(1) make projections regarding the impact of the health security plan upon the state budget;

(2) project the costs of establishing and administering the health security plan;

(3) prepare a report of its determinations with the specific options and recommendations no later than November 2, 2015; and

(4) submit its report prepared pursuant to Paragraph (3) of this subsection to the appropriate interim legislative committees for consideration by the fifty-second legislature.

D. The commission shall reimburse the legislative finance committee for any state funds it expended in

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undertaking the fiscal analysis pursuant to this section.

SECTION 42. [NEW MATERIAL] GRANT FUNDING AND OTHER RESOURCES--PARTNERSHIPS.--The legislative finance committee shall seek partnerships among state agencies and private nonprofit persons to identify and apply for available grant funding and other in-kind and financial resources for its study of financing options for the health security plan pursuant to Section 41 of the Health Security Act. Any amounts received in grant funds or from other financial resources shall first be used to offset any state funds that the legislature appropriates or allocates. Any grant funds or other financial resources received in excess of legislative appropriations or allocations shall be used for the study of financing options for the health security plan.

SECTION 43. [NEW MATERIAL] REIMBURSEMENT TO HEALTH SECURITY PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The commission shall seek payment to the health security plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

B. The commission shall seek to maximize federal contributions and payments for health care services provided in New Mexico and shall ensure that the contributions of the federal government for health care services in New Mexico will

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not decrease in relation to other states as a result of any waivers, exemptions or agreements.

C. The commission shall maintain sufficient reserves to provide for catastrophic and unforeseen expenditures.

SECTION 44. [NEW MATERIAL] HEALTH BENEFITS EXCHANGE OR HEALTH INSURANCE EXCHANGE PROPERTY--FEDERAL WAIVER FOR TRANSFER OF HEALTH INSURANCE EXCHANGE FUNCTIONS--TRANSFER OF HEALTH INSURANCE EXCHANGE.--

A. Unless otherwise provided by federal law, any personal property that the state has procured to implement or operate a state health benefits exchange or health insurance exchange pursuant to federal law shall remain state property.

B. As soon as allowed under federal law, the secretary of human services shall seek a waiver to allow the state to suspend operation of any health benefits exchange or health insurance exchange and to allow the commission to administer in accordance with federal law the federal premium tax credits, cost-sharing subsidies and small business tax credits. In implementing the provisions of the Health Security Act, the human services department shall provide for the commission's use any personal property used in the operation of a state health insurance exchange.

C. As used in this section:

(1) "health insurance exchange" means an

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entity established pursuant to federal law to provide qualified health plans to qualified individuals and qualified employers on the individual and small group or large group insurance markets;

(2) "personal property" means property other than real property; and

(3) "real property" means an estate or interest in, over or under land and other things or interests, including minerals, water, structures and fixtures that by custom, usage or law pass with a transfer of land even if the estate or interest is not described or mentioned in the contract of sale or instrument of conveyance and, if appropriate to the context, the land in which the estate or interest is claimed.

SECTION 45. [NEW MATERIAL] TRANSITION PERIOD ARRANGEMENTS--PRIVATE CONTRACT--COLLECTIVE BARGAINING.--A person who, on the date benefits are available under the Health Security Act's health security plan, receives health care benefits under a private contract or collective bargaining agreement entered into prior to July 1, 2017 shall continue to receive those benefits until the contract or agreement expires or unless the contract or agreement is renegotiated to provide participation in the health security plan.

SECTION 46. Section 41-4-3 NMSA 1978 (being Laws 1976, Chapter 58, Section 3, as amended) is amended to read:

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"41-4-3. DEFINITIONS.--As used in the Tort Claims Act:

A. "board" means the risk management advisory board;

B. "governmental entity" means the state or any local public body as defined in Subsections C and H of this section;

C. "local public body" means all political subdivisions of the state and their agencies, instrumentalities and institutions and all water and natural gas associations organized pursuant to Chapter 3, Article 28 NMSA 1978;

D. "law enforcement officer" means a full-time salaried public employee of a governmental entity, or a certified part-time salaried police officer employed by a governmental entity, whose principal duties under law are to hold in custody any person accused of a criminal offense, to maintain public order or to make arrests for crimes, or members of the national guard when called to active duty by the governor;

E. "maintenance" does not include:

(1) conduct involved in the issuance of a permit, driver's license or other official authorization to use the roads or highways of the state in a particular manner; or

(2) an activity or event relating to a public building or public housing project that was not foreseeable;

F. "public employee" means an officer, employee or

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servant of a governmental entity, excluding independent contractors except for individuals defined in Paragraphs (7), (8), (10), (14) and (17) of this subsection, or of a corporation organized pursuant to the Educational Assistance Act, the Small Business Investment Act or the Mortgage Finance Authority Act or a licensed health care provider, who has no medical liability insurance, providing voluntary services as defined in Paragraph (16) of this subsection and including:

(1) elected or appointed officials;

(2) law enforcement officers;

(3) persons acting on behalf or in service of a governmental entity in any official capacity, whether with or without compensation;

(4) licensed foster parents providing care for children in the custody of the human services department, corrections department or department of health, but not including foster parents certified by a licensed child placement agency;

(5) members of state or local selection panels established pursuant to the Adult Community Corrections Act;

(6) members of state or local selection panels established pursuant to the Juvenile Community Corrections Act;

(7) licensed medical, psychological or dental arts practitioners providing services to the corrections department pursuant to contract;

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(8) members of the board of directors of the New Mexico medical insurance pool;

(9) individuals who are members of medical review boards, committees or panels established by the educational retirement board or the retirement board of the public employees retirement association;

(10) licensed medical, psychological or dental arts practitioners providing services to the children, youth and families department pursuant to contract;

(11) members of the board of directors of the New Mexico educational assistance foundation;

(12) members of the board of directors of the New Mexico student loan guarantee corporation;

(13) members of the New Mexico mortgage finance authority;

(14) volunteers, employees and board members of court-appointed special advocate programs;

(15) members of the board of directors of the small business investment corporation;

(16) health care providers licensed in New Mexico who render voluntary health care services without compensation in accordance with rules promulgated by the secretary of health. The rules shall include requirements for the types of locations at which the services are rendered, the allowed scope of practice and measures to ensure quality of

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care;

(17) an individual while participating in the state's adaptive driving program and only while using a special-use state vehicle for evaluation and training purposes in that program; [~~and~~]

(18) the staff and members of the board of directors of the New Mexico health insurance exchange established pursuant to the New Mexico Health Insurance Exchange Act; and

(19) the staff and members of the health care commission established pursuant to the Health Security Act;

G. "scope of duty" means performing any duties that a public employee is requested, required or authorized to perform by the governmental entity, regardless of the time and place of performance; and

H. "state" or "state agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions."

SECTION 47. TEMPORARY PROVISION--HEALTH CARE COMMISSION--TRANSFER OF HEALTH INSURANCE EXCHANGE DUTIES.--The health care commission shall devise a plan for the timely and efficient transfer of health insurance exchange functions and health insurance exchange property to the commission pursuant to Section 44 of the Health Security Act.

SECTION 48. TEMPORARY PROVISION.--

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A. If the fifty-second legislature approves implementation and financing of the health security plan, the health security plan shall be operational by July 1, 2018. Upon an affirmative vote by a two-thirds majority of the health care commission's members, the commission may extend the operational date by as much as one year.

B. If the fifty-second legislature fails to implement the recommendations of the legislative finance committee or otherwise fails to determine and approve financing of the health security plan, the health security plan shall not become effective.

SECTION 49. APPROPRIATION.--Two hundred fifty thousand dollars ($250,000) is appropriated from the general fund to the legislative finance committee for expenditure in fiscal year 2016 to undertake the fiscal analysis required pursuant to Section 41 of the Health Security Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

SECTION 50. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2015.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

AN ACT

RELATING TO HEALTH CARE; ENACTING THE HEALTH SECURITY ACT TO PROVIDE FOR COMPREHENSIVE STATEWIDE HEALTH CARE; PROVIDING FOR HEALTH CARE PLANNING; ESTABLISHING PROCEDURES TO CONTAIN HEALTH CARE COSTS; CREATING A COMMISSION; PROVIDING FOR ITS POWERS AND DUTIES; PROVIDING FOR HEALTH CARE DELIVERY REGIONS AND REGIONAL COUNCILS; DIRECTING AND AUTHORIZING THE DEVELOPMENT OF A STATE HEALTH SECURITY PLAN; PROVIDING FOR TRANSFER OF HEALTH INSURANCE EXCHANGE PERSONAL PROPERTY TO THE COMMISSION; PROVIDING PENALTIES; AMENDING A SECTION OF THE TORT CLAIMS ACT; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--Sections 1 through 45 of this act may be cited as the "Health Security Act".

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SECTION 2. [NEW MATERIAL] PURPOSES OF ACT.--The purposes of the Health Security Act are to:

A. create a program that ensures health care coverage to all New Mexicans through a combination of public and private financing;

B. control escalating health care costs; and

C. improve the health care of all New Mexicans.

SECTION 3. [NEW MATERIAL] DEFINITIONS.--As used in the Health Security Act:

A. "beneficiary" means a person eligible for health care and benefits pursuant to the health security plan;

B. "budget" means the total of all categories of dollar amounts of expenditures for a stated period authorized for an entity or a program;

C. "capital budget" means that portion of a budget that establishes expenditures for:

(1) acquisition or addition of substantial improvements to real property; or

(2) acquisition of tangible personal property;

D. "case management" means a comprehensive program designed to meet an individual's need for care by coordinating and linking the components of health care;

E. "commission" means the health care commission;

F. "consumer price index for medical care prices" means that index as published by the bureau of labor statistics

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of the federal department of labor;

G. "controlling interest" means:

(1) a five percent or greater ownership interest, direct or indirect, in the person controlled; or

(2) a financial interest, direct or indirect, that, because of business or personal relationships, has the power to influence important decisions of the person controlled;

H. "essential community provider" means an entity that is designated in federal law as serving a health care provider that serves predominately low-income or medically underserved populations and that includes any of the following health care facilities:

(1) a federally qualified health center, or "look alike" community health center;

(2) a health facility that receives federal funds to treat individuals living with human immunodeficiency virus or acquired immunodeficiency syndrome;

(3) a safety net care pool hospital;

(4) a family planning clinic that receives federal funding pursuant to Title X of the federal Public Health Service Act;

(5) a hemophilia treatment center;

(6) a medical care program operated by the federal Indian Health Service or an Indian nation, tribe or

pueblo; or

(7) a hospital defined under federal law as a disproportionate share hospital or a hospital eligible for disproportionate share payments; a children's hospital; a rural referral center; a free-standing cancer center; or a critical-access hospital;

I. "financial interest" means an ownership interest of any amount, direct or indirect;

J. "group practice" means an association of health care providers that provides one or more specialized health care services or a tribal or urban Indian coalition in partnership or under contract with the federal Indian health service that is authorized under federal law to provide health care to Native American populations in the state;

K. "health care" means health care provider services and health facility services;

L. "health care provider" means:

(1) a person or network of persons licensed or certified and authorized to provide health care in New Mexico;

(2) an individual licensed or certified by a nationally recognized professional organization and designated as a health care provider by the commission; or

(3) a person that is a group practice of licensed providers or a transportation service;

M. "health facility" means a school-based clinic,

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an Indian health service facility, a tribally operated health care facility, a state-operated health care facility, a general hospital, a special hospital, an outpatient facility, a psychiatric hospital, a primary clinic pursuant to the Rural Primary Health Care Act, a laboratory, a skilled nursing facility or a nursing facility; provided that the health facility is authorized to receive state or federal reimbursement;

N. "health security plan" means the program that is created and administered by the commission for provision of health care pursuant to the Health Security Act;

O. "major capital expenditure" means construction or renovation of facilities or the acquisition of diagnostic, treatment or transportation equipment by a health care provider or health facility that costs more than an amount recommended and established by the commission;

P. "medicare offset" means a reimbursement that the federal government makes pursuant to the federal Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended;

Q. "operating budget" means the budget of a health facility exclusive of the facility's capital budget;

R. "person" means an individual or any other legal entity;

S. "primary care provider" means a health care

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provider who is a physician, osteopathic physician, nurse practitioner, physician assistant, osteopathic physician's assistant, pharmacist clinician or other health care provider certified by the commission to provide the first level of basic health care, including diagnostic and treatment services; services delivered at a primary clinic, telehealth site or a school-based health center; and behavioral health services if those services are integrated into the provider's service array;

T. "provider budget" means the authorized expenditures pursuant to payment mechanisms established by the commission to pay for health care furnished by health care providers participating in the health security plan;

U. "superintendent" means the superintendent of insurance; and

V. "transportation service" means a person providing the services of an ambulance, helicopter or other conveyance that is equipped with health care supplies and equipment and that is used to transport patients to health care providers or health facilities.

SECTION 4. [NEW MATERIAL] HEALTH CARE COMMISSION CREATED--GOVERNMENTAL INSTRUMENTALITY.--As of December 1, 2016, the "health care commission" is created as a public body, politic and corporate, constituting a governmental instrumentality. The commission consists of fifteen members.

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SECTION 5. [NEW MATERIAL] CREATION OF HEALTH CARE COMMISSION MEMBERSHIP NOMINATING COMMITTEE--MEMBERSHIP, TERMS AND DUTIES OF COMMITTEE.--

A. As of April 15, 2016, the "health care commission membership nominating committee" is created, consisting of ten members, to reflect the geographic diversity of the state, as follows:

(1) three members appointed by the speaker of the house of representatives;

(2) three members appointed by the president pro tempore of the senate;

(3) two members appointed by the minority floor leader of the house of representatives; and

(4) two members appointed by the minority floor leader of the senate.

B. By March 1, 2016, the legislative council service shall provide the public with public notice to allow members of the public to request consideration of appointment to the nominating committee. The notice shall be advertised and reported on a publicly accessible web site, in media outlets throughout the state and through publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks preceding June 1, 2016.

C. At the first meeting of the nominating

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committee, it shall elect a chair and any other officers it deems necessary from its membership. The chair shall vote only in the case of a tie vote.

D. Members shall serve two-year terms.

E. A member shall serve until the member's successor is appointed and qualified. Successor members shall be appointed by the appointing authority that made the initial appointment to the nominating committee. A state employee who is exempt from the Personnel Act is not eligible to serve on the nominating committee. A member shall be eligible for or enrolled in the health security plan. An elected official shall not serve on the nominating committee.

F. Appointed members of the nominating committee shall have substantial knowledge of the health care system as demonstrated by education or experience. A person shall not be appointed to the nominating committee if, currently or within the previous thirty-six months, the person or a member of the person's household is employed by, is an agent or officer of or has a controlling interest in:

(1) a health facility;

(2) a person that provides health care services in the regular course of business; or

(3) a person that is licensed to provide health insurance.

G. The nominating committee shall take appropriate

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action to ensure that adequate prior notice of its meetings is advertised and reported at least seventy-two hours before each meeting on a publicly accessible web site, in media outlets throughout the state and through the publication of a legal notice in major newspapers. Publication of the legal notice shall occur once each week for the two weeks immediately preceding the date of a meeting. Meetings of the nominating committee shall be open to the public, and public comment shall be allowed.

H. A majority of the nominating committee constitutes a quorum. The nominating committee may allow members' participation in meetings by telephone or other electronic media that allow full participation. Meetings may be closed only for discussion of candidates prior to selection. Final selection of candidates shall be by vote of the members and shall be conducted in a public meeting.

I. The New Mexico legislative council shall convene the first meeting of the nominating committee on or before May 16, 2016. The nominating committee shall actively solicit, accept and evaluate applications from qualified persons for membership on the commission subject to the requirements for commission membership qualifications pursuant to Section 6 of the Health Security Act.

J. No later than October 1, 2016, the nominating committee shall submit to the governor the names of persons

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recommended for appointment to the commission by a majority of the nominating committee. Immediately after receiving the nominating committee's nominations, the governor may make one request of the nominating committee for submission of additional names. If a majority of the nominating committee finds that additional persons would be qualified, the nominating committee shall promptly submit additional names and recommend those persons for appointment to the commission. The nominating committee shall submit no more than three names for a membership position for each initial or additional appointment.

K. Appointed nominating committee members may be reimbursed pursuant to the Per Diem and Mileage Act for expenses incurred in fulfilling their duties.

L. Staff to assist the nominating committee in its duties until a commission is appointed shall be furnished by the legislative council service.

SECTION 6. [NEW MATERIAL] APPOINTMENT OF COMMISSION MEMBERS--MEETINGS--QUALIFICATIONS--TERMS.--

A. From the nominees submitted by the health care commission membership nominating committee, the governor shall appoint fifteen members to the commission, and the initial commission shall be in place by December 1, 2016. In the event that the governor does not appoint a member to a commission membership slot by December 1, 2016, the nominating committee

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shall make that appointment.

B. The New Mexico legislative council shall convene a first meeting of the commission by January 4, 2017. At the first meeting of the commission, the members shall elect from their membership a chair and a vice chair and any other officers they deem necessary. The chair, vice chair and any other officers shall serve for terms of two years.

C. After the first meeting of the commission, the commission shall meet at the call of the chair as the chair deems necessary and at least once each month.

D. The terms of the initial commission members appointed shall be chosen by lot: five members shall be appointed for terms of four years; five members shall be appointed for terms of three years; and five members shall be appointed for terms of two years. Thereafter, all members shall be appointed for terms of four years. After initial terms are served, no member shall serve more than two consecutive four-year terms. A member may serve until a successor is appointed.

E. A person who served on the health care commission membership nominating committee shall not be nominated for or serve on the commission within thirty-six months from the time served on the committee. A state employee who is exempt from the Personnel Act is not eligible to serve on the commission. An elected official shall not serve on the

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commission. A commission member shall be eligible for or enrolled in the health security plan.

F. When a vacancy occurs in the membership of the commission, the health care commission membership nominating committee shall meet and act within thirty days of the occurrence of the vacancy. From the nominees submitted, the governor shall fill the vacancy within thirty days after receiving final nominations. In the event that the governor does not appoint a member to the vacancy within thirty days, the nominating committee shall appoint a member to fill the vacancy.

G. The fifteen members of the commission shall include:

(1) five persons who represent either health care providers or health facilities;

(2) six persons who represent consumer interests; and

(3) four persons who represent employer interests.

H. Except for persons appointed to represent health facilities or health care providers, a person shall be disqualified for appointment to the commission if:

(1) the person has served on the health care commission membership nominating committee within the past thirty-six months; or

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(2) currently or within the previous thirty-six months, the person or a member of the person's household is employed by, is an agent or officer of or has a controlling interest in:

(a) a health facility;

(b) a person that provides health care services in the regular course of business; or

(c) a person that is licensed to provide health insurance.

I. Persons appointed who do not represent health care providers or health facilities must have a knowledge of the health care system as demonstrated by experience or education. To ensure fair representation of all areas of the state, members shall be appointed from each of the public education commission districts as follows:

(1) two from public education commission district 1;

(2) one from public education commission district 2;

(3) one from public education commission district 3;

(4) two from public education commission district 4;

(5) two from public education commission district 5;

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(6) one from public education commission district 6;

(7) two from public education commission district 7;

(8) two from public education commission district 8;

(9) one from public education commission district 9; and

(10) one from public education commission district 10.

J. The presence of a majority of the commission's members constitutes a quorum for the transaction of business. The commission may allow members' participation in meetings by telephone or other electronic media that allow full participation.

K. A member may receive per diem and mileage at a rate equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act for expenses incurred in fulfilling their duties. Additionally, members shall be compensated at the rate of two hundred dollars ($200) for each day of a meeting or training event actually attended not to exceed compensation for one hundred twenty meetings for a two-year period occurring in a term.

L. The commission shall establish an electronic

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mail or "email" system for use by members in the conduct of commission business. Commission business shall be exclusively conducted on the commission's email system.

SECTION 7. [NEW MATERIAL] CONFLICT OF INTEREST--DISCLOSURE BY MEMBERS AND DISQUALIFICATION FROM VOTING ON CERTAIN MATTERS.--

A. The commission shall adopt a conflict-of-interest disclosure statement for use by all members that requires disclosure of a financial interest, whether or not a controlling interest, of the member or a member of the member's household in a person providing health care or health insurance.

B. A member representing health facilities or health care providers may vote on matters that pertain generally to health facilities or health care providers.

C. If there is a question about a conflict of interest of a commission member, the other members shall vote on whether to allow the member to vote.

SECTION 8. [NEW MATERIAL] COMMISSION CODE OF CONDUCT--MEMBER DISCIPLINE--REMOVAL.--The commission shall adopt and promulgate a code of conduct and procedures to be observed by members in the execution of their duties. The commission may remove a member for a violation of the commission code of conduct or a violation of the Health Security Act by a two-thirds' majority vote of all of the members at a meeting where

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a quorum is duly constituted. A member shall not be removed without proceedings consisting of at least one ten-day notice of hearing and an opportunity to be heard. Removal proceedings shall be before the board and in accordance with procedures the commission has adopted and promulgated.

SECTION 9. [NEW MATERIAL] APPLICATION OF CERTAIN STATE LAWS TO COMMISSION.--The commission and regional councils created pursuant to the Health Security Act:

A. shall be subject to and shall comply with the provisions of the:

(1) Open Meetings Act;

(2) State Rules Act;

(3) Inspection of Public Records Act;

(4) Public Records Act;

(5) Financial Disclosure Act;

(6) Accountability in Government Act;

(7) Gift Act; and

(8) Tort Claims Act; and

B. shall not be subject to the provisions of the Procurement Code or the Personnel Act.

SECTION 10. [NEW MATERIAL] CHIEF EXECUTIVE OFFICER--STAFF--CONTRACTS--BUDGETS.--

A. The commission shall appoint and set the salary of a "chief executive officer". The chief executive officer shall serve at the pleasure of the commission and has authority

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to carry on the day-to-day operations of the commission and the health security plan.

B. The chief executive officer shall employ those persons necessary to administer and implement the provisions of the Health Security Act.

C. The chief executive officer and the chief executive officer's staff shall implement the Health Security Act in accordance with that act and the rules adopted by the commission. The chief executive officer may delegate authority to employees and may organize the staff into units to facilitate its work.

D. If the chief executive officer determines that the commission staff or a state agency does not have the resources or expertise to perform a necessary task, the chief executive officer may contract for performance from a person who has a demonstrated capability to perform the task. The commission shall establish the standards and requirements by which a contract is executed by the commission or the chief executive officer. A contract shall be reviewed by the commission or the chief executive officer to ensure that it meets the criteria, performance standards, expectations and needs of the commission.

E. The chief executive officer shall prepare and submit an annual budget request and plan of operation to the commission for its approval. The chief executive officer shall

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provide at least quarterly status reports on the budget and advise of a potential shortfall as soon as practically possible.

SECTION 11. [NEW MATERIAL] COMMISSION--GENERAL DUTIES.--The commission shall:

A. adopt a transition plan to ensure the seamless transition of health security plan beneficiaries from other sources of coverage, public and private. The transition plan shall ensure the proper assignment and payment of claims incurred on behalf of beneficiaries before the implementation of the health security plan;

B. by February 15, 2017, obtain legal counsel to advise the commission in the execution of its duties;

C. by April 1, 2017, adopt and promulgate rules for the procurement of goods and services. With the exception of audit-related services, rules relating to the procurement of goods and services shall provide for a preference for New Mexico vendors;

D. pursuant to federal law, apply for any federal waiver that the commission deems necessary to implement the health security plan;

E. design the health security plan to fulfill the purposes of and conform with the provisions of the Health Security Act;

F. provide a program to educate the public, health

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care providers and health facilities about the health security plan and the persons eligible to receive its benefits;

G. study and adopt as provisions of the health security plan cost-effective methods of providing quality health care to all beneficiaries, according high priority to increased reliance on:

(1) preventive and primary care that includes immunization and screening examinations;

(2) providing health care in rural or underserved areas of the state;

(3) in-home and community-based alternatives to institutional health care; and

(4) case management services when appropriate;

H. establish compensation methods for health care providers and health facilities and adopt standards and procedures for negotiating and entering into contracts with participating health care providers and health facilities;

I. establish annual health security plan budgets and budgets for those projected future periods that the commission believes appropriate;

J. establish capital budgets for health facilities, limited to capital expenditures subject to the Health Security Act, and include and adopt in establishing those budgets:

(1) standards and procedures for determining the budgets; and

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(2) a requirement for prior approval by the commission for major capital expenditures by a health facility;

K. negotiate and enter into health care reciprocity agreements with out-of-state health care providers and negotiate and enter into other health care agreements with out-of-state health care providers and health facilities;

L. develop claims and payment procedures for health care providers, health facilities and claims administrators and include provisions to ensure timely payments and provide for payment of interest when reimbursable claims are not paid within a reasonable time;

M. establish, in conjunction with state agencies similarly charged, a comprehensive system to collect and analyze health care data, including claims data and other data, necessary to improve the quality, efficiency and effectiveness of health care and to control costs of health care in New Mexico, which system shall include data on:

(1) mortality, including accidental causes of death, and natality;

(2) morbidity;

(3) health behavior;

(4) physical and psychological impairment and disability;

(5) health care system costs and health care availability, utilization and revenues;

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(6) environmental factors;

(7) availability, adequacy and training of health care personnel;

(8) demographic factors;

(9) social and economic conditions affecting health; and

(10) other factors determined by the commission;

N. standardize data collection and specific methods of measurement across databases and use scientific sampling or complete enumeration for reporting health information;

O. foster a health care delivery system that is efficient to administer and that eliminates unnecessary administrative costs;

P. adopt rules necessary to implement and monitor a preferred drug list, bulk purchasing or other mechanism to provide prescription drugs and a pricing procedure for nonprescription drugs, durable medical equipment and supplies, eyeglasses, hearing aids and oxygen;

Q. establish a pharmacy and therapeutics committee to:

(1) research federal and state incentives and discount programs for the purchase, manufacture or supply of drugs, biologics and medical equipment and supplies to maximize the health security plan's savings potential through these

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incentives and programs;

(2) conduct research and analysis to establish a formulary of drugs and biologics that is in accordance with clinical best practices for safety, efficacy and effectiveness while, in strict observance of those best practices, maximizing fiscal soundness;

(3) conduct concurrent, prospective and retrospective drug utilization review;

(4) consult with specialists in appropriate fields of medicine for therapeutic classes of drugs;

(5) recommend therapeutic classes of drugs, including specific drugs within each class to be included in the preferred drug list;

(6) identify appropriate exclusions from the preferred drug list; and

(7) conduct periodic clinical reviews of preferred, nonpreferred and new drugs;

R. study and evaluate the adequacy and quality of health care furnished pursuant to the Health Security Act, the cost of each type of service and the effectiveness of cost-containment measures in the health security plan;

S. in conjunction with the human services department, apply to the United States department of health and human services for all waivers of requirements under health care programs established pursuant to the federal Social

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Security Act that are necessary to enable the health security plan to receive federal payments for services rendered to medicaid or medicare beneficiaries;

T. except for those programs designated in Subsection B of Section 21 of the Health Security Act, identify other federal programs that provide federal funds for payment of health care services to individuals and apply for any waivers or enter into any agreements that are necessary for services covered by the health security plan; provided, however, that agreements negotiated with the federal Indian health service or tribal governments shall not impair treaty obligations of the United States government and that other agreements negotiated shall not impair portability or other aspects of the health care coverage;

U. seek an amendment to the federal Employee Retirement Income Security Act of 1974 to exempt New Mexico from the provisions of that act that relate to health care services or health insurance, or apply to the appropriate federal agency for waivers of any requirements of that act if congress provides for waivers to enable the commission to extend coverage through the Health Security Act to as many New Mexicans as possible; provided, however, that the amendment or waiver requested shall not impair portability or other aspects of the health care coverage;

V. analyze developments in federal law and

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regulation relevant to the health security plan, and provide updates and any legislative recommendations to the legislature that the commission deems necessary pursuant to those developments;

W. work with the counties to determine the expenditure of funds generated pursuant to the Indigent Hospital and County Health Care Act and the Statewide Health Care Act;

X. seek to maximize federal contributions and payments for health care services provided in New Mexico and ensure that the contributions of the federal government for health care services in New Mexico will not decrease in relation to other states as a result of any waivers, exemptions or agreements;

Y. study and monitor the migration of persons to New Mexico to determine if persons with costly health care needs are moving to New Mexico to receive health care and, if migration appears to threaten the financial stability of the health security plan, recommend to the legislature changes in eligibility requirements, premiums or other changes that may be necessary to maintain the financial integrity of the health security plan;

Z. collaborate with state agencies and experts to study and evaluate health care work force data and research, and information solicited from health care providers and health

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care work force experts, on the effect of the health security plan on the state's provider community. This shall include the study and evaluation of the supply of health care providers in the state and providers' ability to provide high-quality health care under the health security plan;

AA. study and evaluate the cost of health care provider professional liability insurance and its impact on the price of health care services and recommend changes to the legislature as necessary;

BB. establish and approve changes in coverage benefits and benefit standards in the health security plan in compliance with federal and state law;

CC. conduct necessary investigations and inquiries;

DD. adopt rules necessary to implement, administer and monitor the operation of the health security plan;

EE. designate a Native American liaison who shall assist the commission in developing and ensuring implementation of communication and collaboration between the commission and Native Americans in the state. The Native American liaison shall serve as a contact person between the commission and New Mexico Indian nations, tribes and pueblos and shall ensure that training is provided to the staff of the commission, which may include training in:

(1) cultural competency;

(2) state and federal law relating to Indian

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health; and

(3) other matters relating to the functions of the health security plan with respect to Native Americans in the state;

FF. report annually to the legislature and the governor on the commission's activities and the operation of the health security plan and include in the annual report:

(1) a summary of information about health care needs, health care services, health care expenditures, revenues received and projected revenues and other relevant issues relating to the health security plan, the initial five-year plan and future updates of that plan and other long- and short-range plans; and

(2) recommendations on methods to control health care costs and improve access to and the quality of health care for state residents, as well as recommendations for legislative action; and

GG. provide at least one annual training for its members on health care coverage, policy and financing.

SECTION 12. [NEW MATERIAL] COMMISSION--AUTHORITY.--The commission has the authority necessary to carry out the powers and duties pursuant to the Health Security Act. The commission retains responsibility for its duties but may delegate authority to the chief executive officer; provided, however, that only the commission may:

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A. approve the commission's budget and plan of operation;

B. approve the health security plan and make changes in the health security plan, but only after legislative approval of those changes specified in Section 30 of the Health Security Act;

C. make rules and conduct both rulemaking and adjudicatory hearings in person or by use of a hearing officer;

D. issue subpoenas to persons to appear and testify before the commission and to produce documents and other information relevant to the commission's inquiry and enforce this subpoena power through an action in a state district court;

E. make reports and recommendations to the legislature;

F. subject to the prohibitions and restrictions of Section 21 of the Health Security Act, apply for program waivers from any governmental entity if the commission determines that the waivers are necessary to ensure the participation by the greatest possible number of beneficiaries;

G. apply for and accept grants, loans and donations;

H. acquire or lease real property and make improvements on it and acquire by lease or by purchase tangible and intangible personal property;

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I. dispose of and transfer personal property, but only at public sale after adequate notice;

J. appoint and prescribe the duties of employees, fix their compensation, pay their expenses and provide an employee benefit program;

K. establish and maintain banking relationships, including establishment of checking and savings accounts;

L. participate as a qualified entity in the programs of the New Mexico finance authority; and

M. enter into agreements with an employer, group or other plan to provide health care services for the employer's employees or retirees; provided, however, that nothing in the Health Security Act shall be construed to reduce or eliminate benefits to which the employee or retiree is entitled.

SECTION 13. [NEW MATERIAL] ADVISORY BOARDS.--

A. The commission shall establish a "health care provider advisory board" and a "health facility advisory board". The commission may establish additional advisory boards to assist it in performing its duties. Advisory boards shall assist the commission in matters requiring the expertise and knowledge of the advisory boards' members.

B. The commission may appoint not more than two commission members and up to five additional persons to serve on an advisory board it creates. Advisory board members may be paid per diem and mileage equal to the rate at which state

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legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

C. Except for the health care provider advisory board and the health facility advisory board, no more than two advisory board members shall have a controlling interest, direct or indirect, in a person providing health care or a person duly authorized to transact the business of health insurance in the state pursuant to the New Mexico Insurance Code.

D. The commission shall establish an advisory committee made up of Native Americans, some of whom live on a reservation and some of whom do not live on a reservation, to make recommendations to the commission on:

(1) matters relating to Native American beneficiaries; and

(2) agreements between the commission and tribal governments.

E. Staff and technical assistance for an advisory board shall be provided by the commission as necessary.

SECTION 14. [NEW MATERIAL] HEALTH CARE DELIVERY REGIONS.--The commission shall establish health care delivery regions in the state, based on geography and health care resources. The regions may have differential fee schedules, budgets, capital expenditure allocations or other features to encourage the provision of health care in rural and other

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underserved areas or to tailor otherwise the delivery of health care to fit the needs of a region or a part of a region.

SECTION 15. [NEW MATERIAL] REGIONAL COUNCILS.--

A. The commission shall designate regional councils in the designated health care delivery regions. In selecting persons to serve as members of regional councils, the commission shall consider the comments and recommendations of persons in the region who are knowledgeable about health care and the economic and social factors affecting the region.

B. The regional councils shall be composed of the commission members who live in the region and five other members who live in the region and are appointed by the commission. No more than two noncommission council members shall have a controlling interest, direct or indirect, in a person providing health care. An individual who is, or whose household contains an individual who is, employed by or an officer of or who has a controlling interesting in a person providing health insurance, directly or as an agent of a health insurer, shall not be appointed to a regional council.

C. Members of a regional council may be paid per diem and mileage equal to the rate at which state legislators are reimbursed in accordance with the provisions of the Per Diem and Mileage Act.

D. The regional councils shall hold public hearings to receive comments, suggestions and recommendations from the

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public regarding regional health care needs. The councils shall report to the commission at times specified by the commission to ensure that regional concerns are considered in the development and update of the five-year plan, other short- and long-range plans and projections, fee schedules, budgets and capital expenditure allocations.

E. Staff technical assistance for the regional councils shall be provided by the commission.

SECTION 16. [NEW MATERIAL] RULEMAKING.--

A. The commission shall adopt rules necessary to carry out the duties of the commission and the provisions of the Health Security Act.

B. The commission shall not adopt, amend or repeal any rule affecting a person outside the commission without a public hearing on the proposed action before the commission or a hearing officer designated by the commission. The hearing officer may be a member of the commission's staff. The hearing shall be held in a county that the commission determines would be in the interest of those affected. Notice of the subject matter of the rule, the action proposed to be taken, the time and place of the hearing, the manner in which interested persons may present their views and the method by which copies of the proposed rule or an amendment or repeal of an existing rule may be obtained shall be published once at least thirty days prior to the hearing date in a newspaper of general

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circulation in the state and shall also be published in an informative nonlegal format in one newspaper published in each health care delivery region and mailed at least thirty days prior to the hearing date to all persons who have made a written request for advance notice of hearing.

C. All rules adopted by the commission shall be filed in accordance with the State Rules Act.

SECTION 17. [NEW MATERIAL] HEALTH SECURITY PLAN.--

A. The health security plan shall be designed to provide comprehensive, necessary and appropriate health care benefits, including minimum essential health benefits required under federal and state law as well as additional preventive health care and primary, secondary and tertiary health care for acute and chronic conditions. The health security plan shall include in its networks each essential community provider that is found in the health security plan's service area.

B. Covered health care services shall not include:

(1) surgery for cosmetic purposes other than for reconstructive purposes;

(2) medical examinations and medical reports prepared for purchasing or renewing life insurance or participating as a plaintiff or defendant in a civil action for the recovery or settlement of damages; and

(3) orthodontic services and cosmetic dental services except those cosmetic dental services necessary for

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reconstructive purposes.

C. The health security plan shall specify the health care to be covered and the amount, scope and duration of services.

D. The health security plan shall contain provisions to control health care costs so that beneficiaries receive comprehensive, high-quality health care consistent with available revenue and budget constraints.

E. The health security plan shall phase in eligibility for beneficiaries as their participation becomes possible through contracts, waivers or federal legislation. The health security plan may provide for certain preventive health care to be offered to all New Mexicans regardless of a person's eligibility to participate as a beneficiary.

SECTION 18. [NEW MATERIAL] LONG-TERM CARE.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "long-term care committee" made up of representatives of health care consumers, providers and administrators to develop a plan for integrating long-term care into the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The long-term care component of the health

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security plan shall provide for case management and noninstitutional services when appropriate.

C. Nothing in this section affects long-term care services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 19. [NEW MATERIAL] MENTAL AND BEHAVIORAL HEALTH SERVICES--PARITY.--

A. No later than one year after the effective date of the operation of the health security plan, the commission shall appoint an advisory "mental and behavioral health services committee" made up of representatives of mental and behavioral health care consumers, providers and administrators to develop a plan for coordinating mental and behavioral health services within the health security plan. The committee shall report its plan to the commission no later than one year from its appointment. Committee members may receive per diem and mileage as provided in the Per Diem and Mileage Act.

B. The commission shall ensure that the health security plan conforms to state and federal mental and behavioral health services parity laws.

C. The mental and behavioral health services component of the health security plan shall provide, where appropriate, for:

(1) inpatient residential substance abuse

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treatment services without a step therapy requirement; and

(2) case management and noninstitutional services.

D. Nothing in this section limits mental and behavioral health services paid through private insurance or state or federal programs subject to the provisions of Section 39 of the Health Security Act.

SECTION 20. [NEW MATERIAL] MEDICAID COVERAGE--AGREEMENTS.--The commission may enter into appropriate agreements with the human services department, another state agency or a federal agency for the purpose of furthering the goals of the Health Security Act. These agreements may provide for certain services provided pursuant to the medicaid program under Title 19 or Title 21 of the federal Social Security Act and any waiver or provision of that act to be administered by the commission to implement the health security plan.

SECTION 21. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE--CONDITIONS OF ELIGIBILITY FOR BENEFICIARIES--EXCLUSIONS.--

A. An individual is eligible as a beneficiary of the health security plan if the individual has been physically present in New Mexico for one year prior to the date of application for enrollment in the health security plan and if the individual has a current intention to remain in New Mexico and not to reside elsewhere. A dependent of an eligible

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individual is included as a beneficiary.

B. Individuals covered under the following governmental programs shall not be brought into coverage:

(1) federal retiree health plan beneficiaries;

(2) active duty and retired military personnel; and

(3) individuals covered by the federal active and retired military health programs.

C. Federal Indian health service or tribally operated health care program beneficiaries shall not be brought into coverage except through agreements with:

(1) Indian nations, tribes or pueblos;

(2) consortia of tribes or pueblos; or

(3) a federal Indian health service agency subject to the approval of the tribes or pueblos located in that agency.

D. If an individual is ineligible due to the residence requirement, the individual may become eligible by paying the premium required by the health security plan for coverage for the period of time up to the date the individual fulfills that requirement if the individual is an employee who physically resides and intends to reside in the state because of employment offered to the individual in New Mexico while the individual was residing elsewhere as demonstrated by furnishing that evidence of those facts required by rule adopted by the

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commission.

E. An employer, group or other plan that provides health care benefits for its employees after retirement, including coverage for payment of health care supplementary coverage if the retiree is eligible for medicare, may agree to participate in the health security plan, provided that there is no loss of benefits under the retiree health benefit coverage. An employer, group or other plan that participates in the health security plan shall contribute to the health security plan for the benefit of the retiree, and the agreement shall ensure that the health benefit coverage for the retiree shall be restored in the event of the retiree's ineligibility for health security plan coverage.

F. The commission shall prescribe by rule conditions under which other persons in the state may be eligible for coverage pursuant to the health security plan.

SECTION 22. [NEW MATERIAL] HEALTH SECURITY PLAN COVERAGE OF NONRESIDENT STUDENTS.--

A. Except as provided in Subsection B of this section, an educational institution shall purchase coverage under the health security plan for its nonresident students through fees assessed to those students. The governing body of an educational institution shall set the fees at the amount determined by the commission.

B. A nonresident student at an educational

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institution may satisfy the requirement for health care coverage by proof of coverage under a policy or plan in another state that is acceptable to the commission. The student shall not be assessed a fee in that case.

C. The commission shall adopt rules to determine proof of an individual's eligibility for the health security plan or a student's proof of nonresident health care coverage.

SECTION 23. [NEW MATERIAL] REMOVING INELIGIBLE PERSONS.--The commission shall adopt rules to provide procedures for removing persons no longer eligible for coverage.

SECTION 24. [NEW MATERIAL] ELIGIBILITY CARD--USE--PENALTIES FOR MISUSE.--

A. A beneficiary shall receive a card as proof of eligibility. The card shall be electronically readable and shall contain a photograph or electronic image of the beneficiary, information that identifies the beneficiary for treatment and billing, payment and other information the commission deems necessary. The use of a beneficiary's social security number as an identification number is not permitted.

B. The eligibility card is not transferable. A beneficiary who lends the beneficiary's card to another and an individual who uses another's card shall be jointly and severally liable to the commission for the full cost of the health care provided to the user. The liability shall be paid in full within one year of final determination of liability.

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Liabilities created pursuant to this section shall be collected in a manner similar to that used for collection of delinquent taxes.

C. A beneficiary who lends the beneficiary's card to another or an individual who uses another's card after being determined liable pursuant to Subsection B of this section of a previous misuse is guilty of a misdemeanor and shall be sentenced pursuant to the provisions of Section 31-19-1 NMSA 1978. A third or subsequent conviction is a fourth degree felony, and the offender shall be sentenced pursuant to the provisions of Section 31-18-15 NMSA 1978.

SECTION 25. [NEW MATERIAL] PRIMARY CARE PROVIDER--RIGHT TO CHOOSE--ACCESS TO SERVICES.--

A. Except as provided in the Workers' Compensation Act, a beneficiary has the right to choose a primary care provider.

B. The primary care provider is responsible for providing health care provider services to the patient except for:

(1) services in medical emergencies; and

(2) services for which a primary care provider determines that specialist services are required, in which case the primary care provider shall advise the patient of the need for and the type of specialist services.

C. Except as otherwise provided in this section,

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health care provider specialists shall be paid pursuant to the health security plan only if the patient has been referred by a primary care provider. Nothing in this subsection prevents a beneficiary from obtaining the services of a health care provider specialist and paying the specialist for services provided.

D. The commission shall by rule specify when and under what circumstances a beneficiary may self-refer, including self-referral to a chiropractic physician, a doctor of oriental medicine, mental and behavioral health service providers and other health care providers who are not primary care providers.

E. The commission shall by rule specify the conditions under which a beneficiary may select a specialist as a primary care provider.

SECTION 26. [NEW MATERIAL] DISCRIMINATION PROHIBITED.--A health care provider or health facility shall not discriminate against or refuse to furnish health care to a beneficiary on the basis of age, race, color, income level, national origin, religion, gender, sexual orientation, disabling condition or payment status. Nothing in this section shall require a health care provider or health facility to provide services to a beneficiary if the provider or facility is not qualified to provide the needed services or does not offer them to the general public.

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SECTION 27. [NEW MATERIAL] BENEFICIARY RIGHTS--GRIEVANCES--INTERNAL APPEALS--EXTERNAL APPEALS--UTILIZATION REVIEW.--

A. The commission shall adopt rules and shall monitor and oversee the health security plan to ensure that each beneficiary enrolled in the health security plan is treated fairly and in accordance with the requirements of the Health Security Act.

B. The rules that the commission adopts to protect beneficiary rights shall provide at a minimum that:

(1) before enrolling or at the time of enrolling in the health security plan, the plan shall provide a summary of benefits and exclusions, premium information and a provider listing;

(2) within a reasonable time after enrollment and at subsequent periodic times as appropriate, the health security plan shall provide written material that contains, in a clear, conspicuous and readily understandable form, a full and fair disclosure of the health security plan's benefits, limitations, exclusions, conditions of eligibility, prior authorization requirements, beneficiary financial responsibility for payments, grievance procedures, appeal rights and the patients' rights available to all beneficiaries; and

(3) the health security plan shall provide

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notice to each beneficiary, in a culturally and linguistically appropriate manner, of:

(a) the availability of internal and external appeals processes for grievances and the time lines for hearing and decisions on internal and external appeals;

(b) the availability of expedited appeals, the grounds for expedited appeals and the time lines for hearing and decisions on expedited appeals;

(c) the availability of the office of ombudsman at the office of superintendent of insurance to assist beneficiaries with the appeals process;

(d) the beneficiary's right to review the beneficiary's file and to present evidence and testimony as part of the grievance and appeals process; and

(e) the beneficiary's right to receive continued coverage pending the outcome of the grievance and appeals process.

C. In providing reasonably accessible health care services that are available in a timely manner, the health security plan shall ensure that:

(1) the plan offers sufficient numbers and types of qualified and adequately staffed health care providers at reasonable hours of service to provide health care services to the plan's beneficiaries;

(2) health care providers that are specialists

may act as primary care providers for patients with chronic medical conditions; provided that the specialists offer all basic health care services that are required of them by the health security plan;

(3) reasonable access is provided to out-of-network health care providers if medically necessary covered services are not reasonably available through participating health care providers or if necessary to provide continuity of care during brief transition periods;

(4) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs; and

(5) the plan, through provider selection, provider education, the provision of additional resources or other means, reasonably addresses the cultural and linguistic diversity of its beneficiary population.

D. The commission shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the health security plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify beneficiaries of their rights to obtain review by the plan, their rights to

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obtain review by the superintendent, their right to expedited review of emergent utilization decisions and their rights under the Health Security Act.

E. The commission shall adopt and implement a comprehensive utilization review program. The basis of a decision to deny care shall be disclosed to an affected beneficiary. The decision to approve or deny care to a beneficiary shall be made in a timely manner, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that each beneficiary has proper access to health care services, including referrals to necessary specialists. A decision made in the health security plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the superintendent.

F. The superintendent shall adopt and promulgate rules to establish an external appeals process for review of beneficiary grievances in accordance with the provisions of the Health Security Act.

G. The superintendent may appoint one or more qualified individuals to review external grievance appeals. The superintendent shall fix the reasonable compensation of each appointee based upon, but not limited to, compensation amounts suggested by national or state legal or medical professional societies, organizations or associations. The

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commission shall pay the compensation directly to each appointee who participated in the external grievance appeal review.

H. Upon completion of the external grievance appeal review, the superintendent shall prepare a detailed statement of compensation due each appointee and shall present the statement to the beneficiary and the commission.

I. The decision to approve or deny a claim based on a technicality shall be made in a timely manner and shall not exceed time limits established by rule of the commission. A final decision to deny payment for services based on medical necessity or utilization shall be based on a recommendation made by a health care professional having appropriate and adequate qualifications to make the recommendation. A denial of a claim for payment of a medical specialty service based on medical necessity or utilization shall be made only after a written recommendation for denial is made by a member of that medical specialty with credentials equivalent to those of the provider.

J. The fact of and the specific reasons for a denial of a health care claim shall be communicated promptly in writing to both the provider and the beneficiary involved.

SECTION 28. [NEW MATERIAL] QUALITY OF CARE--HEALTH CARE PROVIDER AND HEALTH FACILITIES--PRACTICE STANDARDS.--

A. The commission shall adopt rules to establish

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and implement a quality improvement program that monitors the quality and appropriateness of health care provided by the health security plan, including evidence-based medicine, best practices, outcome measurements, consumer education and patient safety. The commission shall set standards and review benefits to ensure that effective, cost-efficient, high-quality and appropriate health care is provided under the health security plan.

B. The commission shall establish a quality improvement program. The quality improvement program shall include an ongoing system for monitoring patterns of practice. Pursuant to the quality improvement program, the commission shall review and adopt professional practice guidelines developed by state and national medical and specialty organizations, federal agencies for health care policy and research and other organizations as it deems necessary to promote the quality and cost-effectiveness of health care provided through the health security plan.

C. The commission shall appoint a "health care practice advisory committee" consisting of health care providers, health facilities and other knowledgeable persons to advise the commission and staff on health care practice issues. The committee shall include both health care providers and health facilities from counties having fifty thousand or fewer inhabitants as of the most recent federal decennial census and

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health care providers and health facilities from counties having more than fifty thousand inhabitants as of the most recent federal decennial census. The committee may appoint subcommittees and task forces to address practice issues of a specific health care provider discipline or a specific kind of health facility, provided that the subcommittee or task force includes providers of substantially similar specialties or types of facilities. The advisory committee shall provide to the commission recommended standards and guidelines to be followed in making determinations on practice issues.

D. With the advice of the health care practice advisory committee, the commission shall establish a system of peer education for health care providers or health facilities determined to be engaging in aberrant patterns of practice pursuant to Subsection B of this section. If the commission determines that peer education efforts have failed, the commission may refer the matter to the appropriate licensing or certifying board.

E. The commission shall provide by rule the procedures for recouping payments or withholding payments for health care determined by the commission with the advice of the health care practice advisory committee or subcommittee to be medically unnecessary.

F. The commission may provide by rule for the assessment of administrative penalties for up to three times

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the amount of excess payments if it finds that excessive billings were part of an aberrant pattern of practice. Administrative penalties shall be deposited in the current school fund.

G. After consultation with the health care practice advisory committee, the commission may suspend or revoke a health care provider's or health facility's privilege to be paid for health care provided under the health security plan based upon evidence clearly supporting a determination by the commission that the provider or facility engages in aberrant patterns of practice, including inappropriate utilization, attempts to unbundle health care services or other practices that the commission deems a violation of the Health Security Act or rules adopted pursuant to that act. As used in this subsection, "unbundle" means to divide a service into components in an attempt to increase, or with the effect of increasing, compensation from the health security plan.

H. The commission shall report a suspension or revocation of the privilege to be paid for health care pursuant to the Health Security Act to the appropriate licensing or certifying board.

I. The commission shall report cases of suspected fraud by a health care provider or a health facility to the attorney general for investigation and prosecution. The office of the attorney general has independent authority to

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investigate and prosecute suspected fraud without a prior commission report of fraud.

SECTION 29. [NEW MATERIAL] PROVIDER AND HEALTH FACILITY DISPUTE RESOLUTION.--

A. The health security plan shall not:

(1) adopt a gag rule or practice that prohibits a health care provider from discussing a treatment option with a beneficiary even if the health security plan does not approve of the option;

(2) include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary services to a beneficiary; or

(3) require a health care provider to violate any recognized fiduciary duty of the health care provider's profession or place the health care provider's license in jeopardy.

B. If the health security plan proposes to terminate a health care provider from participation in the health security plan, it shall explain in writing the rationale for its proposed termination and deliver reasonable advance written notice to the provider prior to the proposed effective date of the termination.

C. The commission shall adopt and implement a process pursuant to which providers may raise with the health

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security plan concerns that they may have regarding operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care providers and the adequacy of the plan's provider network. The process shall include, at a minimum, the right of the provider to present to the commission any concerns that the provider has regarding operation of the health security plan. In addition, the commission shall adopt and implement a fair hearing plan that permits a health care provider to dispute the existence of adequate cause to terminate the provider's participation in the plan to the extent that the relationship is terminated for cause and shall include in each provider contract a dispute resolution mechanism.

SECTION 30. [NEW MATERIAL] HEALTH SECURITY PLAN BUDGET--PREMIUM RATES.--

A. Annually, the commission shall develop and submit to the legislature a health security plan budget. The budget shall be the commission's recommendation for the total amount to be spent by the plan for covered health care services in the next fiscal year.

B. In establishing or changing premium rates or employer contribution rates, the commission shall comply with the provisions of Sections 59A-18-13 through 59A-18-14 NMSA 1978.

C. In developing the health security plan budget,

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the commission shall provide that credit be taken in the budget for all revenues produced for health care in the state pursuant to any law other than the Health Security Act.

D. The health security plan shall include a maximum amount or percentage for administrative costs, and this maximum, if a percentage, may change in relation to the total costs of services provided under the health security plan. For the sixth and subsequent calendar years of operation of the health security plan, administrative costs shall not exceed five percent of the health security plan budget.

SECTION 31. [NEW MATERIAL] PAYMENTS TO HEALTH CARE PROVIDERS--CO-PAYMENTS--OUT-OF-STATE SERVICES--SUBROGATION--PAYMENTS FROM THIRD PARTIES.--

A. The commission shall prepare a provider budget. Consistent with the provider budget, the health security plan shall provide payment for all covered health care rendered by health care providers. A variety of payment plans, including fee-for-service, may be adopted by the commission. Payment plans shall be negotiated with providers as provided by rule. In the event that negotiation fails to develop an acceptable payment plan, the disputing parties shall submit the dispute for resolution pursuant to Section 29 of the Health Security Act.

B. To the extent required to avoid violating federal antitrust law, the commission shall facilitate and

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supervise the participation of health care providers and health facilities in the planning and implementation of the health security plan. The commission shall ensure the establishment and operation of the health security plan in cooperation with the office of the attorney general to ensure compliance with federal antitrust law.

C. As it deems appropriate, the commission may create a shared incentive pool for health care providers and health facilities.

D. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care in rural and other underserved areas throughout the state.

E. An annual percentage increase in the amount allocated for provider payments in the budget shall be no greater than the annual percentage increase in the consumer price index for medical care prices published by the bureau of labor statistics of the federal department of labor using the year prior to the year in which the health security plan is implemented as the baseline year. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

F. Payment, or the offer of payment whether or not that offer is accepted, to a health care provider for services covered by the health security plan shall be payment in full

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for those services. A health care provider shall not charge a beneficiary an additional amount for services covered by the plan.

G. The commission may establish a co-payment schedule if a required co-payment is determined to be an effective cost-control measure. A co-payment shall not be required for preventive health care services, as the commission defines "preventive health care services" by rule in accordance with state and federal law. When a co-payment is required, the health care provider shall not waive it, and if it remains uncollected, the health care provider shall demonstrate a good-faith effort to have collected the co-payment.

H. A beneficiary may obtain health care services covered by the health security plan out of state; provided, however, that the services shall be reimbursed at:

(1) the same rate that would apply if those services had been received in New Mexico; or

(2) a rate higher than the reimbursement rate the health security plan would have paid if the services had been received in New Mexico if the commission negotiates a reimbursement agreement or other agreement with:

(a) the state in which the health care services were received; or

(b) the health care provider or health facility rendering the services.

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I. The health security plan shall make reasonable efforts to ascertain any legal liability of third-party persons that are or may be liable to pay all or part of the health care services costs of injury, disease or disability of a beneficiary.

J. When the health security plan makes payments on behalf of a beneficiary, the health security plan is subrogated to any right of the beneficiary against a third party for recovery of amounts paid by the health security plan.

K. By operation of law, an assignment to the health security plan of the rights of a beneficiary:

(1) is conclusively presumed to be made of:

(a) a payment for health care services from any person, including an insurance carrier; and

(b) a monetary recovery for damages for bodily injury, whether by judgment, contract for compromise or settlement;

(2) shall be effective to the extent of the amount of payments by the health security plan; and

(3) shall be effective as to the rights of any other beneficiary whose rights can legally be assigned by the beneficiary.

SECTION 32. [NEW MATERIAL] PAYMENTS TO HEALTH FACILITIES--CO-PAYMENTS.--

A. A health facility shall negotiate an annual

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operating budget with the commission. The operating budget shall be based on a base operating budget of past performance and projected changes upward or downward in costs and services anticipated for the next year. If a negotiated annual operating budget is not agreed upon, a health facility shall submit the budget to dispute resolution pursuant to Section 29 of the Health Security Act. An annual percentage increase in the amount allocated for a health facility operating budget shall be no greater than the change in the annual consumer price index for medical care prices, published annually by the bureau of labor statistics of the federal department of labor. The annual limitation in this subsection may be adjusted up or down by the commission based on a showing of special and unusual circumstances in a hearing before the commission.

B. Supplemental payment rates may be adopted to provide incentives to help ensure the delivery of needed health care services in rural and other underserved areas throughout the state.

C. Each health care provider employed by a health facility shall be paid from the facility's operating budget in a manner determined by the health facility.

D. The commission may establish a co-payment schedule if a required co-payment is determined to be an effective cost-control measure. The commission shall not require a co-payment for preventive health care services, as

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the commission defines "preventive health care services" by rule in accordance with state and federal law. When a co-payment is required, the health facility shall not waive it, and if it remains uncollected, the health facility shall demonstrate a good-faith effort to have collected the co-payment.

SECTION 33. [NEW MATERIAL] STANDARD CLAIM FORMS FOR INSURANCE PAYMENT.--The commission shall adopt standard claim forms and electronic formats that shall be used by all health care providers and health facilities that seek payment through the health security plan or from private persons, including private insurance companies, for health care services rendered in the state. Each claim form or electronic format may indicate whether a person is eligible for federal or other insurance programs for payment. To the extent practicable, the commission shall require the use of existing, nationally accepted standardized forms, formats and systems.

SECTION 34. [NEW MATERIAL] HEALTH RESOURCE CERTIFICATE--COMMISSION RULES--REQUIREMENT FOR REVIEW.--

A. The commission shall adopt rules stating when a health facility or health care provider participating in the health security plan shall apply for a health resource certificate, how the application will be reviewed, how the certificate will be granted, how an expedited review is conducted and other matters relating to health resource

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projects.

B. Except as provided in Subsection F of this section, a health facility or health care provider participating in the health security plan shall not make or obligate itself to make a major capital expenditure without first obtaining a health resource certificate.

C. A health facility or health care provider shall not acquire through rental, lease or comparable arrangement or through donation all or a part of a capital project that would have required review if the acquisition had been by purchase unless the project is granted a health resource certificate.

D. A health facility or health care provider shall not engage in component purchasing in order to avoid the provisions of this section.

E. The commission shall grant a health resource certificate for a major capital expenditure or a capital project undertaken pursuant to Subsection C of this section only when the project is determined to be needed.

F. This section does not apply to:

(1) the purchase, construction or renovation of office space for health care providers;

(2) expenditures incurred solely in preparation for a capital project, including architectural design, surveys, plans, working drawings and specifications and other related activities, but those expenditures shall be

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included in the cost of a project for the purpose of determining whether a health resource certificate is required;

(3) acquisition of an existing health facility, equipment or practice of a health care provider that does not result in a new service being provided or in increased bed capacity;

(4) major capital expenditures for nonclinical services when the nonclinical services are the primary purpose of the expenditure; and

(5) the replacement of equipment with equipment that has the same function and that does not result in the offering of new services.

G. No later than November 1, 2017, the commission shall report to the appropriate committees of the legislature on the capital needs of health facilities, including facilities of state and local governments, with a focus on underserved geographic areas with substantially below-average health facilities and investment per capita as compared to the state average. The report shall also describe geographic areas where the distance to health facilities imposes a barrier to care. The report shall include a section on health care transportation needs, including capital, personnel and training needs. The report shall make recommendations for legislation to amend the Health Security Act that the commission determines necessary and appropriate.

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SECTION 35. [NEW MATERIAL] FISCAL AND ACTUARIAL REVIEWS--AUDITS.--

A. The commission shall provide for annual independent fiscal and actuarial reviews of the health security plan and any funds of the commission or the plan.

B. The commission shall provide by rule requirements for independent financial audits of health care providers and health facilities.

C. The commission, through its staff or by contract, shall perform announced and unannounced reviews, including financial, operational, management and electronic data processing reviews of health care providers and health facilities. Review findings shall be reported directly to the commission. The commission may request the state auditor to review preliminary findings or to consult with review staff before the findings are reported to the commission.

D. Actuarial review, fiscal reviews, financial audits and internal audits are public documents after they have been released by the commission, provided that the reports protect private and confidential information of a patient or provider. Copies of reviews, audits and other reports shall be transmitted to the governor, the legislature, appropriate interim committees of the legislature and the office of the state auditor as well as made available via the internet.

SECTION 36. [NEW MATERIAL] INFORMATION TECHNOLOGY

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SYSTEM.--The commission shall establish guidelines for maximizing participation of health care providers and health facilities in the health security plan's information technology network that provides for electronic transfer of payments to health care providers and health facilities; transmittal of reports, including patient data and other statistical reports; billing data, with specificity as to procedures or services provided to individual patients; and any other information required or requested by the commission. To the extent practicable, the commission shall require the use of existing, nationally accepted standardized forms, formats and systems.

SECTION 37. [NEW MATERIAL] REPORTS REQUIRED--CONFIDENTIAL INFORMATION.--

A. The commission shall require reports by all health care providers and health facilities of information needed to allow the commission to evaluate the health security plan, cost-containment measures, utilization review, health facility operating budgets, health care provider fees and any other information the commission deems necessary to carry out its duties pursuant to the Health Security Act.

B. The commission shall establish uniform reporting requirements for health care providers and health facilities.

C. Information confidential pursuant to other provisions of law shall be confidential pursuant to the Health Security Act. Within the constraints of confidentiality,

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reports of the commission are public documents.

SECTION 38. [NEW MATERIAL] CONSUMER, PROVIDER AND HEALTH FACILITY ASSISTANCE PROGRAM.--

A. The commission shall establish a consumer, health care provider and health facility assistance program to take complaints and to provide timely and knowledgeable assistance to:

(1) eligible persons and applicants about their rights and responsibilities and the coverages provided in accordance with the Health Security Act; and

(2) health care providers and health facilities about the status of claims, payments and other pertinent information relevant to the claims payment process.

B. The commission shall establish a toll-free telephone line and publicly accessible web site for the consumer, health care provider and health facility assistance program and shall have persons available throughout the state to assist beneficiaries, applicants, health care providers and health facilities in person.

SECTION 39. [NEW MATERIAL] PRIVATE HEALTH INSURANCE COVERAGE LIMITED--VOLUNTARY PURCHASE OF OTHER INSURANCE.--

A. After the date on which the health security plan begins operating:

(1) a beneficiary may purchase supplemental health insurance benefits; and

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(2) a person shall not provide private health insurance to a beneficiary for a health care service that is covered by the health security plan, except as follows:

(a) transitional coverage as provided in Section 45 of the Health Security Act; and

(b) a retiree health insurance plan that does not enter into contract with the health security plan.

B. Nothing in this section affects insurance coverage pursuant to the federal Employee Retirement Income Security Act of 1974 unless the state obtains a congressional exemption or a waiver from the federal government. Health coverage plans that are covered by the provisions of that act may elect to participate in the health security plan.

C. Nothing in the Health Security Act shall be construed to prohibit the voluntary purchase of insurance coverage for health care services not covered by the health security plan or for individuals not eligible for coverage under the health security plan.

SECTION 40. [NEW MATERIAL] INSURANCE RATES--SUPERINTENDENT DUTIES.--

A. The superintendent shall work closely with the legislative finance committee pursuant to Section 41 of the Health Security Act to identify premium costs associated with health care coverage in workers' compensation and automobile medical coverage. The superintendent shall develop an estimate

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of expected reduction in those costs based upon assumptions of health care services coverage in the health security plan and shall report the findings to the legislative finance committee to determine the financing of the health security plan.

B. The superintendent shall ensure that workers' compensation and automobile insurance premiums on insurance policies written in New Mexico reflect a lower rate to account for the medical payment component to be assumed by the health security plan.

SECTION 41. [NEW MATERIAL] STUDY--FINANCING THE HEALTH SECURITY PLAN.--

A. The legislative finance committee shall undertake a fiscal analysis relating to the first five years of the health security plan's establishment and operation. The fiscal analysis shall include a review of financing options for the health security plan and a projection of costs to the plan.

B. In its fiscal analysis performed pursuant to Subsection A of this section, the legislative finance committee shall be guided by the following requirements and assumptions:

(1) health care services to be included and for which costs are to be projected in determining the financing options shall be no less than the health care services afforded to state employees pursuant to the Health Care Purchasing Act; and

(2) financing options may set minimum and

maximum levels of costs to a beneficiary based on the following factors, as they apply to a given beneficiary:

(a) the beneficiary's income;

(b) federal premium tax credits;

(c) federal cost-sharing subsidies;

(d) medicare offsets; and

(e) contributions from the beneficiary's employer or any other third-party payor; provided that an employer may cover all or part of a beneficiary's premium to the extent that a collective bargaining agreement is not violated.

C. The legislative finance committee shall:

(1) make projections regarding the impact of the health security plan upon the state budget;

(2) project the costs of establishing and administering the health security plan;

(3) prepare a report of its determinations with the specific options and recommendations no later than November 2, 2015; and

(4) submit its report prepared pursuant to Paragraph (3) of this subsection to the appropriate interim legislative committees for consideration by the fifty-second legislature.

D. The commission shall reimburse the legislative finance committee for any state funds it expended in

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undertaking the fiscal analysis pursuant to this section.

SECTION 42. [NEW MATERIAL] GRANT FUNDING AND OTHER RESOURCES--PARTNERSHIPS.--The legislative finance committee shall seek partnerships among state agencies and private nonprofit persons to identify and apply for available grant funding and other in-kind and financial resources for its study of financing options for the health security plan pursuant to Section 41 of the Health Security Act. Any amounts received in grant funds or from other financial resources shall first be used to offset any state funds that the legislature appropriates or allocates. Any grant funds or other financial resources received in excess of legislative appropriations or allocations shall be used for the study of financing options for the health security plan.

SECTION 43. [NEW MATERIAL] REIMBURSEMENT TO HEALTH SECURITY PLAN FROM FEDERAL AND OTHER HEALTH INSURANCE PROGRAMS.--

A. The commission shall seek payment to the health security plan from medicaid, medicare or any other federal or other insurance program for any reimbursable payment provided under the plan.

B. The commission shall seek to maximize federal contributions and payments for health care services provided in New Mexico and shall ensure that the contributions of the federal government for health care services in New Mexico will

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not decrease in relation to other states as a result of any waivers, exemptions or agreements.

C. The commission shall maintain sufficient reserves to provide for catastrophic and unforeseen expenditures.

SECTION 44. [NEW MATERIAL] HEALTH BENEFITS EXCHANGE OR HEALTH INSURANCE EXCHANGE PROPERTY--FEDERAL WAIVER FOR TRANSFER OF HEALTH INSURANCE EXCHANGE FUNCTIONS--TRANSFER OF HEALTH INSURANCE EXCHANGE.--

A. Unless otherwise provided by federal law, any personal property that the state has procured to implement or operate a state health benefits exchange or health insurance exchange pursuant to federal law shall remain state property.

B. As soon as allowed under federal law, the secretary of human services shall seek a waiver to allow the state to suspend operation of any health benefits exchange or health insurance exchange and to allow the commission to administer in accordance with federal law the federal premium tax credits, cost-sharing subsidies and small business tax credits. In implementing the provisions of the Health Security Act, the human services department shall provide for the commission's use any personal property used in the operation of a state health insurance exchange.

C. As used in this section:

(1) "health insurance exchange" means an

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entity established pursuant to federal law to provide qualified health plans to qualified individuals and qualified employers on the individual and small group or large group insurance markets;

(2) "personal property" means property other than real property; and

(3) "real property" means an estate or interest in, over or under land and other things or interests, including minerals, water, structures and fixtures that by custom, usage or law pass with a transfer of land even if the estate or interest is not described or mentioned in the contract of sale or instrument of conveyance and, if appropriate to the context, the land in which the estate or interest is claimed.

SECTION 45. [NEW MATERIAL] TRANSITION PERIOD ARRANGEMENTS--PRIVATE CONTRACT--COLLECTIVE BARGAINING.--A person who, on the date benefits are available under the Health Security Act's health security plan, receives health care benefits under a private contract or collective bargaining agreement entered into prior to July 1, 2017 shall continue to receive those benefits until the contract or agreement expires or unless the contract or agreement is renegotiated to provide participation in the health security plan.

SECTION 46. Section 41-4-3 NMSA 1978 (being Laws 1976, Chapter 58, Section 3, as amended) is amended to read:

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"41-4-3. DEFINITIONS.--As used in the Tort Claims Act:

A. "board" means the risk management advisory board;

B. "governmental entity" means the state or any local public body as defined in Subsections C and H of this section;

C. "local public body" means all political subdivisions of the state and their agencies, instrumentalities and institutions and all water and natural gas associations organized pursuant to Chapter 3, Article 28 NMSA 1978;

D. "law enforcement officer" means a full-time salaried public employee of a governmental entity, or a certified part-time salaried police officer employed by a governmental entity, whose principal duties under law are to hold in custody any person accused of a criminal offense, to maintain public order or to make arrests for crimes, or members of the national guard when called to active duty by the governor;

E. "maintenance" does not include:

(1) conduct involved in the issuance of a permit, driver's license or other official authorization to use the roads or highways of the state in a particular manner; or

(2) an activity or event relating to a public building or public housing project that was not foreseeable;

F. "public employee" means an officer, employee or

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servant of a governmental entity, excluding independent contractors except for individuals defined in Paragraphs (7), (8), (10), (14) and (17) of this subsection, or of a corporation organized pursuant to the Educational Assistance Act, the Small Business Investment Act or the Mortgage Finance Authority Act or a licensed health care provider, who has no medical liability insurance, providing voluntary services as defined in Paragraph (16) of this subsection and including:

(1) elected or appointed officials;

(2) law enforcement officers;

(3) persons acting on behalf or in service of a governmental entity in any official capacity, whether with or without compensation;

(4) licensed foster parents providing care for children in the custody of the human services department, corrections department or department of health, but not including foster parents certified by a licensed child placement agency;

(5) members of state or local selection panels established pursuant to the Adult Community Corrections Act;

(6) members of state or local selection panels established pursuant to the Juvenile Community Corrections Act;

(7) licensed medical, psychological or dental arts practitioners providing services to the corrections department pursuant to contract;

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(8) members of the board of directors of the New Mexico medical insurance pool;

(9) individuals who are members of medical review boards, committees or panels established by the educational retirement board or the retirement board of the public employees retirement association;

(10) licensed medical, psychological or dental arts practitioners providing services to the children, youth and families department pursuant to contract;

(11) members of the board of directors of the New Mexico educational assistance foundation;

(12) members of the board of directors of the New Mexico student loan guarantee corporation;

(13) members of the New Mexico mortgage finance authority;

(14) volunteers, employees and board members of court-appointed special advocate programs;

(15) members of the board of directors of the small business investment corporation;

(16) health care providers licensed in New Mexico who render voluntary health care services without compensation in accordance with rules promulgated by the secretary of health. The rules shall include requirements for the types of locations at which the services are rendered, the allowed scope of practice and measures to ensure quality of

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care;

(17) an individual while participating in the state's adaptive driving program and only while using a special-use state vehicle for evaluation and training purposes in that program; [~~and~~]

(18) the staff and members of the board of directors of the New Mexico health insurance exchange established pursuant to the New Mexico Health Insurance Exchange Act; and

(19) the staff and members of the health care commission established pursuant to the Health Security Act;

G. "scope of duty" means performing any duties that a public employee is requested, required or authorized to perform by the governmental entity, regardless of the time and place of performance; and

H. "state" or "state agency" means the state of New Mexico or any of its branches, agencies, departments, boards, instrumentalities or institutions."

SECTION 47. TEMPORARY PROVISION--HEALTH CARE COMMISSION--TRANSFER OF HEALTH INSURANCE EXCHANGE DUTIES.--The health care commission shall devise a plan for the timely and efficient transfer of health insurance exchange functions and health insurance exchange property to the commission pursuant to Section 44 of the Health Security Act.

SECTION 48. TEMPORARY PROVISION.--

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A. If the fifty-second legislature approves implementation and financing of the health security plan, the health security plan shall be operational by July 1, 2018. Upon an affirmative vote by a two-thirds majority of the health care commission's members, the commission may extend the operational date by as much as one year.

B. If the fifty-second legislature fails to implement the recommendations of the legislative finance committee or otherwise fails to determine and approve financing of the health security plan, the health security plan shall not become effective.

SECTION 49. APPROPRIATION.--Two hundred fifty thousand dollars ($250,000) is appropriated from the general fund to the legislative finance committee for expenditure in fiscal year 2016 to undertake the fiscal analysis required pursuant to Section 41 of the Health Security Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

SECTION 50. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2015.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO DEVELOP A CENTER OF EXCELLENCE TO EXPAND AND REPLICATE THE FOCUS-MILAGRO INTEGRATED CARE MODEL; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Three million five hundred thousand dollars ($3,500,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal years 2015 through 2018 to establish a center of excellence to expand and replicate the university of New Mexico health sciences center's FOCUS-milagro integrated care model. Any unexpended or unencumbered balance remaining at the end of fiscal year 2018 shall revert to the general fund.

SECTION 2. EMERGENCY.--It is necessary for the public

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peace, health and safety that this act take effect immediately.

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO ESTABLISH A STATEWIDE BEHAVIORAL HEALTH WARMLINE AND CLEARINGHOUSE; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--One million nine hundred eleven thousand two hundred fifty dollars ($1,911,250) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal years 2015 through 2020 to establish, maintain and evaluate a statewide behavioral health warmline and clearinghouse at the university of New Mexico health sciences center's brain and behavioral health institute. Any unexpended or unencumbered balance remaining at the end of fiscal year 2020 shall revert to the general fund.

SECTION 2. EMERGENCY.--It is necessary for the public

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peace, health and safety that this act take effect immediately.

SENATE JOINT MEMORIAL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

A JOINT MEMORIAL

REQUESTING THE NEW MEXICO LEGISLATIVE COUNCIL TO CHARGE THE INTERIM 2015 LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE WITH CONVENING A BASIC HEALTH PROGRAM TASK FORCE TO EXPLORE THE FEASIBILITY OF IMPLEMENTING A BASIC HEALTH PROGRAM TO COVER INDIVIDUALS WITH LOW INCOMES WHO ARE NOT ELIGIBLE FOR MEDICAID.

WHEREAS, the federal Patient Protection and Affordable Care Act, also known as the "Affordable Care Act" or "Obamacare", provides that states may establish a health insurance program for low-income individuals who do not quality for medicaid coverage; and

WHEREAS, the individuals who may be covered under a basic health program are adult citizens of the United States with household incomes of one hundred thirty-eight percent to two hundred percent of the federal poverty level, also known as the

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"FPL", as well as noncitizen, legal permanent residents with incomes below two hundred percent of the FPL who are excluded from medicaid coverage during their first five years of residence; and

WHEREAS, the Affordable Care Act also provides individuals and families with incomes below four hundred percent of the FPL premium tax credits and cost-sharing subsidies on qualified health plan coverage available through state health insurance exchanges; and

WHEREAS, to assist states in funding a basic health program, the federal government would give participating states ninety-five percent of what the federal government would have provided to enrollees in the form of premium tax credits and cost-sharing subsidies that they would have received had these individuals and families purchased qualified health plans instead of enrolling in a basic health plan; and

WHEREAS, the state of New Mexico used to provide health coverage through the "state coverage insurance" or "SCI" program to adults who did not qualify for medicaid and whose incomes fell below two hundred percent of the FPL; and

WHEREAS, since January 1, 2014, the state of New Mexico has exercised its option under the Affordable Care Act to expand medicaid coverage to otherwise ineligible adults with incomes below one hundred thirty-eight percent of the FPL; and

WHEREAS, adult New Mexicans whose incomes are above one

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hundred thirty-eight percent of the FPL must now purchase health insurance on the private market, either through the New Mexico health insurance exchange or elsewhere; and

WHEREAS, the average monthly premium on the New Mexico health insurance exchange for a qualified health plan is two hundred thirty-two dollars ($232); and

WHEREAS, the Affordable Care Act requires that basic health program premiums be lower than the second-lowest-cost plan offered at the "silver" level, or an eighty percent actuarial value, of qualified health plans on the New Mexico health insurance exchange; and

WHEREAS, the state of Minnesota has implemented a "look-alike" health coverage program for low-income adults, and for an enrollee with an income at one hundred seven percent of the FPL, premiums are just thirty-three dollars ($33.00) a month, with a thirty-three-dollar ($33.00) annual deductible and a three-dollar ($3.00) co-payment per primary care or specialty care office visit; and

WHEREAS, even with premium tax credits and cost-sharing subsidies, the New Mexico health insurance exchange reports that fifty-six percent of New Mexicans have cited affordability as the primary reason why they do not have health insurance; and

WHEREAS, for the average qualified health plan enrollee with an income of one hundred seventy percent of the FPL, the

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urban institute states that the monthly premium would be eighty dollars ($80.00) with a federal subsidy; the annual deductible would be seven hundred fifty dollars ($750), and co-payments for primary care would be ten dollars ($10.00) per visit, and for specialists, the co-payment would be thirty dollars ($30.00) per visit; and

WHEREAS, the basic health program has the potential for increasing the number of insured New Mexicans, thus increasing access to health care services and decreasing the amount of uncompensated care in the state;

NOW, THEREFORE, BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO that the New Mexico legislative council be requested to charge the chair of the interim 2015 legislative health and human services committee with convening a basic health program working group during the 2015 interim to analyze the feasibility of implementing a basic health program in the state to increase access to health coverage for low-income adults who are not eligible for medicaid coverage; and

BE IT FURTHER RESOLVED that the chair of the legislative health and human services committee be requested to invite to participate in the basic health program working group experts in the areas of health coverage, actuarial science, health care finance, public benefits and public finance, including representatives from the office of superintendent of insurance, the human services department and the legislative finance

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committee; and

BE IT FURTHER RESOLVED that the basic health program working group be requested to study and make recommendations regarding:

A. the options that New Mexico has for financing the basic health program using federal grants;

B. whether state funds should be allocated to keep premiums and cost-sharing affordable for low-income New Mexicans;

C. what safeguards may be available for avoiding any adverse risk pooling or for adverse selection;

D. the possibilities for reducing "churn" between public and private health coverage;

E. the effect of a basic health program on the New Mexico health insurance exchange;

F. the costs of administering a basic health program; and

G. any legislation necessary to create a basic health program; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the president pro tempore of the senate, the speaker of the house of representatives, the chair of the legislative health and human services committee, the chair of the legislative finance committee, the secretary of human services and the superintendent of insurance.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO EXPAND ACCESS TO BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT THROUGH TRAINING AND SUPPORT OF THE PRIMARY CARE WORK FORCE IN COMMUNITY CLINICS; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Twelve million dollars ($12,000,000) is appropriated from the general fund to the board of regents of the university of New Mexico for expenditure in fiscal years 2015 through 2020 to expand access to behavioral health and substance use disorder treatment through training and support of the primary care work force in twenty community clinics, using the university of New Mexico health sciences center's project ECHO model. Any unexpended or unencumbered balance remaining at the end of fiscal year 2020

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shall revert to the general fund.

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO INCREASE THE NUMBER OF PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONERS THAT GRADUATE FROM NEW MEXICO STATE UNIVERSITY AND REMAIN IN NEW MEXICO FOR AT LEAST THREE YEARS FOLLOWING GRADUATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Three hundred ninety-five thousand dollars ($395,000) is appropriated from the general fund to the board of regents of New Mexico state university for expenditure in fiscal year 2016 to increase the number of psychiatric mental health nurse practitioners that graduate from the university and remain in New Mexico for at least three years following graduation. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO EXPAND ACCESS TO BEHAVIORAL HEALTH TREATMENT AND SERVICES THROUGH SCHOOL-BASED HEALTH CENTERS; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Sixteen million six hundred twenty-five thousand dollars ($16,625,000) is appropriated from the general fund to the department of health for expenditure in fiscal years 2015 through 2020 for its office of school and adolescent health to expand access to behavioral health treatment and services through school-based health centers, to expand hours of operation for existing centers and to establish twenty-two new school-based health centers by 2020. Any unexpended or unencumbered balance remaining at the end of fiscal year 2020 shall revert to the general fund.

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SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH TO OPERATE A SCHOOL-BASED HEALTH CLINIC AT WEST MESA HIGH SCHOOL IN ALBUQUERQUE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--One hundred fifty thousand dollars ($150,000) is appropriated from the general fund to the department of health for expenditure in fiscal year 2016 to operate a school-based health clinic at West Mesa high school in Albuquerque. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO VOTER REGISTRATION; ENACTING A NEW SECTION OF CHAPTER 1, ARTICLE 4 NMSA 1978 TO PROVIDE FOR VOTER REGISTRATION THROUGH THE NEW MEXICO HEALTH INSURANCE EXCHANGE; ENACTING A NEW SECTION OF THE NEW MEXICO HEALTH INSURANCE EXCHANGE ACT TO REQUIRE VOTER REGISTRATION REPORTING TO THE SECRETARY OF STATE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of Chapter 1, Article 4 NMSA 1978 is enacted to read:

"[NEW MATERIAL] NEW MEXICO HEALTH INSURANCE EXCHANGE--VOTER REGISTRATION.--

A. A person who applies to enroll in or renew enrollment in a qualified health plan shall be simultaneously registered to vote:

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(1) if the applicant or enrollee consents to registration; and

(2) if the applicant or enrollee who prospectively registers to vote is in fact qualified to register to vote.

B. The chief executive officer of the exchange shall identify employees or agents of the exchange that shall be charged with administration of voter registration of qualified health plan applicants and enrollees at sites at which the exchange provides in-person assistance to applicants for or enrollees in qualified health plans.

C. Any site at which the exchange provides in-person assistance to applicants for or enrollees of qualified health plans shall post signs visible to applicants and enrollees stating "voter registration assistance available" and:

(1) personnel in each office shall advise each applicant and enrollee that initial voter registration or a change of address for voter registration may be made simultaneously by qualified electors with enrollment in or renewal of a qualified health plan;

(2) voter registration shall be conducted in a manner such that the prospective registrant completes the full certificate of registration electronically; and

(3) the prospective registrant's digital

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signature shall be affixed to the certificate of registration using an electronic signature in conformance with the Electronic Authentication of Documents Act and the Uniform Electronic Transactions Act.

D. An agent or employee of the exchange shall not intentionally influence the prospective registrant in the selection of political party, or independent status, by word or act. An agent or employee of the exchange shall not reveal the existence of or the nature of the voter registration to anyone other than a registration officer.

E. A voter registration made or accepted at an exchange in-person assistance site shall be transmitted to the secretary of state and the appropriate registration officer within seven calendar days.

F. The secretary of state shall work with the chief executive officer of the exchange to:

(1) ensure compliance in the application of the provisions of this section with the federal National Voter Registration Act of 1993;

(2) ensure consistent implementation in the various counties, based on county classification and developing technology; and

(3) develop procedures to ensure that, once voter registration information is transmitted to the appropriate registration officer, the voter's certificate of

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registration is printed and placed in the county's register of voters.

G. For the purposes of this section:

(1) "exchange" means the New Mexico health insurance exchange established pursuant to the New Mexico Health Insurance Exchange Act; and

(2) "qualified health plan" means health insurance coverage offered through the exchange."

SECTION 2. A new section of the New Mexico Health Insurance Exchange Act is enacted to read:

"[NEW MATERIAL] VOTER REGISTRATION--REPORTING.--The chief executive officer of the exchange shall report annually the following information to the secretary of state pursuant to the chief executive officer's duties as provided in Section 1 of this 2015 act:

A. the number of applicants or enrollees applying to enroll or to renew enrollment in a qualified health plan who have registered to vote in the preceding calendar year; and

B. the number of applicants or enrollees applying to enroll or to renew enrollment in a qualified health plan who have updated their voter registration with a change of address during the preceding calendar year."

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; ENACTING A NEW SECTION OF THE HEALTH CARE PURCHASING ACT TO REQUIRE THAT PURCHASERS ESTABLISH GROUP COVERAGE FOR OBESITY PREVENTION, SCREENING AND TREATMENT AND WEIGHT REDUCTION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. A new section of the Health Care Purchasing Act is enacted to read:

"[NEW MATERIAL] COVERAGE FOR OBESITY PREVENTION, SCREENING AND TREATMENT--WEIGHT REDUCTION.--As of January 1, 2016, group health coverage, including any form of self-insurance, offered, issued or renewed under the Health Care Purchasing Act shall provide coverage for:

A. prevention of obesity;

B. screening for obesity; and

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C. interventions to promote weight reduction and treat obesity."

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION TO ESTABLISH FIVE ENTERPRISE ZONE SUPPORTIVE HOUSING INITIATIVES USING THE HEADING HOME COLLECTIVE IMPACT MODEL; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--Ten million nine hundred fifty thousand dollars ($10,950,000) is appropriated from the general fund to the department of finance and administration for distribution to the New Mexico mortgage finance authority for expenditure in fiscal years 2015 through 2020 to establish five enterprise zone supportive housing initiatives using the heading home collective impact model. Any unexpended or unencumbered balance remaining at the end of fiscal year 2020 shall revert to the general fund.

SECTION 2. EMERGENCY.--It is necessary for the public

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peace, health and safety that this act take effect immediately.

SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

MAKING AN APPROPRIATION FOR IN-STATE ADOLESCENT TRANSITIONAL LIVING AND RECOVERY SERVICES; DECLARING AN EMERGENCY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. APPROPRIATION.--One million twenty-four thousand dollars ($1,024,000) is appropriated from the general fund to the children, youth and families department for expenditure in fiscal years 2015 through 2020 to contract with a Bernalillo county nonprofit organization for transitional living and recovery services for adolescents statewide. Any unexpended or unencumbered balance remaining at the end of fiscal year 2020 shall revert to the general fund.

SECTION 2. EMERGENCY.--It is necessary for the public peace, health and safety that this act take effect immediately.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO HEALTH; ESTABLISHING AN ALL-PAYER CLAIMS DATABASE TO PROVIDE FOR THE SECURE STORAGE, MAINTENANCE AND ANALYSIS OF HEALTH CARE DATA; PROVIDING FOR FEES AND PENALTIES; MAKING AN APPROPRIATION.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] SHORT TITLE.--This act may be cited as the "All-Payer Claims Database Act".

SECTION 2. [NEW MATERIAL] DEFINITIONS.--As used in the All-Payer Claims Database Act:

A. "commission" means the all-payer claims database commission;

B. "database" means the all-payer claims database;

C. "health information exchange" means an arrangement among persons participating in a defined secure

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electronic network service, such as a regional health information organization, that allows the sharing of health care information about individual patients among different health care institutions or unaffiliated providers. The use of an electronic medical record system by a health care provider, by or within a health care institution or by an organized health care arrangement as defined by the federal Health Insurance Portability and Accountability Act of 1996 does not constitute a health information exchange;

D. "limited insurance" means a limited-benefit policy that is intended to supplement major medical coverage, including vision, dental, disease-specific, accident-only or hospital indemnity-only insurance policies, or that only issues policies for long-term care or disability income;

E. "major medical coverage" means coverage offered under authority of the New Mexico Insurance Code or the Health Care Purchasing Act by a health insurer, nonprofit health service provider, health maintenance organization, managed care organization, fraternal benefit society or provider service organization for hospital and medical expenses. "Major medical coverage" excludes limited insurance;

F. "reporting entity" means:

(1) a person authorized pursuant to the New Mexico Insurance Code as a health insurer, nonprofit health service provider, health maintenance organization, managed care

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organization, fraternal benefit society or provider service organization to offer major medical coverage in the state;

(2) an insurance administrator required to obtain a license pursuant to Chapter 59A, Article 12A NMSA 1978;

(3) a pharmacy benefits manager, fiscal intermediary or other person that is by statute, contract or agreement legally responsible for payment of a claim for a health care item or service;

(4) the state medicaid program operated by the human services department pursuant to Title 19 or 21 of the federal Social Security Act; or

(5) a person that provides coverage pursuant to Part C of, or to supplement coverage under, Title 18 of the federal Social Security Act Amendments of 1965, as then constituted or later amended; and

G. "superintendent" means the superintendent of insurance.

SECTION 3. [NEW MATERIAL] ALL-PAYER CLAIMS DATABASE--REPORTING--RULEMAKING.--

A. By December 31, 2015, the superintendent shall adopt and promulgate rules in accordance with the recommendations of the commission to establish the "all-payer claims database" in the state.

B. The superintendent shall contract with an entity

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with experience in operating a health information exchange in the state to collect, store and maintain data for the database in accordance with state and federal law.

C. Each reporting entity in the state shall report to the entity designated pursuant to Subsection B of this section, for purposes of collection in the database, health care data specified pursuant to office of superintendent of insurance rules for the following purposes:

(1) determining the maximum capacity and distribution of existing resources allocated to health care;

(2) identifying the demands for health care;

(3) allowing health care policymakers to make informed choices;

(4) evaluating the effectiveness of intervention programs in improving health outcomes;

(5) comparing the costs and effectiveness of various treatment settings and approaches;

(6) providing information to consumers and purchasers of health care;

(7) improving the quality and affordability of health care and health care coverage; and

(8) evaluating health disparities.

D. The superintendent shall prescribe, by rule, standards that are consistent with standards adopted by the accredited standards committee X12 of the American national

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standards institute, the centers for medicare and medicaid services and the national council for prescription drug programs and that:

(1) establish the time, place, form and manner of reporting data under this section, including but not limited to:

(a) requiring the use of unique patient and provider identifiers;

(b) specifying a uniform coding system that reflects all health care utilization and costs for health care services provided to New Mexico residents in other states; and

(c) establishing enrollment thresholds below which reporting will not be required; and

(2) establish the types of data to be reported under this section, including but not limited to:

(a) health care claims and enrollment data used by reporting entities and paid health care claims data;

(b) reports, schedules, statistics or other data relating to health care costs, prices, quality, utilization or resources determined by the superintendent to be necessary to carry out the purposes of this section; and

(c) data related to race, ethnicity and primary language collected in a manner consistent with

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established national standards.

SECTION 4. [NEW MATERIAL] ALL-PAYER CLAIMS DATABASE COMMISSION--CREATED--MEMBERSHIP--DUTIES.--

A. By July 1, 2015, the superintendent shall contract with an entity in the state with expertise in health care cost and quality analysis to convene and coordinate the "all-payer claims database commission". By December 1, 2015, the commission shall make recommendations relating to the following:

(1) sources among public and private entities for health care claims data in the state and the manner in which the database may receive data from these entities;

(2) sources of funding for the establishment and operation of a database, including fees for the use of data;

(3) the possibilities afforded in state and other applicable law for a governance structure and an operational entity that will provide for:

(a) the safe collection, management, storage and sharing of health care claims data;

(b) a public-private partnership to manage the database's duties; and

(c) accountability to the public and state government;

(4) criteria for deeming persons eligible to

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receive data from the database and protocols for applying for the use of data;

(5) applications for the data in the database that will achieve the goal of high-quality health care while cutting health care costs; and

(6) entities with which the database may partner to achieve improvements in the quality and cost of health care services in the state.

B. The commission shall meet at least once monthly at the call of the superintendent until December 2015.

C. The commission shall consist of representatives of the following:

(1) the medical assistance division of the human services department, appointed by the secretary of human services;

(2) the behavioral health services division of the human services department, appointed by the secretary of human services;

(3) the public health division of the department of health, appointed by the secretary of health;

(4) the developmental disabilities supports division of the department of health, appointed by the secretary of health;

(5) the corrections department, appointed by the secretary of corrections;

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(6) the university of New Mexico, appointed by the president of the university of New Mexico; and

(7) New Mexico state university, appointed by the president of New Mexico state university.

D. In addition to the commission members appointed pursuant to Subsection C of this section, the commission shall consist of representatives of the following entities, who shall be appointed by the superintendent:

(1) the interagency benefits advisory committee;

(2) the entity with experience in operating a health information exchange with which the office of superintendent of insurance contracts pursuant to Subsection B of Section 3 of the All-Payer Claims Database Act;

(3) each reporting entity in the state;

(4) the New Mexico primary care association;

(5) the New Mexico hospital association;

(6) the New Mexico medical society;

(7) the New Mexico osteopathic medical association;

(8) the New Mexico nurses association; and

(9) a health care consumer advocacy organization.

SECTION 5. [NEW MATERIAL] FEES.--The superintendent shall establish reasonable fees to users of the database to cover the

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costs of administering the database.

SECTION 6. [NEW MATERIAL] CIVIL PENALTIES FOR FAILURE TO REPORT HEALTH CARE DATA.--The superintendent shall establish civil penalties for reporting entities that fail to report health care data as required pursuant to the All-Payer Claims Database Act.

SECTION 7. APPROPRIATION.--One hundred thousand dollars ($100,000) is appropriated from the general fund to the office of superintendent of insurance for expenditure in fiscal year 2016 to cover the costs of establishing the all-payer claims database pursuant to the All-Payer Claims Database Act. Any unexpended or unencumbered balance remaining at the end of fiscal year 2016 shall revert to the general fund.

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SENATE BILL

52ND LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2015

INTRODUCED BY

DISCUSSION DRAFT

FOR THE LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

AN ACT

RELATING TO PUBLIC ASSISTANCE; ESTABLISHING A HUMAN SERVICES DEPARTMENT FEE TO BE IMPOSED ON MANAGED CARE ORGANIZATIONS AND HOSPITALS THAT SERVICE MEDICAID RECIPIENTS TO FUND THE ADMINISTRATION OF A STATEWIDE NURSE ADVICE LINE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] NURSE ADVICE LINE FEE--CERTAIN MEDICAID PROVIDERS--RULEMAKING.--

A. The secretary of human services shall adopt and promulgate rules to:

(1) establish a fee to cover the administrative cost of operating a statewide nurse advice line in the state; and

(2) require that any managed health care plan or hospital that provides health care services to medicaid

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recipients pay the fee as a condition of accepting reimbursement from the state medicaid program.

B. As used in this section:

(1) "hospital" means a facility that is licensed by the department of health and that provides emergency or urgent care, inpatient medical care and nursing care for acute illness, injury, surgery or obstetrics. "Hospital" includes, but is not limited to, a facility licensed by the department of health as a critical access hospital, general hospital, long-term acute care hospital, psychiatric hospital, rehabilitation hospital, limited services hospital or special hospital;

(2) "managed health care plan" means an entity licensed as an insurer, nonprofit health care plan or administrator pursuant to the New Mexico Insurance Code to provide health coverage in the normal course of business; and

(3) "nurse advice line" means a statewide telephonic service that provides callers with access to health care consultation services delivered by individuals licensed in the state as registered nurses or certified nurse practitioners.