MINUTES
for the
SEVENTH MEETING
of the
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE

November 14-15, 2016
Room 321, State Capitol
Santa Fe

The seventh meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on November 14, 2016 by Senator Gerald Ortiz y Pino, chair, at 9:00 a.m. in Room 321 of the State Capitol in Santa Fe.

Present
Sen. Gerald Ortiz y Pino, Chair
Rep. Deborah A. Armstrong
Rep. Miguel P. Garcia
Sen. Gay G. Kernan
Sen. Mark Moores
Sen. Mimi Stewart

Absent
Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis

Advisory Members
Sen. Craig W. Brandt
Sen. Jacob R. Candelaria (11/15)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Howie C. Morales (11/14)
Sen. Bill B. O'Neill
Sen. Mary Kay Papen (11/14)
Sen. Nancy Rodriguez (11/15)
Sen. William P. Soules
Rep. Christine Trujillo
Sen. James P. White (11/14)

Rep. Gail Chasey
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
Rep. Don L. Tripp

(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, Staff, LCS
Alexandria Tapia, Contractor, LCS

Minutes Approval

Because the committee will not meet again this year, the minutes for this meeting have not been officially approved by the committee.

Guests

The guest list is in the meeting file.

Handouts

Handouts and other written testimony are in the meeting file. Handouts can also be found at https://www.nmlegis.gov/Committee/Interim_Committee?CommitteeCode=LHHS.

Monday, November 14

Welcome and Introductions

Senator Ortiz y Pino welcomed everyone to the seventh and final meeting of the LHHS for the 2016 interim. Members of the committee and staff introduced themselves. The morning agenda was set to provide different perspectives on the pharmaceutical industry with input from manufacturers, pharmacists and health insurers.

Pharmaceutical Costs

Jenny Felmley, Ph.D., program evaluator, Legislative Finance Committee (LFC), shared the LFC's "Health Notes" on pharmaceutical costs with the committee, specifically looking at state agency prescription drug spending (please see report for full information). In the years between 2000 and 2012, the country saw a steady but relatively gradual increase in spending on prescription drugs; at the same time, the growth rate of spending from year to year actually declined. The decline was due to a combination of the "patent cliff", which is the expiration of many drug patents at approximately the same time, and lower costs for the generic versions of these drugs. By 2014, spending on drugs increased by more than 11 percent due to few patent expirations, raising prices for both generic and brand-name drugs and expanding use of new high-cost specialty drugs. These specialty drugs can be enormously beneficial and may ultimately reduce medical cost by treating and curing conditions before they become chronic or require costly medical interventions. They include drugs for cancer, hepatitis C and multiple sclerosis. While these advances in prescription drugs are important, they have been very costly for state budgets and have increased the out-of-pocket expenses for insured patients. In fiscal year (FY) 2016, the 10 state agencies that purchased prescription drugs spent a combined total of over $680 million, an almost 54 percent increase from FY 2014.

New Mexico agencies that spend money on prescription drugs have varying structures and serve different populations. However, all of the state agencies reviewed by the LFC report are experiencing each of the prescription drug cost trends, adding to the statewide spending increase. The Human Services Department (HSD) is by far the biggest spender, with over $423 million in FY 2016 spent on prescription drugs for more than 800,000 New Mexicans in the Medicaid program. The Medicaid drug spending from FY 2014 through FY 2016 has risen by 83

percent, with a 212 percent increase in spending on specialty drugs, particularly for hepatitis C. Dr. Felmley noted that the HSD's prescription drug spending patterns are similar to other state Medicaid programs, particularly those that expanded their programs under the federal Patient Protection and Affordable Care Act (ACA). Because the HSD sets payment rates annually based on data from previous years and assumptions about the future, the HSD often ends up paying more than necessary up front and then recovers its overpayments later. There are two ways the HSD balances out overpayments: (1) rebates available through the Medicaid Drug Rebate Program; and (2) recovering overpaid funds from the managed care organizations (MCOs) through risk corridors.

Dr. Felmley highlighted several aspects detailed in the LFC report, focusing on the expansion of the hepatitis C risk corridor. In FY 2015, 451 patients received treatment for hepatitis C, with the average cost of treatment per patient at $81,000. While hepatitis C is at the top of the list of Medicaid's most costly conditions, medical conditions like diabetes, cancer and inflammatory conditions account for large portions of state agency prescription drug spending and are also indicative of the health issues prevalent in the state. The four member agencies — the Risk Management Division of the General Services Department, the Albuquerque Public School District, the Public School Insurance Authority and the Retiree Health Care Authority (RHCA) — together spent approximately $220 million on drug coverage in FY 2016 for about 175,000 school employees, state government employees, state retirees and their eligible dependents. The Interagency Benefits Advisory Committee (IBAC) estimates that it saves approximately $25 million per year through joint purchasing, about $10 million of which is associated with pharmacy spending. Dr. Felmley discussed some the key efforts for cost containment by state agencies. Each of the agencies are pursuing cost-containment options that focus primarily on increasing cost-sharing with their members through some degree of expanded copayments, coinsurance and out-of-pocket maximums. Dr. Felmley cautioned that if drugs become so expensive that health plans and state agencies can only contain their costs by shifting more of the burden to consumers, they do so at the risk of leading their members to cut their own out-of-pocket costs by refusing to fill prescriptions to begin with or by extending drugs by methods, such as skipping doses. If patients are noncompliant with necessary medications due to costs, then the original promise of improved outcomes and cost savings disappears. In general, it appears that solutions to the rising prices of prescriptions drugs through any sort of restructuring of market incentives, patent protections or other means would need to be made at the national level.

Mark Tyndall, executive director, RHCA, talked about the members of the IBAC, of which the RHCA is a member. The IBAC represents around 175,000 members throughout the state with an estimated $220 million in prescription costs. Mr. Tyndall acknowledged the report prepared by the LFC and Dr. Felmley, noting that the report is well-researched and factually correct. IBAC members are self-funded purchasers that use market leverage and utilization management. The IBAC has a partnership with Express Scripts, the largest pharmacy benefit manager (PBM) in the country, with a reputation as a ruthless negotiator with the pharmaceutical industry. Express Scripts has between 85 million and 90 million members. While New Mexico

does not have many members, the state is able to join in some of the same benefits as other large Express Scripts PBM populations, providing a better opportunity for price negotiation. IBAC benefits from Express Scripts' huge mail-order operation and help with prescription rebates from manufacturers and sale of generic drugs.

Mr. Tyndall discussed Express Scripts' utilization management and other benefits offered through the company. Express Scripts processes claims in real time and works on prior authorizations, while offering immediate medication management review for contraindicated prescribed medications and drug interactions. Express Scripts uses step therapy, which requires members to try the lowest-cost alternative before moving on to medications that are more expensive. Mr. Tyndall explained the exclusionary formulary, which began in 2014 and initially placed downward pressure on prescription prices. This tactic was not popular with prescribers and pharmacists. That price trend has since halted, and it is time to begin looking at other possible options. The contract with the Express Scripts ends this year, and the IBAC will be looking to see if any other companies can better meet the needs of the state. Mr. Tyndall added that part of the reason the cost for prescriptions is so high is due to the sheer number of prescriptions individuals are taking; on average, a person has five or more prescriptions. The state needs to begin discussions about the prevalence of larger health problems.

Senator Ortiz y Pino shared a statement by Alex Sanchez, deputy secretary of administration, Corrections Department (NMCD), regarding information incorporated in the LFC report. Over one-half of New Mexico's prison population, or approximately 7,700 inmates, has hepatitis C. The NMCD has spent over $6.5 million on hepatitis C treatments alone, and if it were to treat all individuals with the disease, the cost to the state would be about $250 million.

Nancy Smith-Leslie, director, Medical Assistance Division, HSD, thanked Dr. Felmley for the informative report. Ms. Smith-Leslie noted that 10.4 percent of the total budget for Centennial Care is spent on pharmaceuticals. This is a 14 percent increase on a per-capita basis. The Medicaid dispensing rate in New Mexico is higher than the national average; however, 87 percent of the dispensing rate is for generics. A consulting firm hired by the Texas Association of Health Plans reported that New Mexico was ranked fourth best in net cost for prescriptions. Ms. Smith-Leslie recommended greater flexibility for MCOs to manage pharmaceutical benefits. Each New Mexico MCO has a PBM and a formulary. MCOs have flexibility to negotiate exclusivity provisions for specialty drugs. Around 14,000 Medicaid members have hepatitis C; the state cannot afford to treat this entire population, but it has a strategy to treat 1,750 each year. The previous year, more than 400 people were treated at a total cost of $32.6 million. With rebates, the cost of the new hepatitis C drug has decreased from $70,000 to $50,000 per patient; the cost of the medication is also decreasing. Everyone except those with the mildest forms of hepatitis C is being treated by Medicaid. The HSD is trying to be conservative, but it is also mindful of cost avoidance. Additionally, the HSD is working to avoid any potential class actions lawsuits, which can be extremely costly for the state.

Following the presentation about pharmaceutical costs, the committee discussed the following points:

- medical care provided by other states to their prison populations;
- the potential for 340B pricing for treatment of HIV/AIDS, and the use of the Minnesota purchasing collaborative;
- the importance of correct usage of medication for health and cost containment;
- rebates in Medicaid;
- the impact of eliminating the retirement fund for state employees in light of the current state budget crisis;
- prioritizing treatment for patients with hepatitis C and ongoing research of the disease;
- the cost of drug treatments outside the United States;
- the approval process for generic drugs through the U.S. Food and Drug Administration (FDA) process;
- the negotiation process for MCOs; and
- the need for incentives for cost containment by MCOs.

Pharmaceutical Manufacturers

Saumil Pandya, senior director of policy and research, Pharmaceutical Research and Manufacturers of America, responded to some of the statements made by the previous panel. Mr. Pandya noted that there is a difference between the net price and the list price, and when rebates are taken into account, the actual cost increases are not as high as they appear. Mr. Pandya explained how manufacturers set a list price and that is the starting point for negotiation, similar to the sticker price on a car. Cost-sharing is based on the list price of the drug, and the consumer pays the full list price as part of the deductible. The rebate is given to the insurance company, so the patient is not getting the benefit of the negotiated rates. Consumers are seeing the growth in the list price, but that is not the real cost. What has changed, however, is more awareness by consumers of the list price.

Prescription drug costs account for about 10 percent of the total health care expenditures in the United States. Physician- or hospital-administered drugs add an additional four percent. Spending on prescription drugs is increasing, but so are the rest of health care costs. As a share of total health care spending, spending on prescription drugs is staying constant. Mr. Pandya informed the committee that the consolidation of practices in hospitals was intended to institute practice guidelines and dictate structure; but in reality, hospitals have the highest cost for care. Medicaid has a price increase cap: a statutory rebate of about 23.1 percent for name-brand products and 13 percent for generics. Medicaid also gets the best price in the market; the net overall rebate in Medicaid is 60 percent off the list price. Fee for service is a very small part of Medicaid.

In regard to who funds research, Mr. Pandya said that the federal government conducts the research of pharmaceuticals through the National Institutes of Health (NIH). The NIH's

entire budget for 2013 was $30.8 billion, a large potion of which is not research. In 2015, pharmaceutical companies spent $58.8 billion on research alone. The industry is extremely high-risk, with only 30 percent of products making it to drug trials and only 12 percent of those products actually making it to market. It can take up to 10 years for a product to get through the FDA process. Competition exists not only with the release of generics but also among brands. Currently, there is no market to develop drugs for rare diseases and conditions. Mr. Pandya emphasized the overall impact of hepatitis C on not only medical expenses and resources, but also the number of lives lost to the disease. There are significant cost savings in reducing the number of individuals needing liver transplants, and great work is being done in the industry to expand treatment options.

PBMs

Mark Wermes, vice president, Public Sector Clients, Express Scripts, provided the committee with some background on the pharmaceutical benefits industry. Express Scripts has about 35 different state health plans and is the largest PBM in the country, serving more than 85 million members. Mr. Wermes stated that Express Scripts takes a lot of actions to reduce costs. The company was the first PBM to get hepatitis C drug prices reduced by rebates. Prices in the United States for this drug are better than those in the United Kingdom. Express Scripts develops a formulary and works with pharmacy networks. All independent pharmacies are allowed in its network, which has helped these pharmacies stay in business. Partnerships with independent pharmacies are transparent, and Express Scripts works to pass 100 percent of discounts and rebates on to the clients. Express Scripts has a fixed administrative fee, with only one source of margin on generics in the mail-order pharmacy.

Pharmacists

Minda McGonagle, government relations, New Mexico Pharmacy Business Council (NMPBC), shared with the committee how independent pharmacies fit into the overall industry. The NMPBC is an advocacy arm of Texas-based American Pharmacies, an independent pharmacy cooperative with more than 600 stores in Arizona, New Mexico, Oklahoma, Louisiana and Texas. The mission of the NMPBC is to advance and defend the business model of New Mexico independent pharmacies by making lawmakers and policymakers aware of the critical health care and economic contributions that independent pharmacies make to communities and the growing challenges of that role. Pharmacists are often the only health care available to rural New Mexicans, who have limited access to physician care. Independent, or community, pharmacists typically spend more time with patients than do their chain counterparts; they counsel patients on medications and chronic health conditions, give immunizations and offer referrals to physicians for treatment, when necessary. Ms. McGonagle provided the LHHS with a handout detailing some the issues and challenges that members of the NMPBC are facing and how they hope to evolve with the industry as it changes. The NMPBC has no current legislation requests but will be looking at legislative proposals to address some of the issues facing independent pharmacies in the future. Ms. McGonagle added that the goal of the presentation is to provide an overview of what independent pharmacists have done historically, what they currently do and where they would like to go in the future. Community pharmacists help lower

the overall costs of health care by going beyond filling medications. Prescription drugs are a tool to help patients stay healthy, but another value of the service is working with and engaging patients to improve outcomes.

Danny Cross, owner, Southwest Pharmacy, stressed the important role community pharmacies play by ensuring that individuals are using prescriptions properly. Community pharmacists are the front line for checking for adverse drug interactions, identifying problems and working with patients to solve any issues. Mr. Cross noted that the effectiveness of medications relies heavily on individuals taking them appropriately; community pharmacies can and do play a major role in that. Approximately 30 percent of prescriptions around the country are filled by independent pharmacies. Southwest Pharmacy in Carlsbad employs about 40 people in Eddy and Lea counties and is very involved in the community. Mr. Cross stated that the pressures he sees from PBMs make it more difficult to do business as an independent pharmacy. Independent pharmacies are excluded from contracts, and pricing is set by PBMs. Independent pharmacies do receive a dispensing fee, but that is the only compensation they receive. There is a set fee for prescriptions, regardless of what it costs the pharmacists to purchase. As a small business owner, Mr. Cross finds it difficult to sustain operations because networks are constantly restricting patients' use of independent pharmacies, resulting in a loss of business. Mr. Cross added that there are also new quality initiatives from PBMs to reward and penalize pharmacists. These are retroactive adjustments that can go back for up to 30 days.

R. Dale Tinker, executive director, New Mexico Pharmacists Association, acknowledged that New Mexico's good ranking for cost containment is due in large part to the efforts of community pharmacies. New Mexico's Medicaid data illustrate that the overall pharmacy generic substitution rate is 85 percent. With the exception of 2007, New Mexico has had the lowest cost for prescriptions for the past 12 years. The state has been a leader in pharmacists providing clinical care since 1993, with the passage of the advance practice pharmacist law. Pharmacists' prescribing protocols were added statutorily in 2001, and there are currently five approved protocols: immunization; tobacco cessation; emergency contraception; tuberculosis testing; and naloxone (an opioid antagonist). There is an opportunity for the legislature to recognize the significant contributions to patient health and to cost containment that pharmacists provide to health care in New Mexico through the support of proposed legislation for pharmacist clinical services reimbursement. The proposed legislation was included for the committee, and Representative Armstrong agreed to carry the bill in the 2017 regular session.

In response to the presentation, the committee addressed the following topics with the panel of pharmacists:

- price-setting of prescription drugs at independent pharmacies;
- limitations by health plans on using independent pharmacies;
- inquiries about the proposed legislation;
- the status and implementation of previously passed medication synchronization legislation;

- successes of independent pharmacies in providing patient care;
- mail order versus retail sales of pharmaceuticals;
- the increasing mandated use of mail-order delivery;
- concern over waste of medication following hospice care;
- a description of how medication adherence is measured;
- the importance of supporting independent pharmacies, particularly in rural areas;
- a network adequacy evaluation to include pharmacies;
- price comparisons; and
- potential future legislation and regulation to address some of the other issues facing independent pharmacies.

Health Insurers

Louanne Cunico, pharmacy director, Presbyterian Healthcare Services (PMS), discussed the escalating costs of pharmaceuticals and what tools insurance companies have to manage those cost increases. Since 1998, Medicaid has had closed formularies. PMS uses traditional care and pharmaceuticals that are clinically effective, while approving prior authorizations and conducting network negotiations. The insurance company can no longer cut reimbursement rates to pharmacies. Ms. Cunico believes that the only alternative to cutting costs is to look at health conditions that are the biggest spenders for pharmaceuticals: diabetes; rheumatoid arthritis; and multiple sclerosis. Giving the example of diabetes, Ms. Cunico stated that even a 25 percent rebate does not justify retail drug cost increases. The solution is finding other methods of managing these patients by working with providers and practitioners. Most health plans have difficulties managing patients with hepatitis C. Companies want to ensure that patients are taken care of, but they also need to be sure that treatment is being approached in a cost-effective manner. Less than one percent of the total number of written prescriptions are for specialty drugs, yet they account for the largest share of the costs to health plans. Health plans have done all they can to reduces costs from their side. The next step in addressing cost is knowing how much pharmaceutical companies are spending on marketing products.

Frank B. Koronkiewicz, pharmacy director, Molina Healthcare of New Mexico, is a third-generation pharmacist who now works for Molina. Molina serves around 232,000 members of the Medicaid population in New Mexico. Molina is located in 11 other states, and in comparison, Mr. Koronkiewicz noted, Centennial Care and the HSD do a good job of administering the program. The HSD allows Molina to do its job without being overly prescriptive or mandating rules and requirements like in other states. Molina has the ability to create its own preferred drug lists and maintain its own provider network. Rebates are only available for brand-name pharmaceuticals, and over 89 percent of prescriptions filled in New Mexico are generic; therefore, concentrating on rebates will not get the lowest net cost. Mr. Koronkiewicz explained supplemental rebates, clarifying that in order to receive a rebate, manufacturers want a greater market share. For that reason, Molina often forgoes the supplemental rebate. Approximately 50 percent of supplemental rebates through Molina are on test strips for blood glucose, not pharmaceuticals. By federal law, rebates are collected by the HSD.

Mr. Koronkiewicz addressed hepatitis C treatment and what Molina is currently doing in cooperation with the HSD. While Molina is attempting to treat as many cases as possible, the approach has been to treat the worst cases first, based on the level of fibrosis. Cost is not the only barrier to treatment; there is also a lack of providers to treat these patients. There are not enough prescribers in the state. Molina does support community pharmacies and uses mail-order services sparingly. Due to the tendency for the Medicaid population to move around and the large number of homeless members, Molina does not believe that mail order is an appropriate service. Beginning in 2017, Molina will be instituting the filling of 90-day supplies of medications at community pharmacies. This practice helps ensure medication adherence, which is an important component of disease management. Molina goes to great lengths in this area, particularly with medications for hepatitis C. Molina contracts with University of New Mexico (UNM) Hospital for medication therapy management.

Martin Hickey, M.D., executive director, New Mexico Health Connections, presented a recent course on the ACA at UNM. Dr. Hickey suggested that to understand why health care is so expensive, one must follow the money. Many concerns have been raised about what the recent presidential election means for health care and the ACA. Prior to the election, there was an inability to fix some parts of the ACA, but cost increases soared due to individuals with advanced conditions receiving coverage for the first time. Over 90 percent of the increases in premiums are a result of specialty drugs. According to Dr. Hickey, the United States is the only country that lacks oversight in the area of drug pricing. Inpatient costs are undoubtedly decreasing, while outpatient costs are on the rise. Nationally, more than 29 million people have diabetes. The treatment cost for this disease is over $245 billion. This cost is expected to rise 20 percent over the next several years. The average consumer is paying for these increases of specialty drugs in their premiums and in their tax dollars. President-Elect Donald Trump proposed expanding the high-risk pool, which is necessary to reduce the cost of health insurance. There may also be consideration of legislation or regulations to re-import pharmaceuticals back into the United States that have been approved for use. The pricing of drugs in the United States is well beyond what they are sold for in the rest of the world.

Mark Epstein, M.D., chief medical officer, New Mexico Health Connections, acknowledged that games are being played in the pharmaceutical industry. The business model has been built upon monopolistic behavior and then pacification. Dr. Epstein explained that when a patent is about to run out, there are minor changes made to extend the life of the product's patent. Products like EpiPen have a monopoly on the medication, disallowing competition and resulting in pricing that is uninhibited. Dr. Epstein calls for greater transparency for patients, clinicians and physicians. There is a frequent lack of clarity about who is paying for what. He added that coupons are used by drug companies as a method of steering business toward particular products. Health plans have done what they can to reduce costs; the last hurdle is addressing pharmaceutical costs, particularly those of specialty drugs.

On questioning, the health insurer panelists and the committee members discussed the following topics:

- the need for price transparency;
- the estimated impact on New Mexico from the potential dismantling of the ACA;
- the need to fund school-based health centers and the availability of long-acting reversible contraceptives (LARCs);
- the increase in demand for LARCs following the presidential election;
- challenges with electronic records, reporting and data tracking;
- criteria consistency among New Mexico's four MCOs for hepatitis C treatment;
- the cons of using rebates for pharmaceuticals;
- the respective roles of the state and the federal government in addressing issues related to the pharmaceutical industry; and
- the overall need for regulation in the pharmaceutical industry.

Consumers and Providers on Pharmaceutical Costs

Betsy Imholz, special projects director, Consumers Union, gave a presentation to the LHHS via videoconferencing about the consumer perspective on rising prescription drug prices. Consumers Union is the policy and advocacy arm of the nonprofit *Consumer Reports* magazine (see handout for full remarks). The United States still pays the most for health care among high-income countries but has worse outcomes. A *Consumer Reports* survey from March 2016 shows that when people are hit with higher drug costs, they are more likely to take unhealthy steps, such as skipping doctor appointments, tests and procedures; not filling their prescriptions; or not taking prescriptions as directed. Even individuals with insurance are experiencing challenges with high-deductible plans and rising out-of-pocket costs imposed by insurers. Beginning in 2014, there was a spike in spending on prescriptions due to growth in brand-name drug prices, the emergence of new brand medications and moderate growth in generic drug prices. Specialty drugs are the primary driver of recent drug spending; the pricing trend for specialty drugs jumped from 14.1 percent in 2013 to 30.9 percent in 2014. Part of the issue is that policymakers and the public are largely unaware of how drug prices are determined. There is publicly available data on research and development (R&D) costs; however, 38 percent of all basic science research is paid for with tax money through federal and state governments. The share spent on R&D by pharmaceutical companies is not publicly known. It is also important to compare R&D expenditures by private companies to marketing costs for particular drugs. A 2014 report from GlobalData found that nine out of 10 major pharmaceutical companies spent more on marketing than on R&D. The lack of transparency around the real pricing of drugs needs to be addressed.

Ms. Imholz provided several examples of drugs whose costs have been left completely unchecked, leaving consumers without any options but to pay the list price or take riskier measures. One such product is the EpiPen, which has risen in price by nearly 550 percent since 2007. There are two approaches that could be taken to contain drug prices, according to Ms. Imholz. The first is to make the currently dysfunctional marketplace work by creating true competition. This would require transparency around costs and curbing monopoly power in the market. An additional approach would be greater government intervention in pricing through direct government negotiation with drug manufacturers, formulary creation and exercising "march-in rights" for essential medicines, or price setting. The conversation about drug pricing is

beginning to occur at both the state and federal levels. While many approaches to addressing underlying costs require federal action, some things the states can do include: (1) pressing New Mexico's congressional delegation to take action at the federal level; (2) requiring transparency by drug manufacturers regarding how drug prices are set; (3) creating an independent entity to review prescription drug effectiveness and oversee pricing, or joining with other states or purchasers that have one, and empowering the entity to challenge price gouging; and (4) enacting consumer protections, such as capping out-of-pocket monthly expenses and requiring fair formulary designs that do not discriminate against particular conditions and keep medications affordable. Ms. Imholz emphasized that in a wealthy nation, consumers should not have to choose among paying the rent, putting food on the table or getting medications they need to cure or control health conditions.

Betty Chang, M.D., member, American College of Physicians, shared her perspective as a physician on prescription drug pricing. Prescription drug costs have steadily risen since 2012, and the trend will continue. Patients are bearing the cost burden, with approximately 18 percent of patients paying out of pocket. Like a few of the previous presenters, Dr. Chang noted that many patients choose not to take medications or skip doses due to the steep cost. The EpiPen is a prime example of patients avoiding proper dosages due to cost. With a price of over $600 per dose, patients frequently wait to decide if the reaction is bad enough to justify using the lifesaving medicine. Dr. Chang stated that she is regularly having conversations with patients who have to decide between paying their rent or filling a prescription. The majority of patients do not know how to shop around for prescriptions. A good tool is the download GoodRX, which allows consumers to compare prices of medication through various pharmacies, which can fluctuate. Dr. Chang agreed with the importance of greater transparency in the industry, adding that policies to increase competition could help reduce costs.

Dick Mason, Health Action New Mexico, shared several stories of patients grappling with price increases on lifesaving medications. These stories included an individual unable to afford epilepsy medication and a parent trying to pay for prescriptions for a medically fragile child. Mr. Mason noted that these are frequent struggles for everyday New Mexicans. He stated that New Mexico Health Connections is in good shape and running well. One area of concern is the escalating cost of inpatient care due to the cost of drugs being nearly double when prescribed in the hospital. The number of generic manufacturers has also decreased as companies are being consolidated. Mr. Mason mentioned several pieces of legislation relating to price transparency for pharmaceuticals, including one that will be introduced during the 2017 regular legislative session. A bill passed by the legislature in 2013 authorized the Office of Superintendent of Insurance (OSI) to regulate PBMs. The issue with this bill was the lack of funding, which prevented its implementation. Mr. Mason believes this would have been helpful had the funding component been available. The formation of the New Mexico Coalition for Affordable Pharmaceuticals is currently under way and will hopefully begin addressing some of these issues.

In response to committee members' questions, the following points were discussed by the panel:

- pharmaceutical companies spend more money on advertising than R&D;
- there is a growing movement among physicians against marketing and a recent trend by pharmaceutical companies to gear advertising toward consumers;
- the United States is one of only two countries that allows advertising for pharmaceuticals; the other is New Zealand;
- a decision by UNM to end the practice of giving out drug samples to influence consumer usage habits, especially since samples are frequently the newest and most expensive drugs;
- a need for action to address these issues at the federal level;
- calls for transparency as a nationwide movement;
- the potential for notification of price increases at the state level or by the PBMs;
- examples of other businesses or corporations, such as public utilities, required to share proprietary information;
- the lack of transparency around the real price of drugs, making it difficult to identify the real cost savings;
- the potential for capping out-of-pocket monthly expenses;
- physicians are unable to do the extensive paperwork required for assistance programs due to existing administrative burdens;
- limits by the state on MCOs for changes during a plan year; and
- an inquiry about laws in other states to guarantee the availability of drugs on the formulary.

Minutes Approval

Upon a motion by Senator Stewart, seconded by Representative Armstrong, the committee considered the minutes from the fifth meeting of the LHHS in Farmington. After discussion, a member noted a spelling error in the name of a presenter. Without further objection, the minutes were adopted as amended with the name change.

PBM Regulation

Andy Romero, director, Consumer Assistance Bureau, OSI, believes there are about 180 companies that may be identified as PBMs in the state. The OSI is working to get as many companies licensed as possible, but that is limited by statutory regulation. Lois Petro, staff counsel, OSI, has done some analysis of what other states are doing in regard to licensure of PBMs. Only two states leave oversight of PBMs to their pharmacy boards. Since 2014, 30 companies have been licensed. Out of 100 companies, 15 claim they are not PBMs and, therefore, are not subject to the Pharmacy Benefits Manager Regulation Act. The OSI will continue to research these companies and send out another communication to remind them that they need to be licensed. If they remain out of compliance, they will be referred to the OSI's investigations bureau for further action.

A member of the committee expressed concern that information would not be gathered in time to make legislative adjustments in the upcoming session. Ms. Petro noted that there is no

designated staff for this effort, and regulation is typically complaint-driven. The OSI will be working to establish procedures, particularly those for complaints, to make sure regulation is fair and transparent. Another member requested that this issue be made a top priority to avoid budgetary concerns. Mr. Romero added that he is worried that pharmacies are doing business with unlicensed PBMs, and because the OSI does not regulate pharmacies, it is limited on what action it can take. The OSI was requested to indicate in its budget request what would be needed to ensure proper staffing to address PBM regulation under the act.

Public Comment

Barbara K. Webber, Health Action New Mexico, thanked the committee and the public for their commitment to addressing the issue of pharmaceutical costs and urged committee members to continue to pursue the issue. Addressing this issue is important for consumers and patients, particularly for a state with high poverty rates. Ms. Webber stated that she is approaching the age of 80 and is currently taking very few medications, yet her costs for medications alone are over $50,000 per year. She views herself as an average consumer. Ms. Webber has a skin condition and is currently taking biologics as part of a clinical trial. She testified that this medication has been a lifesaver for her. Drugs like these are very important to patients, but so many people cannot afford them. The number of life-changing pharmaceuticals that actually make it to market needs to be looked at more closely.

Liz Thomson, a former state representative, noted that consumers do not go into a grocery store without knowing the cost of products, yet the pharmaceutical industry is different. Consumers are frequently forced to go to one place for something they need and, at times, cannot live without, and they pay an unknown price. She believes advertising of pharmaceuticals is misleading and encourages patients to inquire about specific brand-name drugs during doctor visits. Ms. Thomson's son is on Medicaid through the developmental disabilities (DD) waiver. Now that he is 26, he is no longer eligible for his family's private insurance policy. Ms. Thomson added that when private insurance turns down his treatment, so does Medicaid. It is less beneficial for the family to keep him on private insurance, even though it is a savings to the state.

Carol Maestas testified again before the committee, requesting that Rett syndrome be added as a qualifying condition for the DD waiver. Rett syndrome, which primarily affects girls, used to be classified under the autism spectrum but has been removed. The cost to care for individuals with Rett syndrome is astronomical and places a heavy burden on working-class families, even with insurance. Ms. Maestas pursued the DD waiver in the past for her granddaughter and was told that the child was not yet sick enough to qualify. Her goal is to prevent her granddaughter and other children from becoming sick enough by getting them the early intervention and treatment they need before their condition progresses. Senator Michael Padilla, who carried a memorial to that effect in 2016, has requested the drafting of another memorial for the upcoming session asking the Department of Health (DOH) to consider the condition for DD waiver eligibility. A member of the LHHS asked about the fiscal impact of adding Rett syndrome and inquired about a letter to the DOH requesting more information on the

number of individuals this would affect. Ms. Thomson noted that the real issue is the long waiting list for the DD waiver. The wait list is well over 10 years out and currently has more than 6,000 individuals waiting for services. Individuals with Rett syndrome would likely already qualify for the waiver based on their symptoms, but there are no waiver slots available.

Mr. Mason briefly addressed concerns regarding the ACA under the new presidential administration. Mr. Mason plans to request a memorial about the impact the potential repeal of the ACA would have on New Mexico.

Recess

The first day of the LHHS meeting recessed at 4:25 p.m.

Tuesday, November 15

Welcome and Introductions

The LHHS meeting reconvened at 8:58 a.m.

2016 New Mexico Health Care Workforce Committee (NMHCWFC) Report

Richard Larson, M.D., chair, NMHCWFC; and executive vice chancellor, UNM Health Sciences Center (HSC), presented to the LHHS the organization's final report, which includes findings and recommendations (please see handout). The Health Care Work Force Data Collection, Analysis and Policy Act was passed in 2012, requiring licensure boards to develop surveys on practice characteristics. According to Dr. Larson, New Mexico is the only state that tracks health care provider needs within a state. The act was unfunded and to date has not received any funding. Licensure data are directed to UNM HSC for stewardship and storage; confidentiality of data is strictly enforced. Dr. Larson highlighted some of the accomplishments since 2013, primarily the NMHCWFC's role in enhancing funding for various program expansions and workforce positions. The creation and development of New Mexico's telehealth services (Project ECHO) has helped to meet needs around the state. As of December 31, 2015, New Mexico has 9,382 licensed physicians; 1,995 certified nurse practitioners (CNPs) and clinical nurse specialists (CNSs); and 1,293 practices. There has been an increase of 441 practicing medical doctors and 65 CNPs/CNSs since 2014. Dr. Larson explained that not all of the physicians licensed in the state practice here — licensing fees are cheaper in New Mexico than in other states.

Dr. Larson noted that the 2015 survey of medical doctors implemented by the Regulation and Licensing Department (RLD) omitted the item asking for physicians' specialties. It is critically important that the specialties question be reinstated for future years to allow for robust year-to-year comparisons. At Dr. Larson's request for committee assistance with the matter, a member of the committee requested that LCS staff draft a letter to the RLD urging it to reinstate this component of the survey.

A breakdown of the distribution of New Mexico primary care providers was delivered to the committee, and Dr. Larson noted areas of deficiency. Lea County is currently the worst in the state for availability of providers, lacking 21 physicians, 13 CNPs/CNSs and 13 physician assistants (PAs). Since 2013, there has been an overall increase in the number of providers actually practicing in the state. However, the rates are still low — only 65 percent of licensed CNPs are currently practicing. Practitioner shortages are most severe in less-populated counties. Without redistributing the current workforce, New Mexico needs 124 primary care physicians, 36 obstetricians and gynecologists, 18 general surgeons, 109 psychiatrists, 201 CNPs/CNSs, 128 PAs, 67 dentists and 292 pharmacists. One future issue to consider is the fact that New Mexico has the highest percentage of physicians in the nation over the age of 60.

Dr. Larson addressed the status of behavioral health in New Mexico, stating that the behavioral health workforce is in crisis. Limited resources in the state mean limited capacity. There are poor training opportunities surrounding evidence-based therapies and recovery and resiliency. The state is also lacking a targeted workforce recruitment and retention strategy. While New Mexico's rates of behavioral health disorders are similar to the national average, the consequences are frequently more severe. The suicide rate is 59 percent higher than the national rate, and the drug overdose rate in the state is 96 percent higher. The NMHCWFC has several recommendations from its 2016 report that Dr. Larson shared with the committee.

For all health professions:

A. correct the recent omission by the RLD of the practice specialty item from the physician online license renewal survey platform;

B. enhance the PA survey with an added practice specialty item. PAs either go into primary care or surgical specialty, and it would beneficial to track that information;

C. maintain funding for the loan-for-service and loan-repayment programs at their current levels;

D. restructure loan-for-service and loan-repayment programs to target the professions most needed in rural areas;

E. continue funding for expanded primary and secondary care residencies in New Mexico;

F. support further explorations of Medicaid as an avenue for expanding residencies in New Mexico;

G. obtain federal matching funds for loan repayment; and

H. provide funding for the NMHCWFC.

For behavioral health:

A. expedite professional licensure by endorsement for social workers, counselors and therapists. The state would benefit from stronger reciprocity with other states. Due to the lack of providers in some areas of the state, telehealth can aid in the mentoring needed prior to licensure;

B. explore opportunities to leverage federal funding for the New Mexico Health Information Exchange and adoption of electronic health records for behavioral health providers;

C. convene a planning group to develop a statewide telehealth infrastructure to deliver behavioral health services via telehealth to rural communities;

D. add social workers and counselors to the professions eligible for New Mexico's rural health care practitioner tax credit. Pharmacists, therapists and social workers are left out of the current program;

E. identify funding for efforts to support and prepare candidates from diverse backgrounds to complete graduate degrees in behavioral health fields; and

F. support Medicaid funding for community-based psychiatry residency programs in federally qualified health centers (FQHCs). Historically, FQHCs have not been involved in behavioral health care due to billing complications.

Following the presentation, members of the committee discussed the findings and recommendations presented by Dr. Larson. Some key points addressed were:

- the current availability of loan-repayment programs in the state and the potential for federal match funding and expansion;
- the need for reciprocity for all health providers, including social workers, therapists and counselors;
- funding and staffing needs for the NMHCWFC — $250,000 and two full-time employees;
- the potential for more detailed and specific data with additional funding and support;
- the cost of funding resident programs;
- an inquiry about reports of pharmacists graduating but not passing certification;
- the deficiency in the number of providers in parts of the state, particularly the southern region and rural areas;
- challenges with recruitment and retention;
- legislative needs to address some of the recommendations, specifically expediting licensure;
- tracking information for licensed nurse-midwives as a separate data set;
- discrepancies with data reported by MCOs and the need for unbiased reporting for accurately assessing needs in the state;
- creative initiatives by counties to build capacity and encourage professionals to remain in communities following residencies;
- the expansion of FQHCs into behavioral health;
- Senate Memorial 28 (2016) and a recommendation against the program's implementation (see report); and
- a request for draft legislation that includes counselors, social workers and pharmacists in the rural health care practitioner tax credit program.

Kinship Guardianship Report

Liz McGrath, executive director, Pegasus Legal Services for Children, introduced several individuals in the audience representing different organizations of grandparents from Espanola, Rio Rancho and Albuquerque. Pegasus Legal Services for Children provides services to

grandparents raising grandchildren. Ms. McGrath explained that grandparents frequently care for children who would otherwise end up in foster care if it were not for their families. This practice, she explained, is often referred to as "shadow foster care". Unlike the traditional foster care system, grandparents taking in children do not receive any of the help or support that licensed foster parents receive. Resources and assistance for grandparents raising grandchildren are provided through numerous systems, and agency staff are not trained to serve grandparents. These situations affect systems like health care and schools. When grandparents attempt to enroll their grandchildren in school, they are sometimes turned away, even though federal law guarantees these children the right to be enrolled immediately. Children in these circumstances are considered to be "homeless". There are often legal issues and expenses involved in these situations. Children at risk for abuse and neglect sometimes fall into the gap between the requirements of the Kinship Guardianship Act and the Children, Youth and Families Department (CYFD) requirements for taking a child into protective custody. Several states are implementing programs known as "supportive diversion", which avoid the placement of children in foster homes and instead place them with family members.

House Memorial 8 (2015), later extended by Senate Memorial 1 (2016), requested the creation of a task force to study the needs of grandparents raising grandchildren and to make recommendations to the legislature regarding needs for increasing resources and assistance. Ms. McGrath presented the task force's report from the last few years of work (please see handouts), adding that the task force hopes to continue this work. She acknowledged help from the CYFD and the Aging and Long-Term Services Department (ALTSD) in this effort, but she noted that neither agency endorses the recommendations. Ms. McGrath recognized the current state budget situation and requested that further cuts to ALTSD programs that support grandparents be avoided. The following legislation is being proposed to address the needs of grandparents raising grandchildren.

Services and supports for grandparents raising grandchildren. This proposed bill is an appropriation to the ALTSD for $200,000 to create a statewide network of services and supports for grandparents, including general support services, parent training, support groups, case management, social activities and enrichment activities for children.

Revising Section 40-10B-15 NMSA 1978 — Caregiver's Authorization Affidavit. The proposed bill would add enrollment in early intervention services, daycare, Head Start and preschool programs to the caregiver's authorization affidavit to ensure that these vulnerable children have access to vitally important services.

Revision of NMAC 8.15.2.1 — Requirements for Child Care Assistance Programs for Clients and Child Care Providers. This bill would amend the New Mexico Administrative Code to allow grandparents raising grandchildren to obtain child care assistance benefits without regard to their income and without regard to their status as legal guardian of the child.

Renewal of the Task Force on Grandparents Raising Grandchildren for FY 2018. The members of the task force requested the extension of the task force for an additional year to continue to study and recommend concrete policy changes that could be implemented to expand the availability of resources and assistance to grandparents raising grandchildren.

Public Comment

Delphina Romero of Las Cumbres Community Services shared a story about the lack of support around the state for grandparents assuming the care of their grandchildren. This issue is occurring throughout the state, and she would like to see services available statewide. Support groups for grandparents are growing because the need exists. Some groups have up to 30 grandparents and grandchildren at a time, and the need for legal services and subsidies is very common. Ms. Romero added that grandparents are often caught between the needs of the children and the wishes of the parents.

Lupe Salazar from Espanola has two granddaughters that live with her. Las Cumbres Community Services was the only place that helped her when she began caring for them. Ms. Salazar stated that she never imagined she would be in this situation of raising children all over again. She is unable to get a job because of the children's needs and is also unable to afford daycare so she can get a job because she is currently unemployed. Ms. Salazar recently qualified for Supplemental Nutrition Assistance Program (SNAP) benefits. Because she is not yet 55 years old, she does not qualify for respite services through Las Cumbres Community Services. She stated that she loves her grandchildren, but she needs support taking care of them.

Connie Compton has been raising her grandson, who is now 17, since he was a baby. She found a support group when he was seven years old and it made a tremendous difference. Ms. Compton shared that the child's mother was a substance abuser, and he suffered a lot of trauma. Many of these children experience trauma and have behavioral and mental health issues. A lot of these groups are privately funded. When they run out of funds, they are frequently disbanded. Ms. Compton noted the changes in parenting and how that adds to the challenges. There is a great need for a statewide initiative to address this issue. Information and resources for grandparents exist, but it would be helpful to have a clearinghouse created. One example Ms. Compton relayed was the fact that her grandson was eligible for Medicaid, but she was unaware of the benefit.

Betsy Stilton from Albuquerque stated that it is essential not to cut funding for legal services. Grandparents suddenly become parents again without much warning or preparation for it. Ms. Stilton's daughter died from an overdose, and she assumed care for her grandchildren. Each of the children had different fathers, and legal services were critical. There is a need for a statewide network of available services. When the CYFD or police officers present grandparents with a child, they should also provide them with a folder containing information about how to access services and what resources exist for them. Ms. Stilton noted that Bernalillo County does some of this, but she is concerned about rural areas of the state and the limited resources for those grandparents.

Beth Pacheco of Espanola is caring for three grandchildren between the ages of six and 12. The grandchildren came into her care through the CYFD, which was a long process. Ms. Pacheco received support for the children during the process, but once she formally adopted them, she lost those services. The children no longer qualify for free lunches or Medicaid. In addition, she now has expenses for things like clothing and school supplies. Ms. Pacheco stated that any support the legislature could provide would be appreciated.

Tammy Gray, a caseworker at Methodist Children's Home in Albuquerque, helps provide family outreach. Ms. Gray wants to bring a voice to children who are often in the process of losing parents to incarceration, death or overdose. It is essential for communities to support the grandparents raising the next generation. Ms. Gray stressed the importance of putting and keeping programs in place.

LHHS members thanked the speakers for sharing their experiences. A few members expressed interest in sponsoring legislation proposed by the task force. In response the presentation, the committee discussed the following points with Ms. McGrath relating to kinship guardianship and grandparents raising grandchildren:

- a need for greater efforts by the CYFD to maintain family connections for children;
- a need for better training of employees at the CYFD and ALTSD in handling these situations;
- an awareness of the potential behavioral health issues and the trauma experienced by these children;
- programs and initiatives by other states to offer subsidies and support;
- the ability of the task force to assemble informational packets and determine the contents;
- inquiries about supportive diversion;
- a request to the CYFD for the total number of children placed with grandparents;
- recognition of existing services and the need for a clearinghouse or directory;
- coverage of existing funding for legal services through the ALTSD;
- the difficulty in recruiting contract attorneys in some counties and suggestions for advertising;
- the need for more individuals designated at the Public Education Department to handle homeless children;
- the frequency of children being unable to participate in school activities and athletics due to a lack of guardianship; and
- the need for additional efforts to encourage these children to stay in school.

Disabilities Concerns Subcommittee (DCS) Minutes

There being a quorum of voting members of the DCS, subcommittee members considered the minutes from their fourth meeting, on October 7, 2016. Following a motion for adoption by Representative Garcia, seconded by Senator Lopez, the minutes for the DCS were adopted without any objection.

Preliminary Findings on Sexual Assault Evidence Processing Audit

Timothy Keller, state auditor, provided an update on the processing of sexual assault evidence kits. New Mexico is forty-eighth in the nation when it comes to the frequency of sexual assaults. One in every four women and one in every 10 men may experience an attempted or completed sexual assault. In December 2015, the Department of Public Safety (DPS) organized a task force to look at the issue of untested evidence kits. Throughout the state, there were approximately 4,500 untested kits; the current count is closer to 5,000. The DPS was unable to get responses from some departments around the state. The state crime laboratory has been processing kits with the help of legislative funding and some outside funding. State Auditor Keller informed the committee that the Office of the State Auditor (OSA) audit will be concluded in mid-December 2016, and he shared some initial findings and takeaways.

1. The OSA begin picking law enforcement departments, at random, around the state and announced that it was going to conduct on-site audits to confirm counts and check processes. The awareness of the pending audits spurred departments to send everything to the state crime laboratory in Santa Fe, where evidence kits should have been sent in the first place. This happened at every audited location. Now the laboratory has more than double the number of kits than before. The question is why these kits were not being sent in the first place. All it took was an announcement of an inspection to drive action at the local level. State Auditor Keller stated that, many times, local law enforcement hangs on to the kits for various reasons, including waiting to hear back from the victim and lack of evidence to move forward on testing. This is not an issue of resources but rather a department policy issue. The OSA concludes that all kits should be sent for testing.

2. There are two sites for collection of evidence kits that are part of the backlog: the state crime laboratory and Bernalillo County. While almost all evidence goes to the state crime laboratory in Santa Fe, Bernalillo County processes its own kits at the Albuquerque Police Department (APD) Crime Lab. Over one-half of the unprocessed kits are at the Albuquerque facility. The APD Crime Lab is not planning to address the backlog and intends on processing a few hundred per year. There is not a path to getting rid of the backlog at this location.

3. The OSA conducted some confidential surveys with local law enforcement departments regarding the backlog and why the kits were not being tested. From the feedback the OSA received, law enforcement frequently encounters a lack of victim cooperation or credibility. State Auditor Keller emphasized the public safety importance of testing kits regardless of those issues. Attitudes toward sexual assault are driving the backlog and changing the rhetoric matters. In bringing attention to the backlog at local police departments, significant progress was made.

Scott Weaver, secretary-designate, DPS, was present and addressed the committee regarding the backlog. Secretary Weaver stated that law enforcement, including the district attorneys, operate on their skills and training. Often, they are just following standard procedures,

which include not moving forward with cases lacking evidence. Space had to be modified at the state crime laboratory to accommodate the additional evidence from around the state. Secretary Weaver indicated that two full-time employees and three additional employees have been added, funded by outside grants. The money does not address future procedures and policies that need to be established. There are currently eight people working to address the backlog and processing kits. The DPS would like to have 11 by the end of the year.

Members of the committee discussed the following aspects of the OSA's findings:

- the prevalence and reporting of sexual assault on college campuses;
- the difference in how cases are handled based on the entity to which the assault is reported;
- the critical need for protection of witnesses and confidentiality;
- various circumstances that discourage reporting;
- the effect of the backlog on public trust;
- a similar issue of evidence backlogs in other states around the country;
- the importance of testing kits to log evidence into the national registry;
- funding, staffing and equipment needs to address the backlog;
- the need for more accountability among local law enforcement departments and with the district attorneys;
- clarification about the prioritization in testing of evidence kits;
- the distinction between the two laboratories and the lack of authority over the processes in Bernalillo County;
- the difficulty of outsourcing kits for processing;
- challenges with the state budget and the need to prevent reversion of funds;
- the importance of victim advocacy groups in the process;
- the anticipation of completing all testing on kits in the backlog by FY 2019; and
- the potential need for statutory authority to compel local entities to follow procedures for evidence kits.

Burrell College of Osteopathic Medicine (BCOM): Primary Care in Rural and Tribal New Mexico

George Mychaskiw, founding dean, BCOM, shared information about BCOM, which opened August 2, 2016 at New Mexico State University (NMSU). There are currently 162 medical students from New Mexico and elsewhere in the southwest. BCOM is partnered with the University of North Texas Health Science Center and offers a difficult curriculum. Dr. Mychaskiw is very proud of the students and faculty. He shared a story about one student from Espanola and the successes he has had at the school. Residency is very important for students, and BCOM offers programs to offset tuition in exchange for four years of service. BCOM is building partnerships with various hospitals around the state to create opportunities for students. To date, the school has received 4,000 applications — the largest increase in the country at 40 percent. Tuition is equivalent to the UNM School of Medicine. The founding of BCOM has created more than 300 new jobs in the state, with an expected $120 million annually in economic

impact on Dona Ana County. No taxpayer money has been spent on BCOM. The school hopes to expand to locations like the Four Corners area and Gallup with the establishment of satellite campuses. Dr. Mychaskiw noted the challenges of opioid addiction in New Mexico. He will be speaking at the White House during an upcoming conference about opioids and addiction. Dr. Mychaskiw referenced a previous loan-for-service bill for osteopathic medicine. He encouraged the committee's support of that legislation and its consideration for an appropriation to be added.

Responding to questions from the committee, Dr. Mychaskiw discussed the following points:

- the economic impact of BCOM on southern New Mexico;
- the creation of residencies to address the needs of the behavioral health community;
- the emphasis of residencies on community medicine and primary care;
- BCOM as an example of a successful public-private partnership;
- efforts to build capacity at the school and attract students from around the country;
- funding sources for residencies through the federal Centers for Medicare and Medicaid Services and, potentially, the U.S. Department of Veteran Affairs;
- inquiries about residency programs and how they are established;
- the potential for expanding services in developmental pediatrics and addressing a dire need for autism services;
- clarification about appropriation needs for loan-for-service legislation;
- partnerships with tribal entities to establish Native American programs;
- the large numbers of students from the region and the high percentage of Hispanic students; and
- efforts to increase the health care workforce in New Mexico, particularly in rural parts of the state.

Approval of Minutes

Senator Moores made a motion to adopt the minutes of the October 25-28, 2016 meeting of the LHHS. Senator Stewart seconded the motion, and the minutes of the sixth meeting of the LHHS were adopted without objection.

Public Comment

Nat Dean thanked the committee and the OSA for their enthusiasm and attention to the processing of the rape kits. As a victim, she experiences guilt from not being able to prevent it from happening to someone else. Ms. Dean encouraged legislators not to cut funds to the Disability Advisory Group About Tobacco, an organization that focuses on tobacco use prevention for people with disabilities. Approximately 25.4 percent of individuals with disabilities smoke. That is a higher rate than those without disabilities. Ms. Dean expressed concern about requiring medical cannabis patients to renew their user identification cards every year under the current statute. This is an economic burden for those patients with permanent conditions. Ms. Dean would like to see the elimination of restraints in schools. She believes this has a negative impact on other students and normalizes violent behavior. Ms. Dean is a brain

injury survivor and advocates more funding for the Brain Injury Services Fund. Some past legislation was introduced to add more revenues for the fund. One of the bills required a higher motorcycle registration fee for individuals who choose not to wear helmets and another that allocated $5.00 from moving violation fines to the fund. Due to the lack of vehicle citations, the fund has been depleted. Ms. Dean stated that there is approximately $200,000 left in the fund. She requested that other avenues be explored to add more funding.

Ruth Hoffman, Lutheran Advocacy Ministry, acknowledged all of the funding needs around the state and the current budget situation. Ms. Hoffman urged the committee not to "balance the state budget on the backs of the people who need help and services the most".

Ms. Maestas readdressed the committee to answer some questions brought up during her previous testimony and provided the committee with another handout on Rett syndrome. Ms. Maestas emphasized the need for immediate early intervention.

Bill Jordan, New Mexico Voices for Children, echoed the statements made by Ms. Hoffman. The state relies too heavily on the volatile oil and gas industry and has built in a structural deficit by implementing tax cuts. Mr. Jordan stated that the state cannot continue to ask children and families to make up the difference in the budget. He discouraged the notion of taxing food and urged the committee to consider tax increases. Mr. Jordan believes consideration should be given to withdrawing funds from the Land Grant Permanent Funds for K-12, higher education and early childhood development.

Review of Proposed Legislation for the 2017 Regular Session

The following legislation was presented to the committee for endorsement for the 2017 legislative session. Mr. Hely provided a synopsis of each bill, with additional input from stakeholders and advocates who were present at the meeting. Senator Ortiz y Pino noted that support or opposition is reflective only of committee endorsement, not necessarily of the legislation itself.

Carve out behavioral health from Medicaid MCOs (.204335.1). This proposed bill would amend a section of the Public Assistance Act to remove behavioral health services from those services the HSD provides to Medicaid recipients through managed care. This legislation would implement a fee-for-service model and allow the HSD to better track money spent on behavioral health. Pursuant to a motion, the committee voted to endorse this legislation. Two members voted in opposition to endorsement. Senator Ortiz y Pino will carry the bill during the 2017 session.

School nurse in each district (.204382.1). This legislation would amend the Public School Code to require each public school district to employ a minimum of one full-time, licensed registered school nurse. An appropriation for $1,650,000 is included in the bill. Currently, there are 12 small school districts without a school nurse. An exemption from this requirement would have to be requested by the school district. Members of the committee

discussed various aspects of the proposed legislation. Pursuant to a motion, the committee voted to endorse the legislation. Two members voted in opposition to endorsement. Senator Ortiz y Pino will carry the bill during the 2017 session. Representative Yvette Herrell was identified as the sponsor of this bill.

Health professional disclosures (.204396.1). This bill was withdrawn to be redrafted as a house joint memorial.

Amend the Rural Primary Health Care Act (.204398.2). This bill would provide for funding of eligible clinical programs, eligible workforce development programs and eligible workforce recruitment programs in underserved areas of the state. It would allow for the creation of residency programs and expand health care in rural areas. There is no appropriation component, and the bill is authorizing legislation. Members of the committee inquired about details of how residency programs in rural areas would work. Following debate on the legislation and motion to endorse, the committee voted to endorse this legislation. One member voted in opposition to endorsement. Senator Morales was identified as the sponsor of the bill.

Cardiac calcium scans (.204678.1). This bill would amend several sections of law to require coverage of artery calcification screening for early detection of cardiovascular disease in certain individuals. Upon a motion, the committee unanimously endorsed this bill. Representative Christine Trujillo was identified as the sponsor.

Provider parity (.204692.1). This proposed legislation would enact sections of law to ban discrimination against any health care practitioner working within the scope of that practitioner's license or certification. This bill would mirror the parity provisions of the ACA and would also include pharmacists. Some LHHS members expressed concern that this legislation would undermine the scope-of-practice argument. The committee endorsed the bill pursuant to a motion to endorse, with two members voting in opposition. Senator Ortiz y Pino stated that he would carry the bill.

Indoor Tanning Act (.204790.2). This bill bans the use of tanning devices by individuals under the age of 18 and establishes safety measures for indoor tanning. It was noted that no current licensing or inspections are required for indoor tanning salons. A representative from the American Cancer Society Cancer Action Network voiced the organization's support of the legislation. Pursuant to a motion for endorsement, the committee endorsed the bill, with one member voting in opposition. Representative G. Andrés Romero was identified as the bill's sponsor.

Caregiver leave (.204800.3). This legislation would enact the Caregiver Leave Act to provide employees of private entities who have accrued paid sick leave with the opportunity to use sick leave for family caregiving. This bill does not create a new benefit or mandate sick leave; it just allows sick leave to be used to care for a family member if sick leave is offered by the employer. Some members expressed concern about the impact on small businesses and the

potential negative effect the law would have on teachers in terms of performance evaluations. After discussion, the suggestion was made to add "including adverse performance evaluation" on page five after line 24. Upon a motion to endorse, the committee voted to endorse the legislation as amended. Two members voted in opposition to endorsement. Representative Armstrong stated that she would carry the bill in the 2017 regular session.

Remove severe emotional disturbance/severe mental illness diagnosis requirement (.204864.1). This bill would enact a new section of the Public Assistance Act to direct the HSD to change the basis for reimbursement of preventative and early intervention services for children. Specifically, it would remove the diagnosis requirement of serious emotional disturbance or severe mental illness. This was a recommendation by the J. Paul Taylor Early Childhood Task Force. Upon a motion to endorse, the committee voted to endorse this legislation without any opposition. Senator Ortiz y Pino was identified as the bill's sponsor.

Diabetes Committee (.204944.1). This act would establish the Diabetes Committee to identify goals and benchmarks for state entities to reduce the incidence of diabetes and costs and complications relating to diabetes statewide. Following discussion by the LHHS, representatives from the Public Education Department, the Indian Affairs Department and the ALTSD were suggested as members of the proposed committee. Following a motion to endorse, the committee voted to endorse the legislation as amended. Representative Armstrong was identified as the bill's sponsor.

Chiropractic Physician Practice Act changes (.204981.2). This bill would amend and enact sections of the Chiropractic Physician Practice Act to provide for certification of advanced practice chiropractic physicians. Dr. Steve Perlstein explained the intent of the bill and the benefits for the profession. Under this bill, advanced practice chiropractic physicians will not have prescriptive authority for opioids. Members of the committee discussed the bill, and several concerns were raised. A request for input from the Board of Pharmacy was made. Lacking a motion for endorsement, the LHHS did not endorse this legislation.

Pregnancy accommodation (.205014.1). This legislation would enact the Pregnant Worker Accommodation Act, which would prohibit discrimination in employment on the basis of pregnancy or childbirth or a related condition. Under this act, employers would be required to make reasonable accommodation of an employee's or job applicant's pregnancy or childbirth or a related condition. Employers would be prohibited from retaliation for an employee's or job applicant's assertion of a claim pursuant to the act. Following discussion of the bill and a motion to endorse, the committee endorsed the bill, with two members voting in opposition. Representative Chasey was identified as the bill's sponsor.

Lynn and Erin Compassionate Use Act supply and identification card changes (.205107.1). This act would amend the Lynn and Erin Compassionate Use Act to provide for presumptive eligibility for medical marijuana with three-year certification and to establish new content and possession standards. This legislation is the result of a compromise to address an

issue heard by the LHHS throughout the interim. The three-year certification would be granted to individuals with chronic or terminal conditions. Pursuant to a motion, the committee endorsed the legislation, with one member abstaining. Senator McSorley was identified as the sponsor of the bill for the 2017 regular session.

Senate memorial: financial relief for family caregivers (.204816.1). This memorial recognizes the economic contribution of informal or family caregivers and supporting measures to provide them with meaningful financial relief. The committee voted to endorse this memorial without any opposition. Senator O'Neill agreed to carry the memorial during the 2017 session.

Reimbursement for pharmacy services (.204817.1). This proposed legislation amends several sections of existing law to establish reimbursement parity between pharmacists and certain other licensed health professionals for the same pharmaceutical clinical services. Pursuant to a motion for endorsement, the committee voted to endorse the bill, with two members standing in opposition. Representative Armstrong was identified as the sponsor of the bill.

SNAP limitations (.204989.1). This bill, brought for committee endorsement by Senator Cliff R. Pirtle, would establish guidelines to restrict purchases under SNAP to those foods available under the federal Special Supplemental Nutrition Program for Women, Infants, and Children. Lacking a formal motion, this legislation failed to gain endorsement by the LHHS.

Medical and geriatric parole (.205059.2). This bill would require the director of the Adult Probation and Parole Division of the NMCD to identify and authorize the release of eligible inmates on medical or geriatric parole. Under this legislation, authority would be placed with the NMCD instead of by advisement of the Parole Board. Pursuant to a motion for endorsement, the committee voted to endorse this legislation without any opposition. Senator Ortiz y Pino was identified as the sponsor.

Adjournment

There being no further business before the committee, the seventh and final meeting of the LHHS for the 2016 interim adjourned at 5:21 p.m.