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

October 25-28, 2016
State Capitol
Santa Fe

The sixth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order on October 25, 2016 by Senator Gerald Ortiz y Pino, chair, at 8:50 a.m. in Room 322 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 (10/25, 10/26, 10/28)
Sen. Mimi Stewart

Absent
Rep. Nora Espinoza, Vice Chair
Rep. Tim D. Lewis
Sen. Mark Moores

Advisory Members
Sen. Craig W. Brandt
Rep. Gail Chasey (10/26, 10/28)
Sen. Linda M. Lopez
Rep. James Roger Madalena
Sen. Cisco McSorley
Sen. Bill B. O'Neill (10/27, 10/28)
Sen. Nancy Rodriguez (10/27, 10/28)
Rep. Don L. Tripp (10/25)
Rep. Christine Trujillo (10/25, 10/26, 10/27)
Sen. James P. White (10/25)

Sen. Jacob R. Candelaria
Rep. Doreen Y. Gallegos
Sen. Daniel A. Ivey-Soto
Rep. Terry H. McMillan
Sen. Howie C. Morales
Sen. Mary Kay Papen
Sen. Sander Rue
Rep. Patricio Ruiloba
Sen. Benny Shendo, Jr.
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, Staff, LCS
Alexandria Tapia, Contractor, LCS

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.

Tuesday, October 25

Welcome and Introductions

At 8:56 a.m., Senator Ortiz y Pino welcomed members to the sixth meeting of the LHHS. Members of the committee and staff introduced themselves.

Strategies to Reduce Maternal Mortality and Morbidity

Stacie Geller, Ph.D., director, Center for Research on Women and Gender; director, National Center of Excellence in Women's Health; Department of Obstetrics and Gynecology, University of Illinois at Chicago College of Medicine, presented some lessons learned from Illinois' maternal mortality and morbidity studies. According to Dr. Geller, the decline in rates of maternal mortality achieved over the last 35 years in the United States has ended; rates are now trending upwards (please see handout for more information). The rate of maternal deaths per 100,000 live births in New Mexico is currently 23. However, huge racial and ethnic disparities exist with the rate for non-Hispanic Whites (14.9), Hispanics (25.5), African Americans (83) and Native Americans (23.7). According to the Centers for Disease Control and Prevention (CDC), the leading cause of pregnancy-related death in the United States is cardiovascular disease, followed by sepsis and hemorrhage. The number of women with severe maternal morbidity (SMM) has increased significantly across the country.

Dr. Geller explained the regionalized perinatal system established by Illinois consisting of 10 perinatal centers. Surveillance for maternal mortality in Illinois began in 1892 and was defined as "a death caused by direct or indirect complications of pregnancy occurring during the prenatal period or within 90 days after delivery or termination of the pregnancy". In 1989, Illinois added a pregnancy checkbox to death certificates to better monitor data, and perinatal centers began reviewing deaths in 1992. In 2002, the Illinois legislature revisited the maternal death review code and extended the period of surveillance to one year post-pregnancy. Hospitals are required to report any maternal deaths within 24 hours. The Illinois Department of Health collects records from the hospital, coroner, medical examiner, law enforcement and other health care providers. Dr. Geller described the abstract of medical records for these cases and the assessment of whether the death was preventable, as well as the role of Illinois' Statewide Maternal Mortality Review Committee (MMRC). The purpose of these internal and external review processes are to discover whether the death could have been avoided and to identify what medical staff could do differently in the future. The MMRC meets four times per year to review cases in which the patient, provider and hospital are all de-identified; the process is protected, so there is no assignment of blame. Since the beginning of surveillance, the MMRC has determined that 35% to 40% of pregnancy-related deaths in Illinois were potentially preventable. Dr. Geller noted that the MMRC found more cases to be potentially preventable than the perinatal center reviews, highlighting the importance of unbiased review.

In addition, a second review committee, the MMRC-V, was formed to look at maternal deaths due to violence; the MMRC-V examined maternal deaths due to homicide, suicide and substance abuse. While there was not necessarily a connection between these deaths and pregnancy, the MMRC-V wanted to identify missed opportunities for intervention and collect data on social determinants of health. Clinicians have begun screening for intimate partner violence and postpartum depression. Dr. Geller also discussed Illinois' Obstetric Hemorrhage Project and Maternal Hypertension Initiative and implementation of a severe maternal morbidity review that is a facility-level review of cases in which there was an intensive care unit admission or transfusion of four or more units of blood. With proper education and skills training, hospital readiness and patient care can be improved. Several states have active maternal mortality reviews, and others are in the process of establishing review committees. The key steps to establish review of deaths and morbidities are: legislation mandating reporting and protecting the review process and participants from discovery in litigation; infrastructure for collection of medical records and data abstraction; and the creation of an external multidisciplinary team to explore system and community factors.

Sharon Phelan, M.D., Department of Obstetrics and Gynecology, University of New Mexico (UNM) School of Medicine, reported on the status of maternal mortality review in New Mexico. According to Dr. Phelan, the usefulness of data from 2008 to 2014 is limited because it is dependent upon the accuracy of coding and data entry on death certificates or linked death and birth certificates. Based upon those data, New Mexico averages about 20 maternal deaths per year, and for every woman that dies, 50 others have SMM. About 41% of maternal deaths are "accidental", but there is no additional information about the nature of the "accident" that could be used to prevent the deaths. Dr. Phelan discussed several factors complicating New Mexico's current approach to maternal mortality review: the small number of cases and small population affected; the complexity of the health care system that involves many providers and stakeholders; limited access to patient data; and the lack of required reporting of remedial measures or improvements achieved. It is important for the state to develop methods of helping smaller hospitals interface with larger hospitals to provide for timely and smooth transfer of acute cases. Dr. Phelan is seeking legislation that would require the Department of Health (DOH) to create and maintain the maternal mortality and morbidity review process, and she explained what proposed legislation would include. Since those conducting the review would be volunteers, the cost would be minimal for DOH staff activities. There needs to be confidentiality and protections for providers to encourage reporting and ensure patient privacy. Membership of the review committee would be diverse and interdisciplinary. New Mexico has unique challenges in providing health care to its residents due to distances, economics, legal status and cultures. These challenges cannot be ignored. Legislation will provide the statutory authority to enable a comprehensive maternal mortality review.

Eirian Coronado, program manager, Maternal and Child Health Epidemiology, DOH, shared some additional data and statistics with the committee relating to maternal mortality. Ms. Coronado stated that access to data and records is key and that the level of data the state currently collects is inadequate for this purpose. Two major health issues for women in the state are

diabetes and mental health. About 11% of women self-reported diabetes during pregnancy. Several years ago, the CDC found that New Mexico ranked high in the incidence of postpartum depression, approximately 13% of women at the time. In 2009, that number jumped to 20%, which is double the national average. Nearly 56% of New Mexico women of reproductive age are obese. The rate of neonatal abstinence syndrome (newborns needing to go through medically supervised withdrawal as a result of maternal exposure to illicit drugs during pregnancy) has also increased over the last several years. Ms. Coronado stressed the need for more information to get a clearer picture of what is going on in the state.

Kenneth Winfrey, health outreach coordinator, Office on African American Affairs, agreed that a review process would be helpful, adding that this legislation coincides with his organization's goals. He expressed concern that New Mexico's small African American population has some of the highest rates of maternal mortality in the state.

Senator Ortiz y Pino reminded the panelists that the LHHS will be considering legislation for endorsement during its November meeting and invited them to bring a draft of the legislation at that time. In response to committee members' questions, the following points were discussed by the panel:

- the difference between "pregnancy-related" and "pregnancy-associated" conditions;
- details about the MMRC process in Illinois;
- funding for the Illinois project during the current financial crisis;
- usage of the Illinois model by other states;
- the need to protect review materials from discovery and concerns about patient privacy;
- the need for developing trust that the process is not punitive;
- ongoing revisions of language for proposed legislation;
- the existence of a bill on this topic that was introduced in the house of representatives during the 2015 regular session;
- collaboration between the DOH and other stakeholders;
- the need for more comprehensive data on Native Americans and for partnership with the Indian Health Service;
- limitations of the current mortality review process;
- the potential to use videoconferencing, such as Project ECHO, to decrease costs of the review committee;
- the need to address maternal morbidity and increase access to care for pregnant women;
- the prevalence of postpartum depression;
- the use of mandates to require training and reporting;
- the impact of socioeconomic conditions on pregnancy outcomes; and
- concern over the state budget and additional pending budget cuts.

Update on Family Planning Initiatives

Erin Armstrong, reproductive rights attorney, American Civil Liberties Union of New Mexico (ACLU-NM), provided an overview of the key requirements related to family planning. Thanks to advances in evidence-based policy, there is a patchwork of strong requirements that ensure that most women are entitled to comprehensive family planning coverage. Under the federal Patient Protection and Affordable Care Act (ACA), all private insurance plans must include United States Food and Drug Administration (FDA)-approved contraceptives and the related services without any cost-sharing. Ms. Armstrong explained that a plan can choose the brand carried on its formulary as long as there is an exceptions process that is easily accessible. Plans cannot refuse to cover a specific method of contraception or require a patient to use a less expensive method. Medicaid has a long-standing requirement that covers family planning and supplies as part of the full benefits package. There is a category of eligibility for these services, even if the person does not qualify for other Medicaid benefits. Medicaid managed care organizations (MCOs) may not impose cost-sharing, and there are enhanced protections for freedom of choice in family planning, including the right to see the qualified provider of the member's choosing. The federal match for Medicaid family planning is 90%.

New Mexico was one of the first states to require family planning by insurance companies. Now that the ACA is in place, the New Mexico statutes are somewhat outdated and could be revisited to align with federal requirements. One potential change is mandating plans to allow for a one-year supply of contraceptives; many states have passed laws to ensure this, and it would benefit a rural state such as New Mexico. Ms. Armstrong noted that coverage is only one critical piece of family planning. There needs to be a strong safety net to provide access for family planning activities. Steps that can be taken include: 1) training providers on the full range of methods; 2) community education; 3) simplification of coding and billing; 4) administrative and financial assistance for clinics to keep contraceptive products in stock; and 5) prompt payment and reimbursement policies.

Jody Camp, section manager, Family Planning Unit, Colorado Department of Public Health and Environment (CDPHE), shared the successes and lessons learned from the Colorado Family Planning Initiative (CFPI) with the committee (please see handout). The CFPI successfully increased access to long-acting reversible contraception (LARC) while making a tremendous impact on all health indicators for women. The initiative began in 2008 with the primary goal of providing access to all FDA-approved contraceptives, with an emphasis on LARC for women who choose it. LARC is a completely reversible method, lasts between three and 10 years and costs between $400 and $800. Ms. Camp explained how Colorado uses a sliding scale of patient charges and assesses patient needs through patient-centered counseling. After eight years, Colorado saw a significant increase in the usage of LARC across various age groups. Both birth rates and abortion rates of teens decreased by 48%. Additionally, a teen is more likely than women in any other age group to give birth to a second child within two years. This rate decreased by 58%. Ms. Camp highlighted some of the costs avoided following the implementation of the CFPI. These estimated avoided costs impacted both entitlement and non-entitlement programs such as the Supplemental Nutrition Assistance Program (SNAP), Medicaid

and the Colorado Child Care Assistance Program. Total costs avoided from 2010 to 2014 were estimated at between $66 million and $70 million. The CDPHE plans to continue its efforts by training providers outside the Title X network, including those at school-based health centers (SBHCs) and pediatricians. Ms. Camp added that the department will also be conducting an analysis of sexually transmitted infections (STIs) as they relate to LARC usage.

Janis Gonzales, M.D., chief, Family Health Bureau, DOH, updated the committee regarding the DOH's family planning initiatives and partnerships. The DOH has applied for federal funding to purchase LARC products but has so far been unsuccessful. There are 68 Title X providers in 30 counties and 47 public health offices around the state. Of Title X clients, 13% preferred LARC as a contraceptive method. The DOH is working to build its educational programming within the state through age-appropriate websites and programs for both teens and parents. Dr. Gonzales mentioned a largely successful social media campaign and the BrdsNBz text-back service for teens to have their questions about reproductive health answered. The DOH plans to continue social media campaigns on a quarterly basis. New Mexico teens are increasingly interested in learning about LARC. The DOH is currently working with Project ECHO to roll out Reproductive Health ECHO in January 2017. The unbundling of LARC by Medicaid for federally qualified health centers (FQHCs) was completed in September. FQHCs, including many SBHCs, will now be reimbursed for LARC devices separately from the reimbursements they receive for associated office visits.

Megan Pfeffer, chief, Quality Bureau, Medical Assistance Division (MAD), Human Services Department (HSD), shared the HSD's initiatives to expand family planning services in the state. Effective September 1, 2016, the MAD unbundled LARC drugs and devices from FQHC rates, allowing providers at clinics to bill separately for LARC. The HSD does not require prior authorization for LARC. MCOs do not require prior authorization from a physician; however, if the provider does not have the device in stock, it can send the request to a pharmacy. The HSD is revising Medicaid MCO contracts to add a new tracking measure requiring the MCOs to measure the use of LARC among members ages 15 through 19. Ms. Pfeffer added that the HSD continues to be actively engaged with the statewide LARC work group facilitated by Young Women United and the Association of State and Territorial Health Officials LARC learning community.

Nathan Eckberg, program evaluator, Legislative Finance Committee (LFC), presented the progress report and update from the 2015 *Effective Practices to Reduce Teen Pregnancy, Including the Use of SBHC* report. The report assessed New Mexico's teen birth rate as it is consistently one of the highest in the nation. The report found that teen births are concentrated in certain areas of risk, and as a result, evidence-based interventions targeted to these teens and geographic regions could produce significant population-level improvements. In the long term, children from teen pregnancies will cost taxpayers an estimated $84 million due to Medicaid costs associated with their births, increased reliance on public assistance and poor educational outcomes. As a state, New Mexico has seen significant progress in the reduction of teen births but still has many challenges to overcome (please see progress report). Mr. Eckberg recognized

that the DOH and HSD have made significant progress in implementing LFC recommendations, including the unbundling of reimbursement for LARC devices. The LFC progress report highlights efforts by counties to develop comprehensive community plans.

Elaine Sena, executive director, MyPower, Inc., discussed the organization's mentoring program for girls and a road map to prevent unwanted teen pregnancy in Lea County. MyPower, Inc., is a nonprofit organization founded in 2009 that works with girls in fifth through ninth grades through group mentoring programs and a summer life skills camp. Ms. Sena provided details about the organization and shared Lea County's plan, which was developed by concerned citizens to reduce teen pregnancy. In 2008, research showed that Lea County had the highest rate of teen pregnancy in the state — three times the overall state rate. Through the work of various programs and policy changes, that number dropped by 33% in 2014. Ms. Sena emphasized the role of parents and community-based approaches in combating teen pregnancy and STI rates. The "Road Map for Success" developed by the community has five key strategies for Lea County:

1. make evidence-based, comprehensive sex education accessible to all young women and men;
2. identify and promote multiple places where teens can access information and resources about sexual health and contraceptive care;
3. encourage and assist adults to have safe and open conversations with youth about sexual health and healthy relationships;
4. develop programs that expand teens' educational and career goals; and
5. create a countywide coalition that will manage this comprehensive plan and track progress in achieving the goal of reducing the Lea County teen birth rate among 15- to 17-year-olds by 30% to a rate of 29 births per 1,000 by 2018-2019.

MyPower, Inc., requests funding for the DOH offices in Hobbs and Lovington to hire a full-time health care practitioner who focuses on reproductive health. Over the last several years, the local DOH office has gone from having a full-time provider to having a practitioner present only two days a month in Hobbs and one day a month in Lovington. Reinstatement of funding for comprehensive SBHCs is also requested.

Abigail Reese, program director, New Mexico Perinatal Collaborative, shared some of the ongoing programs for the collaborative. The collaborative has shared values of improving access to reproductive health, specifically contraception, for women and all people in New Mexico and leveraging resources to effectively expand access to LARC in appropriate and impactful ways. Ms. Reese noted the importance of provider education and training on non-coercive counseling and insertion and removal techniques in addition to administrative components related to billing, stocking and scheduling. The collaborative has had the ability to provide feedback about what is challenging for clinicians and providers in trying to provide LARC services. Ms. Reese recognized the important collaboration between the many members of the work group and state partners, such as the DOH. The collaborative is led by community,

policy and professional (clinical) expertise. Ms. Reese also acknowledged the participation of Young Women United.

Nancy Rodriguez, executive director, New Mexico Alliance for School-Based Health Care, shared a few facts about SBHCs. There are currently 70 SBHCs across the state, and the DOH contracts with and funds about 50 of those. School boards have the authority to make decisions on what is provided by SBHCs. Ms. Rodriguez stated that access to family planning will not exist if funding to SBHCs is cut and clinics are closed. SBHCs need General Fund money to operate. These clinics serve uninsured and undocumented children who do not qualify for Medicaid and insured youth who do not want their parents' health insurance billed for family planning services. Ms. Rodriguez told the committee that one SBHC in the southern part of the state had to absorb $10,000 in one month for those who were either uninsured or did not want their parents' insurance to be billed. By closing these clinics and reducing funding, teen pregnancy rates are likely to increase.

Following the presentations from the panel, the committee had several comments and questions regarding:

- the lack of obstetricians and other women's health providers in parts of the state, particularly Lea County;
- a specific request that the DOH make a full-time provider of family planning services available in Lea County;
- prior authorization requirements under private insurance and Medicaid;
- the inability for SBHCs to bill insurance while protecting medical confidentiality;
- the need to address confidentiality and patient privacy in a broader context;
- cultural sensitivity and fears relating to usage of LARC;
- the lack of contraceptive options for males;
- ACA coverage for female contraceptives only;
- the need to ensure education for STI prevention as part of LARC efforts;
- ongoing studies to determine whether there is an association between LARC and the incidence of STIs;
- neonatal abstinence syndrome;
- a request that the LFC analyze potential cost savings associated with LARC and teen birth reduction;
- the process for a community to establish a Title X clinic;
- the need to encourage local school boards to approve providing family planning services in SBHCs; and
- the need for easy, teen-friendly access to contraceptive and reproductive health information.

Children, Youth and Families Department (CYFD) Update

Monique Jacobson, secretary, CYFD, addressed the committee with an update on CYFD programs and efforts to increase employee retention within the department. The CYFD is

working to improve the quality of life for all New Mexico children. The department is working hard to change the culture at the agency by creating attainable goals and helping to address employee safety. The notion of "be kind, respectful and responsive" is critical, along with accountability, in all aspects. Secretary Jacobson discussed the CYFD's four major divisions and current initiatives to increase retention of workers, increase quality of services and produce better outcomes for children (please see handout).

Protective Services Division. Secretary Jacobson stated that the nature of the job is very exhausting and emotionally draining on staff. The CYFD added 25% more field workers through nine "rapid hire" events, without decreasing quality of staff or hiring methods. The turnover rate for workers was decreased from 33% in fiscal year (FY) 2014 to 25.3% in FY 2016. Several safety measures were developed to ensure staff and field workers' safety. Secretary Jacobson detailed initiatives to reduce burnout for workers, improve outcomes, improve conditions for foster parents and improve placement stability and timely adoptions. The Protective Services Division is determined to reduce the amount of secondary trauma experienced by children as they come into the system. The CYFD is looking at areas where there are good outcomes and trying to replicate those practices in other areas. The Protective Services Division continues to bring in multiple providers and partners as part of expanding child advocacy centers.

Juvenile Justice Division. Since 2008, the CYFD has transformed New Mexico's juvenile justice system into one based on rehabilitation rather than punishment through its Cambiar initiative in secure facilities and a range of community-based programs. The CYFD continues to improve recruitment and retention efforts for the Juvenile Justice Division. The department has collaborated with the New Mexico Corrections Department Training Academy, modifying the curriculum to focus on foundational skills to ensure workers' success and improve safety with verbal de-escalation training. The CYFD found that many of its day-to-day operations policies and procedures were out of date; it is currently working to address this. Secretary Jacobson shared details about initiatives, such as life skills, to enhance programming for clients in facilities, as well as programming for clients in the field by enhancing transition services.

Early Childhood Services Division. Secretary Jacobson believes that child care is one of the single greatest tools available to prevent child abuse. Educational facilities are safe places for children, providing them an opportunity to get out of the house. Early childhood services also allows for parents to receive education, which helps to address some of the intergenerational problems the state faces. Home visiting is also a powerful prevention tool, providing access and information about services. It is critical to continue to balance quality and access in early childhood services. In response to complaints about additional costs to providers, the CYFD is working to increase incentives for quality services.

Behavioral Health Services Division. Initiatives within the Behavioral Health Services Division include efforts to improve the array of services, the quality of services and services to youth. Several statewide surveys were conducted to determine where service gaps exist. The CYFD is dedicated to treating children as more than just "a file"; employees are getting to know

them and are making them feel heard. Learning how to talk to children and giving them a seat at the table are critical. The department is not just saying it needs more services but, instead, taking note of what services are working well and expanding those.

Pull Together Campaign. Secretary Jacobson stressed that the Pull Together Campaign is not by any means a marketing campaign. The program seeks to address the fragmentation of the system by forcing groups that should be working together to start the conversation on how they can work together. Communities are driving these conversations, placing an emphasis on localization. The state agencies alone cannot be the answer to solving the issues facing New Mexico children; neighbors and communities need to be reminded of their responsibility for the well-being of children. Referring to the backpack program, Secretary Jacobson challenged legislators to promote the collection of backpacks in their districts. The backpack program, which entails filling backpacks with toys, snacks and supplies that are given to children entering protective custody, is meant to help children feel love and support as they enter into protective custody. She stressed the importance of making New Mexicans aware of the programs and resources available by simplifying how people are accessing resources.

Secretary Jacobson shared the legislative priorities for the CYFD during the upcoming legislative session. The list is similar to the objectives from the previous two legislative sessions. A top priority for the department is increasing the penalty for assaulting or battering a CYFD worker. Overall, Secretary Jacobson believes it is about holding people accountable.

Brian Hoffmeister, program evaluator, LFC, shared the LFC program evaluation for the effectiveness of juvenile justice facilities and community-based services in the state (please see handout). The CYFD's Juvenile Justice Division has three secure facilities, three reintegration centers, 14 juvenile probation districts and a total FY 2017 budget of $73 million. Mr. Hoffmeister discussed the positive outcomes the Cambiar initiative has had, highlighting that juvenile recidivism rates have fallen. As the population in juvenile justice facilities decreases, the costs of juvenile commitment are rising. Facilities are operating with excess capacity, resulting in a higher cost per client. LFC staff identified up to $1.2 million in potential unrealized savings from closing Lincoln Pines Youth Center. New Mexico juvenile facilities are showing improvement relative to national averages. Safety and incident tracking is still a concern in facilities; there are growing rates of incidents despite lower populations. Mr. Hoffmeister noted significant issues with data reliability that make community-based program effectiveness difficult. Only 46% of clients were discharged from juvenile community corrections successfully between FY 2013 and FY 2015.

Maria Griego, program evaluator, LFC, described the use of multisystemic therapy (MST) in the state. MST is an evidence-based treatment, funded through Medicaid, with a proven track record in reducing juvenile recidivism. The focus of MST is geared toward juveniles on probation. Provider availability issues have resulted in fewer clients receiving services. Ms. Griego shared a map that illustrated service gaps in areas around the state, noting that those are the areas that may benefit most from MST. It is important to understand drivers of juvenile

justice involvement, and the CYFD catalogues data from the juveniles with whom it works. An emerging topic is the concept of "crossover youth", who are children involved in the child welfare system at higher risk of entering the juvenile justice system. According to the CYFD, 46% of youth who recidivate within 12 months had a history of substantiated involvement with the Protective Services Division.

The LFC recommends that the legislature consider reducing the juvenile justice services budget by $1.2 million to reflect declining facility populations. Cambiar works, Ms. Griego said, but as the population in detention decreases, there is opportunity to use more community-based programs. The LFC has several key recommendations for the CYFD, including: continuation of cohort-specific recidivism analysis with reporting to the legislature; evaluating the juvenile justice services budget and identifying opportunities to achieve efficiencies and cost reductions by reallocating resources and optimizing unused space; working with the HSD to identify MST providers and build teams in high-risk areas; and formalizing policy coordination between the Protective Services Division and Juvenile Justice Division for crossover youth.

Following the presentation, members of the committee discussed several aspects of the presentation. Some key points addressed were:

- the recommendation of identifying top probation violations for juveniles;
- questions regarding the percentage of youth successfully discharged;
- success rates of MST;
- the possibility of housing children's specialized and respite care under the CYFD;
- the percentage of children with special needs in foster care;
- the need for continuation of coordination with MCOs and expansion of wraparound services;
- funding needs for CYFD programs and spending existing funds on efficient programs;
- the use of provider report cards;
- overall vacancy and retention rates at the CYFD;
- the need for early intervention in schools;
- greater recognition and support for the role of foster families;
- inquiries about kinship guardians;
- the CYFD's role in pre-K efforts;
- the LFC recommendation to decrease juvenile justice services funding;
- an update on the CYFD's previous presentation (2015) seeking an emergency placement facility;
- a pilot project on protective services child care;
- the benefits of separating behavioral health into its own division;
- questions regarding the state contract with OptumHealth; and
- a request for a gap analysis.

Approval of Minutes

Upon review and a proper motion by the committee, the minutes from the July 25-29, 2016 meeting of the LHHS were approved unanimously.

Children's Court Improvement Commission Recommendation

The Honorable Petra Jimenez-Maes, senior justice, New Mexico Supreme Court, provided some background on the Children's Court in New Mexico. In 1995, the federal government became concerned with the increase in abuse and neglect cases in New Mexico. At the time, it was taking a long time for youth to get into foster care and released for adoption. The probation office was under the jurisdiction of the courts, and Children's Court cases were typically assigned to the newest judge. The assessment phase of the New Mexico Court Improvement Project (CIP) yielded data that informed the setting of the overall mission of the CIP as well as its initial strategies. The CIP's mission was achieving permanence, in a more timely, efficient and cost-effective manner, for children who have come into the care and custody of the state. Seven implementation strategies were initially adopted by the CIP, and a handout was provided detailing efforts and accomplishments to date. In 2009, the New Mexico Supreme Court ordered a commission of 20 court-appointed members to improve capacity and expand the scope of the CIP. The CIP was subsequently renamed as the New Mexico Children's Court Improvement Commission (CCIC).

With help from a federal grant, the New Mexico Children's Law Institute was founded. The institute is administered through a contract with New Mexico State University. This three-day program provides training for social workers and attorneys, who are able to earn credit in their respective fields. Currently, there is no specific training track offered for judges; however, the Annie E. Casey Foundation sponsors a lunch during the program that provides an opportunity for judges and foster children to interact. The youth are asked to share some of their experiences, and they are given a chance to discuss some of the changes they would like to see in the process. Because Children's Court cases are becoming increasingly complex, this initiative has been very helpful in providing additional training and support.

Justice Jimenez-Maes shared information about the new case management system implemented by the courts. The system, known as Odyssey, has helped to address some of the data entry issues. There are still some problems ensuring that accurate data are being entered. With use of grant funds, efforts are being made to work with information technology personnel to properly train clerks on the new system. Unfortunately, the grant funding will not be continued for training and maintenance of the new data system. The federal government wants New Mexico to achieve permanency for children within 15 months. The CCIC will be reporting back to the federal government about case disposition time lines at the end of October.

Ezra Spitzer, executive director, New Mexico Child Advocacy Networks, is a co-chair on the CCIC. The co-chairs have been looking at the structure of the commission, and their findings will be released within the next week. The CCIC has formed both juvenile justice and behavioral health subcommittees. Systems transitions in health care and schools were identified as

priorities. Mr. Spitzer noted that another issue was the implementation of the Child Welfare Act. Juvenile justice and protective services youth tend to have poor educational experiences. The CCIC is looking at how to get these children the stability they need to succeed in the future. Additionally, the CCIC is looking at the issue of crossover youth, opportunities for intervention and outcomes for children based on race and ethnicity.

Justice Jimenez-Maes added that she assigns specific judges to handle children's cases; these judges want to be involved with these cases. There are about 24 Children's Court judges who participate in various trainings. One recommendation from the CIP was to understand the needs of tribal members. A group of seven state court judges and seven tribal judges works together as part of a tribal consortium for Native American youth. The state needs to ensure that there is funding to cover costs for children and parent attorneys, including the cost of travel for clients in rural areas. Allowing attorneys to see children in their environments is a key component for making better determinations about their needs. Justice Jimenez-Maes stated that the courts and these support services are typically underfunded.

Paid Family Leave

Representative Armstrong presented on behalf of Representative Chasey, who will be sponsoring legislation creating the Caregiver Leave Act. Under this act, employees would be eligible to take paid family leave to care for themselves or a family member in the event of a serious health condition or to bond with a newborn. The act does not create any new benefits and would allow for a broad interpretation of leave policies beyond personal illness.

Pamelya P. Herndon, executive director, Southwest Women's Law Center, provided the recommendations of the Family-Friendly Workplace Task Force. House Memorial (HM) 2 was passed during the 2015 regular session to create a task force to study the benefits of bringing paid family leave to the state (please see handout). The task force met five times with a variety of different stakeholders. The cost of administering this employee contribution program would only be administrative and would likely become part of the Workforce Solutions Department.

Sarah Coffey, staff attorney, Southwest Women's Law Center, noted that the act would essentially bring what is allowed at the federal level to the state level. Currently, the federal Family and Medical Leave Act (FMLA) only applies to employers with 50 or more employees, and employees must meet various criteria to be eligible. Employees who do not qualify for FMLA job protection have no job protection during these circumstances. New Mexico has a rate higher than the national average for aging residents and special needs. Nearly one-half of all working adults, particularly women, in the state have provided care for a family member within the last five years. Additionally, 46% of women and 40% of men are also providing care to minor children while caring for a relative. Almost one-half of these caregivers have experienced some sort of work-life conflict, and 48% of caregivers reported losing income. Many other states are looking at creating paid family leave laws. New Mexico does not have any laws that protect an individual's job following childbirth or while the individual is caring for family.

Ms. Coffey explained the details of the proposal. Under this act, all private and government employers would be required to offer paid family leave regardless of the number of employees. All employees would be paying into the fund, and all employees would be eligible for paid family leave once they contribute a predetermined amount or a predetermined number of contributions to the fund. Employees would be reimbursed 67% of their average salary with a floor and cap. An employee's employment and health benefits would be protected while on paid family leave — this would be the only cost to the employer. The panelists highlighted some of the additional benefits of paid family leave. A program like this could help address New Mexico's ranking as forty-ninth in child well-being. Paid family leave reduces the likelihood for new parents to use public assistance. New Mexico families have limited access to child care for young infants; this is an additional strain for those who do not have other family to rely on for help during the first few months.

Members of the committee inquired about the following aspects of the presentation:

- consideration for employers with generous existing leave policies;
- opt-out potential for individuals who would not use the benefits of the program;
- similarities to disability insurance;
- the potential need for addressing an age requirement of six weeks for admission to a child care facility; and
- requests for more information about costs and logistics for implementation of the act.

TriCore Reference Laboratories (TRL)

John Anderson stated that TRL was founded in 1998 and currently employs 1,300 New Mexicans. TRL would like to host the committee at its facility during the 2017 interim. TRL has been a big success story for the state, according to Mr. Anderson. He mentioned that two of the presenters on the agenda are currently in Washington, D.C., discussing some of TRL's accomplishments with the federal Centers for Medicare and Medicaid Services (CMS).

Michael Crossey, M.D., chief medical officer, TRL, informed the committee that TRL does 98% of its testing in New Mexico. TRL is the largest laboratory in the state with the capacity to perform more than 2,000 different tests. Dr. Crossey stated that TRL has developed its information technology infrastructure to include 15 full-time employees who work to move information to the people who need it in a timely fashion. To him, it is frustrating to see information stuck in silos. Some of these issues relating to the sharing of medical information are regulatory, and legislation will be considered to address those impediments for the upcoming session. Dr. Crossey noted that there is a lot of information that currently exists that could be utilized for addressing some of the issues the state has with health care.

In response to some questions from the committee, Dr. Crossey stated that approximately 75% of TRL's data is interfaced with the New Mexico Health Information Exchange (NMHIE). There are some issues with the need for prior authorization for testing. TRL has a different model with high value that Dr. Crossey believes the health plans will be interested in purchasing.

A member asked about usage of electronic records. In response, Dr. Crossey stated that TRL is interfaced with 250 electronic medical records sources, making it a paperless entity. As part of the private sector, TRL is prohibited from using patient social security numbers for identifying patients. Patients have unique identification numbers, and all of their information is associated and stored as part of the electronic master patient index. The system can triangulate information to identify the correct patient, making it easier to access patient records. While no electronic system is foolproof, it is important to find a balance between total security and total lockdown of information. Paid consultants are typically hired to hack systems to identify vulnerabilities. Patients and medical professionals have very fast and efficient access to records. The committee was invited to take a tour of the facilities during the next interim.

Recess

The first day of the LHHS meeting recessed at 5:31 p.m.

Wednesday, October 26

Welcome and Introductions

Representative John L. Zimmerman, co-chair, Tobacco Settlement Revenue Oversight Committee (TSROC), welcomed everyone to the joint meeting of the LHHS and TSROC and asked members and staff to introduce themselves.

Tobacco Settlement Revenue Expenditures in New Mexico and in Other States

Ari Biernoff, assistant attorney general, provided a brief overview of the Master Settlement Agreement (MSA) signed in 1998 by New Mexico and 46 other states to resolve litigation with five major U.S. tobacco companies over the costs to states resulting from the use of tobacco products. The tobacco companies are referred to in the MSA as "participating manufacturers", or PMs. Pursuant to the MSA, annual payments to the states by the PMs are made in April of each year. The calculation of the annual amount payable to each state, which is made by an independent auditor, has several elements but is generally based on each state's share of national cigarette sales; the New Mexico market is around 0.6% of the national market.

At the time the MSA was executed, the PMs were the largest tobacco companies in the country. There are smaller tobacco companies that did not participate in the settlement, and these companies are referred to as "nonparticipating manufacturers", or NPMs. Upon signing the MSA, the PMs raised concerns that, because of the payments they had to make to the settling states, the NPMs would gain an unfair advantage in sales. This unfair advantage, the PMs argued, would lead to an increased market share for the NPMs and therefore a loss of market share to the PMs as an unintended result of the settlement. To address this concern, the MSA provided that the PMs' annual payments to the states could be reduced if it could be shown that the PMs had lost market share to the NPMs as a result of the settlement. These reductions are called "NPM adjustments". States could avoid the NPM adjustment by passing and "diligently" enforcing escrow statutes that would require NPMs operating in the state to either join the MSA and comply with its terms or to establish an escrow account and make regular payments into that

account to make up the difference between the NPMs' nonparticipation and the MSA payment burdens on PMs. While the principal is in escrow, NPMs collect the interest on the principal deposits and will recover 100% of the principal after 25 years.

The MSA allows the states and the PMs to challenge the calculations or determinations made by the independent auditor of the NPM adjustment. Most states' courts have decided that a dispute over a state's "diligent enforcement" is subject to arbitration. Challenges are initially resolved by arbitration, and the arbitration decisions may be appealed to state court, but the standard of review is very deferential to the arbitrators.

The PMs challenged New Mexico's diligent enforcement of the escrow statute for calendar year 2003. In 2013, an arbitration panel consisting of three retired judges decided that New Mexico had not diligently enforced the escrow requirements in 2003. As a result, the subsequent April payment was reduced significantly (around $21 million versus the prior year amount of around $39 million). The panel's decision also imposed additional liability on the state by including factors that reduced the payment beyond the formula established by the MSA. New Mexico immediately appealed the arbitrators' decision to the district court in Santa Fe, raising two issues: diligent enforcement; and the additional liability. The district court judge issued a decision in September 2016 that left intact the arbitrators' decision that the state had not diligently enforced the escrow requirements in 2003; the judge also vacated the arbitrators' imposition of additional liability because the court found that arbitrators had exceeded their authority by doing so. The court reversed the arbitrators' decision to apply extra penalties that will result in an additional payment to New Mexico of approximately $9 million to $12 million. The Attorney General's Office (AGO) has asked the independent auditor to recalculate the penalty in the 2003 decision and is confident that the next April payment will be adjusted upward. The payment is due to be received in April 2017 at the same time as the regular annual payment; the total payment is expected to be approximately $48 million or more.

Mr. Biernoff explained that the role of the AGO in this case is to protect the payments due to New Mexico from the PMs. That money is initially deposited into the Tobacco Settlement Permanent Fund (TSPF). The AGO does not formally have a role in determining how the settlement money is to be expended. However, Mr. Biernoff commented that the animating goal of the tobacco lawsuit and the MSA is to compensate states for higher health care costs due to misleading claims by tobacco companies regarding the health effects of smoking. To that end, New Mexico law provides that tobacco settlement money be used for health and education programs.

A member asked which companies are not part of the MSA. Mr. Biernoff replied that they are companies that emerged after the MSA was entered into, and most of them are not household names. The only one based in New Mexico is Sandia Tobacco Manufacturers, Inc.; it is currently in bankruptcy. It is one of a dozen companies that emerged and had sales in New Mexico after the MSA was entered into. A member asked if American Spirit cigarettes is one of those companies' products. Mr. Biernoff replied that American Spirit is a product of Santa Fe

Natural Tobacco Company, which used to be based in Santa Fe but is now based in North Carolina and is now part of R.J. Reynolds, one of the largest cigarette manufacturers.

A member asked if New Mexico was indeed lax in enforcing the escrow provision. Mr. Biernoff explained that many of the companies in violation of the escrow provisions were "fly-by-night" companies based overseas, and their home countries often did not recognize U.S. jurisdiction. As a result, enforcing the escrow requirement was problematic. Escrow enforcement has improved considerably today as most NPMs are based in the U.S. and are generally compliant with their escrow obligations.

A member asked if it is believed that New Mexico is complying today, and Mr. Biernoff replied that New Mexico now has a better record of effective enforcement of the escrow provisions. Nonetheless, he expects the PMs to challenge the NPM adjustments every year because their potential for savings is worth the litigation expense for them.

A member asked how long the MSA payments are due to New Mexico, and Mr. Biernoff replied that the payments are in perpetuity.

A member asked if the MSA includes e-cigarettes, and Mr. Biernoff replied that it does not and that it also does not include cigars and most other tobacco products (except for RYO, roll-your-own tobacco, which is included). A member commented that the MSA provisions that reduced or eliminated marketing of cigarettes, especially to youth, were the most beneficial initiatives in the agreement, but they only apply to domestic sales. The MSA did not change the activities of tobacco companies in foreign countries.

Concerning the revenue distribution, a member asked if it was correct that 50% of the revenues received were distributed to health and education programs and 50% of revenues were deposited into the TSPF; Mr. Biernoff responded in the affirmative. Regarding the 2016 special legislative session, a member asked if the funds swept for solvency were from the TSPF and not program funds, and Mr. Biernoff responded in the affirmative.

A member commented that the purpose of the creation of the TSPF was to provide a "wealth fund" that would distribute earnings in a manner that the distributions would continue in perpetuity.

A member discussed the fiscal status of the TSPF and its role as part of the state operating reserve. A member commented that the pressure to use MSA payments to shore up the state operating reserve will have a negative impact on the UNM Health Sciences Center, which is a major recipient of tobacco funds.

In response to a member's question, Mr. Biernoff said that the precipitating event of the 2003 dispute between New Mexico and the tobacco companies concerned an estimated escrow

shortfall of approximately $100,000, and this resulted in a loss of millions of dollars as a result of the 2003 NPM adjustment.

A member asked if the AGO had considered how the new arbitration proposals and possible bills in the U.S. Senate might affect challenges to payments. Mr. Biernoff said that the AGO is aware of the proposals in the U.S. Senate but that the MSA has its own arbitration provision that is unlikely to be affected by legislative changes. In 2003, New Mexico argued that the decision of the 2003 panel should have been heard in court. The MSA provides that the distribution calculation and disputes about the calculation must go to arbitration. New Mexico argued that the state's dispute was not over the computation or issues related to the calculation; rather, it was over what constitutes diligence in enforcement of the escrow requirements of the NPMs. New Mexico and most other states did not prevail in that argument, although Montana did.

A member asked how the Sandia Tobacco Manufacturers, Inc., bankruptcy impacts New Mexico's MSA payments. Mr. Biernoff replied that the bankruptcy does not directly affect New Mexico's MSA payments because Sandia is an NPM. However, the AGO has entered the bankruptcy proceeding to protect New Mexico's interests. A member asked how much money Sandia owes the state, and Mr. Biernoff replied that it was an amount in the thousands, not hundreds of thousands, of dollars.

A member asked what the expected payment is for New Mexico next year. Mr. Biernoff replied that it is estimated to be $38 million to $39 million for the regular annual payment, plus $9 million to $12 million for funds previously withheld since 2003 and ordered released to New Mexico as a result of the district court's ruling. A member asked if the tobacco companies will appeal the district court's decision, and Mr. Biernoff replied that he expects they will.

Winnable Battles: Tobacco Use Prevention and Control (TUPAC) Program and Other DOH Programs Funded from Tobacco Settlement Revenues

Benjamin Jacquez, TUPAC program manager, DOH, worked through his handout at Item (2), TUPAC Presentation 10.26.16. He highlighted Slide 19, which shows a 62% decline in youth smoking from 2003 to 2015; Slide 22, which shows a 19% decline in adult smoking from 2011 to 2015; and Slide 27, which shows a 42% decline in youth secondhand smoke exposure. Referring to Slide 28, Mr. Jacquez illustrated how TUPAC works with tribes around the state. Slide 32 shows that future health cost savings from the TUPAC program are estimated to be $1.3 billion. Mr. Jacquez also provided other handouts that are posted on the website and included in the meeting file but that, in the interest of time, he did not address in the meeting.

A member asked what the target age is of the high school initiatives, and Mr. Jacquez replied that it is directed at all age groups. A member asked what was the effect of raising the legal age of smoking, and Mr. Jacquez replied that it reduces the prevalence of smoking. A member asked if anyone has looked at making e-cigarette use restricted to adults and asked if the TUPAC program would support that. Mr. Jacquez replied that the TUPAC program cannot

recommend the use of e-cigarette products since it is not known what is in them. A member asked if the DOH recommended to the governor to raise cigarette taxes. Mr. Jacquez replied no; however, it is recognized by the CDC as a best practice for reducing the incidence of smoking. Raising cigarette taxes is not a policy recommendation of the DOH. A member asked if the CDC has a recommendation on the price point for cigarette prices, and Mr. Jacquez responded that it does not. A member commented that smokeless tobacco also has an effect on health. Mr. Jacquez responded that the DOH is also focusing on smokeless tobacco and promoting tobacco-free rodeos.

Daniel Burke, chief, Infectious Disease Bureau, DOH, explained his handout to the committees. Regarding Item (2), NMDOH Harm Reduction 10.26.16, Mr. Burke described the DOH's HIV, sexually transmitted disease and hepatitis program activities that are funded with tobacco settlement funds. Mr. Burke reported that New Mexico has the highest incidence of liver disease deaths in the United States, at 400 cases per 100,000. Most of these deaths are attributable to hepatitis C infection, he explained. New Mexico also has the largest needle exchange program in the United States, which aims to reduce transmission of infectious diseases through the avoidance of needle-sharing. Mr. Burke emphasized that funding from the tobacco settlement revenues is essential to the Harm Reduction Program and Hepatitis Program because neither program has any federal funding for contractual services.

Beth Pinkerton, manager, Breast and Cervical Cancer Early Detection Program (BCC), DOH, addressed the items in her handout. Item (2), NMDOH BCC Presentation 10.26.16, described the BCC. The program was established in 1991 and uses a statewide network of contract providers. Approximately 81,000 women in New Mexico are eligible for free BCC screening. In FY 2016, the program received $128,600 and screened 876 women, but the program's fund is sufficient to serve only 15% to 20% of the eligible population. Ms. Pinkerton reported that 100% of tobacco settlement revenue funds appropriated for the BCC are used for direct client services and contribute to making the required funding match for a federal grant.

Judith Gabriele, manager, Diabetes Prevention and Control Program (DPCP), DOH, working through her handout at Item (2), Final DPCP TSROC Committee Presentation 10.26.16, described the program. Ms. Gabriele noted that only one out of four adults in New Mexico with pre-diabetes knows it, and four out of five adults with diabetes know it. In 2012, the estimated cost for adults with diabetes and pre-diabetes was $2.1 billion. Ms. Gabriele noted the positive correlation between smoking and diabetes. The DPCP is funded with a combination of federal, state general and tobacco settlement funds; the tobacco settlement funds comprised 45% of the budget at $748,000 in FY 2016.

A member noted that the Harm Reduction Program and Hepatitis Program tobacco settlement revenue funding request for FY 2018 is $150,000 more than it received in FY 2017 and asked if this request will be coming to the LFC as part of the FY 2018 budget request. Cathy Rocke, deputy director, Public Health Division, DOH, replied that she would confer with Secretary-Designate of Health Lynn Gallagher and follow up with an answer for the committees.

A member asked if the DOH is working with the Corrections Department (NMCD) on treatment of hepatitis C. Mr. Burke replied that the DOH is working independently with the UNM School of Medicine's Extension for Community Healthcare Outcomes or "Project ECHO". Per his understanding, the NMCD is also working with Project ECHO. He commented that the numbers of inmates with hepatitis C and costs for treating them are staggeringly high.

A member asked if the recent tuberculosis (TB) cases in Santa Fe County are under control. Mr. Burke replied that TB is an old enemy to humankind and is the largest killer in the world. There are only 50 cases per year in New Mexico. He said that the DOH has a great TB program, but more nurses are needed. Currently, there are four active TB cases in the Santa Fe area, but there are no public health nurses in Santa Fe, so the department has assigned public health nurses from Espanola to care for the TB patients in Santa Fe. A member asked if the nursing positions have gone away, and Mr. Burke replied in the negative and said that it is partly a budget issue, but mostly it is a staffing availability issue. A member asked if higher pay could attract the skilled people needed. Ms. Rocke replied that the department advertises the position in Santa Fe and receives only one or two applications, and when the discussion turns to salary, the applicant often withdraws because the medical industry is very competitive and the salary the state is able to offer is not comparable to the private sector.

A member asked how the DOH provides data on infectious diseases, and Mr. Burke replied that the Indicator Based Information System for Public Health Data Resource, or "IBIS", is an online database available to the public on the DOH's website. The public can also call and information will be provided.

Regarding the data on Slide 5 of the BCC presentation, a member noted that the numbers have not changed much and asked why. Ms. Pinkerton replied that there is very low variability in the costs and the type of screening. A member asked, if the budget is increased, can more women be served, and the member commented that current research is showing false positives in mammogram screenings and inquired if the DOH is also experiencing this. Ms. Pinkerton replied that the department is following the false positive studies carefully. She replied that the DOH follows national guidelines and educates patients on the benefits of screening.

A member commented that the BCC screening programs need more funding. A member asked if many people are falling through the cracks on BCC screening, and Ms. Pinkerton replied that there is still a need for screening services. Areas in need of improvement are serving the underinsured and uninsured; persons who have high co-pays and deductibles often are not getting follow-up exams if there is something unusual detected in the initial exam.

A member asked whether gene testing is part of the BCC screening, and Ms. Pinkerton replied that it is not at this time.

A member asked if the DOH has any data that link tobacco use to breast and cervical cancer. Ms. Pinkerton replied that in 2014, the U.S. surgeon general issued a report confirming

the link between tobacco use and breast and cervical cancer; the DOH can provide more information to the committees in the future. A member asked the panel to identify specific areas that do not have web access to implement the DCPC.

Regarding diabetes, a member asked whether a sugar consumption relationship to diabetes exists and whether the DPCP includes education on sugar consumption. Ms. Gabriele replied that the primary risk factor is obesity. She said that whether sugar causes diabetes is a complicated issue. She continued that weight, physical activity and caloric consumption are the three factors that are typically studied in determining a person's risk for having or getting diabetes. A member commented that program participation seems low and asked what the agency or legislature can do to increase participation. Ms. Gabriele replied that there are challenges in building up the program infrastructure statewide. The first delivery site in the country was in Chaves County, and the program may be dropped because of the difficulties in operating the program there. Ms. Gabriele expects that when the federal Medicare program begins to pay for diabetes programs in January 2018, participation is expected to go up significantly. She reported that Medicaid and Molina Healthcare of New Mexico already pay for participation in the program. Ms. Gabriele said that at the end of the fiscal year, the DOH will engage all of the stakeholders to work to increase participation in the program.

A member commented that it is frustrating to committee members that the presenters cannot ask the committees for funding though they come before the committees with a funding need. Another member commented that the current hearing is about the use of appropriations from the tobacco settlement funds, not about the operating budget needs.

Centennial Care Tobacco Prevention and Cessation Services

Ms. Pfeffer, working through her handout at Item (3), reported that in FY 2016, Medicaid received $30,019,700 from the Tobacco Settlement Program Fund, and in FY 2017, $27,319,300 was appropriated for Medicaid from the Tobacco Settlement Program Fund. The funds are expended for breast and cervical cancer treatment and for other Medicaid programs, including smoking cessation programs. The smoking cessation services are provided under contracts with four MCOs.

A member asked whether the Medicaid MCOs are incentivized to implement smoking cessation programs, given that they make more money if someone gets sick. Ms. Pfeffer said the MCOs have been cooperative in developing and providing prevention and cessation programs.

A member asked whether, if a patient was not enrolled in Medicaid at the time the patient received BCC screening and breast cancer was detected, would the patient be eligible for Medicaid and have cancer treatments paid for by Medicaid. Ms. Pfeffer replied that the treatments would be paid for under the breast and cervical cancer category only if the patient were screened by the DOH if that patient were otherwise eligible for Medicaid under more generous income eligibility guidelines. Otherwise, the patient may qualify under the normal

Medicaid expansion or family Medicaid. If the patient's income were too high for Medicaid, the patient might be covered under a quality health plan through the exchange.

A member asked whether the HSD had smoking cessation screening requirements in the contracts between the HSD and the MCOs. Ms. Pfeffer replied that the HSD does not at this time, but these requirements are being considered in discussions with the providers. A member asked if there are data on the success of the smoking cessation programs, and Ms. Pfeffer replied that the performance tracking initiative with the MCOs will begin to provide data on effectiveness.

Tobacco Prevention, Cessation and Regulation Legislation

Representative Armstrong presented two draft bills for discussion and said that she was not seeking endorsement at this time. The first bill proposed raising the age limit to legally access tobacco products to 21. The second bill raises the cigarette tax by 10%.

In support of the proposal to raise the age limit for legal access to tobacco products, Representative Armstrong said that the use of flavored tobacco products is rising, particularly among young people. Some states have restricted the sales of flavored tobacco products, she explained. An across-the-board raise of the legal age to purchase tobacco products would address the sale of flavored as well as other tobacco products. She noted that 90% of adult smokers started smoking before age 19.

In response to questions by a member, Representative Armstrong said that one state, Hawaii, set the legal age for purchasing tobacco products at 21 in January 2016; Alabama, Alaska, New Jersey and Utah set the age at 19; and the remaining states either have set the age at 18 or have no age limits.

Members discussed the penalties for underage smoking and enforcement.

In support of the proposal to raise the cigarette tax, Representative Armstrong said that 10% is the lowest cigarette tax raise that should be considered, but studies show that the higher the tax, the less the use, and she would prefer to see the tax increased 35% to 45%.

Members discussed the effects of increases in taxes on cigarettes on smoking reduction and cessation and possible uses for increased revenue from the cigarette tax.

Members generally expressed support for both measures.

New Mexico Allied Council on Tobacco (ACT) — Tobacco Prevention Coalition

Janna Vallo, commercial tobacco control and prevention coordinator, Albuquerque Area Southwest Tribal Epidemiology Center (AASTEC), introduced herself and Laurel McCloskey, executive director, Chronic Disease Prevention Council, and Lacey Daniell, New Mexico grassroots manager, American Cancer Society Cancer Action Network.

Ms. McCloskey, Ms. Daniell and Ms. Vallo, working through the handout at Item (5), related that the Chronic Disease Prevention Council was established in 1997 and partnered with the AASTEC and other community members, health organizations and business professionals to create the ACT, a coalition that advocates for proven tobacco use prevention strategies through statewide partnerships. Ms. Daniell highlighted that tobacco use costs $1.44 billion annually in New Mexico, which translates to a per-household state and federal tax burden from smoking-caused expenditures of $945 per year. The members of the ACT work together to support proven measures to reduce tobacco-related disease and death and associated costs, including regular, significant increases in the price of tobacco, smoke-free workplaces and public places and comprehensive tobacco prevention and cessation programs.

In response to a member's question, Ms. Daniell was very complimentary of the TUPAC program's efforts, calling the program the "experts" in youth tobacco use prevention and cessation.

A member asked what the ACT thinks of the proposed legislation to raise the cigarette tax. Ms. Daniell replied that the CDC recommends raising the price per pack by at least $1.00 in order to impact the incidence level of smoking, noting that tobacco companies often issue discount coupons to users to neutralize the costs of increased taxes.

Update on Tobacco Cessation Programs Funded Through the Indian Affairs Department (IAD)

Suzette Shije, deputy secretary, IAD, explained that in July 2008, the IAD received its first allocation from the tobacco settlement funds, allowing the establishment in early 2009 of a competitive grant system to fund tribal commercial tobacco prevention and cessation programs, with special emphasis on Native American youth, while recognizing the traditional ceremonial role of tobacco use. Deputy Secretary Shije noted other tribal efforts to encourage prevention and cessation of commercial tobacco use, particularly that the Navajo Housing Authority, the largest tribal housing authority with more than 10,000 units, is currently considering making all housing units smoke-free.

Deputy Secretary Shije introduced Allie Moore, project manager, IAD, who described the development of the grant program and summarized the various tribal tobacco prevention and cessation programs, referring to the handouts at Item (6). Ms. Moore reported that outcomes of the program funding and programs include: funding 10 programs in 10 pueblos, tribes and nations; creating six part-time jobs; generating $70,000 of in-kind contributions from grantees; reaching 43% of tribal communities; and engaging more than 8,275 Native American youth and adults. Ms. Moore added that the New Mexico Behavioral Risk Factor Surveillance System estimates a 20% decline in the smoking rate between 2011 and 2015. Between 2003 and 2015, the New Mexico Youth Risk and Resiliency Survey estimates that smoking among American Indian high school youth in New Mexico has declined 63%.

Deputy Secretary Shije testified that the Mescalero Apache Tribe is the first tribe in the country to submit to FDA compliance inspections for growing tobacco. She introduced Willymae Smith-McNeal, program coordinator, Mescalero Apache tribal tobacco cessation and prevention program. Ms. Smith-McNeal, referring to her handout at Item (6), explained the Mescalero recognition of traditional ceremonial uses of tobacco as distinct from commercial personal uses, and she described the parallel development of the commercial tobacco prevention and cessation program and introduction of growing tobacco for ceremonial purposes. She showed members a number of visual aids and games she uses in the tobacco prevention and cessation program; her handout includes a number of examples of student-made posters.

Approval of TSROC Minutes

The TSROC approved the minutes of its September 26, 2016 meeting with no amendments.

Public Comment

Cynthia Serna, former director of New Mexicans Concerned about Tobacco and current grassroots organizer of the American Cancer Society Cancer Action Network, noted that when funding for tobacco prevention and cessation programs is cut, tobacco use increases almost immediately. She urged the legislature to support continuation of funding for programs.

Nat Dean, traumatic brain injury survivor, provided the committees with a brochure from the Disability Advisory Group About Tobacco (DAGAT) New Mexico. Ms. Dean requested that funding for the DAGAT remain intact. She also addressed the importance of the legal availability of medical marijuana and stated that, as a medical cannabis patient for seven years, she has been able to reduce her number of medications from 27 to six.

Lisa Rossignol spoke as a health policy advocate for getting children with autism into Centennial Care coverage. She noted that Centennial Care has cut services, particularly respite care services, to families with children with special health care needs, and she urged legislators to reinstate and protect that funding.

Mary Beresford, DAGAT director, reported that disabled people have a very high rate of smoking, so access to cessation programs is vital to their overall health.

Long-Term Leveraging Medicaid Subcommittee (LTLMS) Recommendations

Angela Medrano, deputy director, MAD, HSD, introduced Carol Luna-Anderson, executive director, the Life Link, and chair, LTLMS, and Nick Estes, member, LTLMS, and member, board of directors, Health Action New Mexico (HANM).

Ms. Luna-Anderson, referring to her handout at Item (8), summarized the LTLMS' eight formal recommendations. Included among the recommendations is a recommendation that the state assess a provider fee or tax that would be used for enhancing Medicaid provider reimbursements through application of a larger federal medical assistance percentage (FMAP).

Mr. Estes told the committees that provider taxation is regulated by federal law and advised proceeding with expert help. With two exceptions (New Mexico and Alaska), every state and the District of Columbia use provider taxes. Alaska is considering provider fees as well. Under these states' laws, a certain "class" of health care providers that receive Medicaid reimbursement is charged a fee, and they generally recover the amount paid through enhanced Medicaid reimbursement. Yet "you cannot guarantee that they will be held harmless", Mr. Estes warned. He stated that the LFC is aware of this concept, as are other agencies in the state.

A member asked whether HANM's handout provides merely an example of the sort of provider fee that could be imposed. Mr. Estes answered that indeed it does, and that the fee would be charged on those services that would garner increased FMAP.

When asked what Secretary of Human Services Brent Earnest's and the governor's reactions were to the LTLMS' recommendations, Ms. Medrano told the committees that Secretary Earnest was reviewing the recommendations and that she did not know of a response from the governor.

A member discussed the role of the New Mexico Medical Insurance Pool, and how it protects the state's private insurance risk pool from incurring extensive losses that would result in greater premium increases for the private health insurance market.

A member asked the panel which of the LTLMS' recommendations were made by unanimous vote of the LTLMS members. Ms. Luna-Anderson answered that the provider tax recommendation was made unanimously. At the member's request, she went on to review other recommendations as follows.

- Recommendation number two on the LTLMS' recommendations listed in the handout was also unanimous, pursuant to which the HSD would work to leverage federal funds through waivers, intergovernmental transfers and Medicare pilot projects. Mr. Estes mentioned that Rio Arriba County Department of Health and Human Services Director Lauren Reichelt was eager to access more funds through such matching funds.
- Recommendation number four related to value-based purchasing by MCOs. Deputy Secretary Medrano said that the HSD is implementing new reimbursement methodologies. One FQHC had a contract pursuant to which the center bears the risk for caring for specific populations. MCOs have been directed to use 16% of their capitated rates for value-based purchasing, according to Deputy Secretary Medrano.
- Recommendation number seven related to home visiting funded through the state's Medicaid program in order to enhance funding through the Medicaid FMAP. Deputy Secretary Medrano stated that the CYFD model of home visiting is not a medical model, and hence, not likely eligible for Medicaid reimbursement. In response, a member stated that 81% of babies statewide are born to mothers enrolled in Medicaid. The member proposed that the HSD seek a waiver of the "medical services"

requirement as home visiting services are for prevention of future medical and social costs.

- A member stated that the member wants recommendation number seven to be "seriously considered".
- A member inquired whether there are any Medicaid co-payments designed to change behaviors and promote more responsibility for health. Deputy Secretary Medrano stated that no formal recommendations came from the LTLMS in this regard. The General Appropriation Act of 2016, however, does require that some cost-sharing be imposed. The CMS would have to approve such an arrangement. Some states have successfully imposed co-payments. Another member stated a belief that the administrative burden and cost of collecting the co-payments become a burden on providers. Also, it may result in Medicaid recipients avoiding care that could prove more costly in terms of their health and their burden to the Medicaid budget. Some insurers, the member noted, have removed co-payments where prevention will save on later costs. Another member noted a discussion of this in the latest LFC newsletter at page 1.

Recess

The meeting recessed at 4:41 p.m.

Thursday, October 27

Welcome and Introductions

Legislators from the LHHS and Courts, Corrections and Justice Committee and staff introduced themselves.

Corrections Health Care: Report of the Corrections Health Care Task Force; Federal Prison Rape Elimination Act of 2013 (PREA)

Maria Martinez Sanchez, staff attorney, ACLU-NM, told the committees that the ACLU-NM receives 70 complaints from New Mexico prisoners each month and that 10% to 20% of those complaints are regarding failures of the prison health system. Ms. Martinez Sanchez said the complaints include neglect in diabetes, cancer and hepatitis C care; untreated broken bones, hernias and kidney stones; dental neglect; and psychiatric medications not being provided.

Ms. Martinez Sanchez stated that she sees a pattern of neglect that violates the Eighth Amendment to the United States Constitution's prohibition on cruel and unusual punishment. She said that the State of New Mexico jails a lot of people but then fails to care for them. In addition, Ms. Martinez Sanchez said that preventative care would save the state money and that the state is opening itself up to liability in its substandard medical care of inmates.

To close, Ms. Martinez Sanchez said that the ACLU-NM wants to be included in the task force created pursuant to Senate Memorial 132 (2015). Without a prisoner health advocate, she said, the task force would be incomplete.

Jody Neal-Post, attorney at law, discussed the difficulties some of her clients faced in receiving health care while incarcerated. There were challenges with missed appointments, shackling on limbs despite a medical prohibition and failure to finalize recommended medical parole by the Parole Board. Ms. Neal-Post highlighted the fact that despite attempts by the NMCD to secure an inmate's medical parole, the Parole Board would not grant it. She urged the committees and the task force to change the statutory guidelines for parole boards to ameliorate the problem. Ms. Neal-Post said that the state faces unnecessary exposure to liability based on a failure to provide adequate health care to inmates. She said that when inmate health care is more compassionate and humane, it is also cheaper. She said that she wants to see the task force continue and to have inmates participate on the task force, as everyone wants to be part of their own health care.

Matthew Coyte, Coyte Law, P.C., said that he gets about 20 inmate requests for help per week. He said that from a legal standpoint, these are difficult cases to win because there is a required showing of deliberate indifference of the prison as a health care provider. As long as the prison doctor gives the inmate Ibuprofen or Tylenol, the prison is immunized from lawsuits. Of course, cases can still be filed alleging negligence and malpractice against the doctor, but those cases are almost never filed. He said that he understands that the prisons are in a difficult situation, too. A lack of funding has led to understaffing, which only aggravates the situation.

Mr. Coyte said that the new contract for inmate health care prioritizes fiscal responsibility over medical care, as evidenced by there being limited medical oversight over the contract, but significant financial oversight.

Wendy Price, Psy.D., chief, Behavioral Health Bureau, NMCD, told the committees that she led the task force created pursuant to Senate Memorial 132 and went over the various issues discussed by the task force. The top maladies faced by inmates are hepatitis C, HIV and psychological disorders. She said that there are challenges to care, but that inmates are educated as to how they can request treatment.

Jillian Shane, PREA coordinator, NMCD, stated that 11 adult prisons and two community jails in the state all passed the PREA audit.

Steve Jenison, M.D., said that he oversaw HIV treatment in all New Mexico prisons, which meant visiting each facility at least every three months and having a state public health nurse involved to ensure continuity of care for each patient.

Questions from members of the committees and the ensuing discussion focused on hepatitis C treatment, including Section 340B of the federal Public Health Service Act discounted drug pricing eligibility; medical oversight at the NMCD; the task force; and the new contract between the NMCD and Centurion.

Members and presenters agreed that hepatitis C treatment under UNM's Project ECHO program has been very effective. In the last year, there were 65 to 70 inmates treated for hepatitis C, which represents a big jump. While this may seem like a low number, with 58% of the state's inmates having hepatitis C, most states only treat about 1% of their inmates with hepatitis C. The biggest hurdle to treatment is the high cost, which is $90,000 to deliver a 12-week course of hepatitis C treatment to one person. Under the deeply discounted pharmaceutical pricing available pursuant to Section 340B, the cost would be half that.

Alex Sanchez, deputy secretary, NMCD, said that 340B eligibility has a number of requirements, and the state fails to qualify, but it is written into the contract with Centurion that vendors will still seek it. A member mentioned a federally funded health provider in Albuquerque that would qualify for 340B pricing and said that the NMCD should partner with the provider. According to information received by another legislator, 340B pricing was actually discontinued at the recommendation of an NMCD medical director who no longer works for the state. That medical director sought pharmaceutical savings through the NMCD's contract with Corizon Correctional Healthcare.

A legislator asked how the NMCD decides who are among the 1% of inmates who are treated for hepatitis C. Deputy Secretary Sanchez said that the NMCD has a process for assessing whether an inmate would compromise treatment with intravenous needle usage or if the inmate has another condition that would have an impact on the viability of the treatment. When selecting an inmate for treatment, the NMCD contacts Project ECHO. Deputy Secretary Sanchez said that, though not all patients receive this expensive course of medicine, all patients receive, at a minimum, the care that an indigent patient would receive on the outside. A legislator said that Project ECHO is a "game changer", but the state cannot expect the same level of delivery if it is underfunded.

Regarding medical oversight of those incarcerated at NMCD facilities, Deputy Secretary Sanchez said that there is a medical director, Dr. Boynton, and Health Services Director Angela Martinez, who is in change of the auditing and medical care. Upon questioning, Deputy Secretary Sanchez stated that Dr. Boynton is not employed by the NMCD but is in fact the Centurion medical director. There is no medical director employed by the NMCD. Some legislators expressed concern that the health services director for the NMCD is not a medical professional as has occurred in the past.

Discussing the Corrections Health Care Task Force, members asked if the right people were on the task force and if there were an opportunity for members and nonmembers to be heard. Legislators voiced concerns when Dr. Price explained that, though it was being finalized for awhile, a draft report of the task force's findings was only sent out the day before for members of the task force to review. A legislator said that it is difficult to assess the task force's work when information is provided at the last minute.

Ms. Martinez Sanchez said that the ACLU-NM got a late invitation to join the task force, and after being assured that the director of the ACLU-NM could call in to participate in the meeting, the videoconferencing technology was a consistent obstacle to his ability to join in. Deputy Secretary Sanchez alleged that the director of the ACLU-NM attended four out of the five task force meetings.

In response to a question, Deputy Secretary Sanchez said that among the task force's recommendations, there is no recommendation that the task force continue. Legislators requested copies of those recommendations, that the task force continue its work and that it include more advocacy groups. Members said that a reason for the task force to continue is that it provides ongoing progress reports to the legislature.

Regarding the contract with Centurion, which went into effect on June 1, 2016, Deputy Secretary Sanchez said that there are actually two contracts, one for $41 million for health care and one not to exceed $11 million for pharmaceuticals. She said that the company does recruit within the state for staff and that, for the most part, the staff will remain the same. The improvement, she said, will happen in the required performance measures. A live dashboard is the centerpiece of that and is the key to real-time assessment.

Deputy Secretary Sanchez said that the dashboard will provide, on request, a real-time update on inmate information. Deputy Secretary Sanchez said that officers do not enter information into the dashboard; it is the vendor's responsibility. Members of the committees expressed concern that requested care by the inmates is not being provided and asked that the dashboard reflect that in an effort to improve care.

To close, a legislator suggested that the NMCD seek offset funding from the Indian Health Service to the extent that the NMCD provides health care to Native American inmates.

Corrections Medicaid Enrollment and Suspension

Kari Armijo, deputy director, MAD, HSD, discussed how the HSD is rolling out its program to ensure that Medicaid-eligible inmates have timely access to post-release health care (see handout). Deputy Director Armijo highlighted the impact of information technology and regulatory changes, the counties and agencies currently participating and the pilot program between the Bernalillo County Metropolitan Detention Center (MDC) and Molina Healthcare.

Deputy Director Armijo said that the HSD is working with more counties than are identified in the handout, but those not mentioned are still a work in progress. She said that there are still some delays with the daily sharing of information, but the process is automated. Another benefit is that over one-half of the inmates are actively engaged in their post-release health care coordination, and this drives down recidivism.

Jerry Roark, director, Adult Prison Division, NMCD, said that the NMCD has started signing up inmates for Medicaid 60 days before their release and have reached a 90% sign-up rate.

Gabriel Nims, special projects coordinator, MDC, said that the MDC accounts for the lion's share of the county budget, some $75 million to $80 million a year, and it is realized how important it is to be fiscally responsible and good custodians of that money.

Mr. Nims said that the MDC used to have a passive enrollment system, according to which the MDC waited until a Medicaid-eligible inmate requested it and even then it would hold the inmate's application for Medicaid until that person's release date. Now, MDC staff is approaching those inmates who qualify, helping them to fill out the application and then sending the applications for processing earlier. In response to a question, Mr. Nims said that inmates can still refuse to enroll, but that is rare. Mr. Nims said that the first 72 hours after release is the most important for recidivism, so any delay in continuity of health care can have an impact.

Currently, the Medicaid enrollment pilot project is ongoing only with Molina Healthcare, one of the four Medicaid MCOs, but other MCOs are watching closely. In fact, the MDC/Molina Project is generating interest by Seattle-King County officials in the State of Washington.

Mr. Nims closed by discussing a proposed reentry resource center, which would include a rest area if an inmate is released at night. The center would be staffed with case managers to connect newly released inmates to available social services. He said that these efforts improve the system and have a positive financial impact.

Solitary Confinement and Custodial Segregation

Mr. Coyte said that whatever one calls it — administrative segregation, administrative housing, protective custody, solitary confinement — these are a lot of names to explain a deprivation of meaningful human contact, where a person is kept in a room for 23 hours a day on weekdays and 24 hours on weekends. Mr. Coyte said that while solitary confinement is banned in many states and New Mexico has paid out million-dollar judgments to people wrongly held in solitary, the state has not passed laws to stop solitary confinement.

Mr. Coyte highlighted the fact that inmates with a mental health diagnosis are not officially allowed to be in solitary confinement, but they should be in an alternative placement area. Despite that, he said, in New Mexico, those inmates are still being put in solitary confinement.

Stuart Grassian, M.D., appearing via videoconferencing, told members that restricted environmental stimulation is toxic to anyone and that inadequate exposure to stimulation, internal or external, results in stupor. Dr. Grassian discussed the history of solitary confinement, from an innovative criminal justice incarceration technique to significant limitation of its use because it was long ago found not to foster reform and to seriously and detrimentally impact

prisoners' mental well-being. In fact, he said, the toxic effect has been known for so long, it is absurd that it is still in use.

Dr. Grassian said the arguments in support of solitary confinement are based on prisoners making rational decisions about how to act to avoid solitary confinement, but this situation rarely plays out where the decisions made by the inmate that resulted in solitary confinement are rationally made. This is especially pernicious in light of the fact that 75% of prison beds are occupied by people whose initial offense can be tied to mental illness. A member agreed and said that inmates with traumatic brain injury often have diminished impulse control, which could cause the exact behavior that lands a person in solitary confinement.

Dr. Grassian said that inmates with impaired cognitive ability do terribly in solitary confinement. He said that the worst thing for people with posttraumatic stress disorder is to put them in a situation that they cannot control, and that is what solitary confinement is all about.

A legislator asked if inmates in solitary confinement can receive visitors and why the 23 hours of confinement is de rigueur. Mr. Coyte said that visitation rights depend on the facility and on the level of the prisoner. The 23-hour rule, according to Mr. Coyte, comes from a dictum in a legal case where the judge wrote, "Well, at least they should get an hour a day outside". Now, for whatever reason, that has been incorporated into the solitary confinement practice of many prisons and jails.

To illustrate the deleterious effects of solitary confinement, he cited the example of a once-healthy young man who was picked up for traffic tickets, placed in solitary confinement and came out with a severe mental illness. While held in solitary confinement, the young man was kept naked and forced to defecate in a hole in the floor.

A 54-year-old woman had severe postpartum depression in her twenties, according to Mr. Coyte. She later became severely mentally ill after being held by Valencia County in solitary confinement, where she had to sleep near a hole in a damp floor. For posttraumatic stress disorder and other complaints, she was awarded a $1.6 million settlement with Valencia County.

Mr. Coyte described the case of a man who was held in Carlsbad in a tiny cell, naked, where he had to endure lights left on 24 hours a day and sleep by a drain into which he was forced to push his feces, which would later bubble up through the drain. He was kept in cold temperatures, with no water with which to wash. He was never released for exercise. "Why do we do this?", Mr. Coyte asked. There needs to be a law that bans these practices, he stated. In 1998, West Virgina banned solitary confinement for juveniles. Mr. Coyte stated that he is currently suing Curry County for use of solitary confinement on juveniles there.

In response to a question about tests that show the different effects of solitary confinement and additional punishment, i.e., leaving the lights on for 24 hours or removing all furniture or the inmate's clothes from the room or the inmate's clothes, Steve Allen, director of

public policy, ACLU-NM, said that most prisons and jails do not collect good data on whom they put in solitary, so no such tests exist. The little data that are collected, Mr. Allen said, are not useful for comparison because each facility collects different information. In the past, house and senate bills were introduced in New Mexico that would have required prisons and jails to collect information on solitary confinement in a uniform way. Those bills did not pass. Colorado, he explained, took a data-driven approach and requires uniform data collection. This has resulted in a drastic decrease in the use of solitary confinement. During their 2017 legislative sessions, Idaho, Maine and Texas are going to consider laws using a data-driven approach to solitary confinement.

Mr. Allen said that other research has shown that there is no good reason for the use of solitary confinement on minors, the mentally ill or anyone for more than 15 days. He said that Colorado is the national leader in improving techniques for the use of solitary confinement.

Grace Philips, general counsel, New Mexico Association of Counties, said that there are correctional facilities in 27 of the 33 counties in the state and far fewer facilities for juvenile inmates, which means that juvenile offenders are often incarcerated farther from home. She stated that New Mexico has a much higher incarceration rate than do other states. One-third of those incarcerated in county jails are in for failure to comply reasons, including probation violations, parole violations and warrants. Housing of probation violators alone cost counties $35.8 million in FY 2016. County jails also hold many people who live with mental illness. On average, 2,557 inmates a day in New Mexico county jails have a diagnosed serious mental illness.

Ms. Philips said that when the legislature seeks harsher criminal penalties, especially in times of financial hardship, longer sentences mean a bigger cost to the taxpayer. She also said that jails and prisons are de facto mental health hospitals and posited that there are more people in jail taking psychotropic medicine than there are in mental health facilities and more county detention staff than clinicians treating the mentally ill.

To close, Ms. Philips said that in her experience, families do not typically bond out the mentally ill, as those families often use the jail as a safe way to remove a person from the home.

Pablo Sedillo, director, Public Safety Department, Santa Fe County, highlighted the county's efforts to handle the mentally ill. All of the county's public safety officers and first responders have crisis management training and know crisis-intervention techniques. Also, Santa Fe County has two reentry specialists and is looking for a third.

Mr. Sedillo reiterated what Ms. Philips said regarding the families of the mentally ill. He said that the families of those with mental illness are often happy when the mentally ill person is held in a detention center. Mr. Sedillo explained that, nevertheless, jails are not hospitals. While they do their best to care for mentally ill inmates, it is not the same as a hospital setting. County jails do not have trauma areas, for example, as a hospital would.

Michael Ferstl, assistant director of operations, Bernalillo County Youth Services Center, said that he is the former head of the United States Marshals Service for New Mexico, and as such, he is very familiar with the state's correctional facilities. He said that New Mexico has well-run jails and that the solitary confinement lawsuits stem from staff failures and not department policy. He said that as a corrections professional, he sees through a lens of prisoner days. He warned against taking these lawsuits out of context and said that five lawsuits arising out of 47 million prisoner days is not a high number at all.

Mr. Ferstl said that the Bernalillo County Youth Services Center does not utilize solitary confinement, as that term is defined. In fact, he thinks that the segregation policy his facility uses is worthy of being a national model. Mr. Ferstl said that he is wary of any blanket legislation regarding solitary confinement because he fears that it will hamper the efforts of corrections officers.

When asked about how long juveniles are kept in isolation at the Bernalillo County Youth Services Center, Darren James, case manager, Bernalillo County Youth Services Center, discussed some case studies and said that when inmates relapse, they might be in isolation more than a few weeks.

Mr. Roark said that New Mexico's adult facilities use the American Correctional Association's definition of restrictive housing, which includes 22 hours of cell time a day. He said that despite all efforts to curb it, there will always be illegal activity in prisons, be it trafficking, gambling or something else. That activity will spur outbursts of violence, which will, in turn, require the separation of inmates. A legislator said that perhaps that is the case, but that there is a difference between segregation and segregation with additional punishment.

A large number of beds are going unused at the DOH's New Mexico Behavioral Health Institute at Las Vegas (BHI), according to one legislator. Why, the legislator asked, is the DOH turning people away from treatment at the BHI? The legislator requested that the LHHS follow up with testimony from the DOH on the BHI's accessibility for seriously mentally ill New Mexicans.

A legislator said that there will be a bill introduced next session and that it is important that legislators learn from the NMCD and county corrections officials about jail management so that the language in the bill reflects the legislative intent. The legislator wants New Mexico to comply with international standards.

Finally, a legislator said that oversight of probation and parole needs to be taken from the NMCD and given to the judiciary, which is better prepared to provide objective administration.

Public Comment

Diana Crowson discussed her son, who spent almost two years in solitary confinement in Las Cruces. She said that she is aware of an inmate, not her son, who received only an Ibuprofen after suffering a stroke.

Ruth Hoffman, director, Lutheran Advocacy Ministry-New Mexico, read the following statement.

> Mr. Chairman and Members of the Committee,
> Our denomination, the Evangelical Lutheran Church in America, adopts social statements which are the underpinnings of our advocacy work. The following is a quote from our newest social statement on criminal justice: 'As people of reason, we accept differences in correctional philosophies, but as people of faith we reject dehumanization of the incarcerated through brutalizing means whether legal, psychological, sexual, emotional, racial, cultural, or spiritual.' With this underpinning, we oppose the use of solitary confinement for juveniles and the seriously mentally ill. We also urge that it be restricted for use with the general population of those incarcerated and that the use of solitary confinement be closely monitored and tracked.

Ms. Hoffman said that Mississippi has virtually eliminated solitary confinement, not because of a moral distaste for its use, but because it saves the state a lot of money.

Reverend Holly Beaumont stated that 80% of the job is just "showing up", and she was present to represent 300 faith leaders in support of limiting solitary confinement. (Please see letter provided in the handouts, Item (18), for the week's hearings.)

Leona Stuckey-Abbott spoke against the use of solitary confinement.

Recess

There being no further business before the committees, the meeting recessed at 5:25 p.m.

Friday, October 28

Welcome and Introductions

Senator Ortiz y Pino reconvened the meeting at 8:59 a.m. and the members and staff of both committees introduced themselves. He also mentioned that legislators and staff were invited by Robin Otten to tour supportive housing facilities at Lomas and Second in Albuquerque at 8:00 a.m. on Veterans Day, November 11.

Adverse Childhood Experiences in Juvenile Offenders in New Mexico and What We Can Do About It

Amir Chapel, research scientist, New Mexico Sentencing Commission, discussed a newly released report about adverse childhood experiences (ACEs). The report features results from a behavioral health risk factor survey, which randomly sampled 26,000 adults nationwide. The field of ACEs is growing quickly. It started with health outcomes, is now being used with juvenile justice issues and will likely be used to assess a number of things in the near future.

The New Mexico Sentencing Commission looked at a number of factors that it considers to be ACEs. Those factors are emotional abuse, physical abuse, sexual abuse, emotional neglect, physical neglect, parental divorce or separation, family violence or domestic abuse, household substance abuse and household member incarceration. One hundred percent of female inmates and 93% of male inmates in New Mexico facilities surveyed were found to have experienced physical neglect, and 81% of inmates had experienced a diagnosable substance abuse or dependence issue. These were the most common correlates for probation violations.

George Davis, M.D., director of psychiatry, CYFD, stated that the ACE study was "one of the greatest behavioral health studies ever done". He said that ACEs have long-term effects on people's physical, mental and emotional lives, but not every ACE has the same deleterious effect. In fact, ACEs work in concert with one another, and typically, four different ACEs is the number where studies show that they have an impact. Studies show that a person who has experienced four or more ACEs will live 20 years less than if the person had not had any ACEs.

Dr. Davis said that juvenile delinquents are created, not born, but intervention needs to happen early, long before the person commits a crime. ACE intervention has to rewire these children's brains. Dr. Davis said that while not all neglected children end up in trouble, 90% of those in the juvenile justice system in New Mexico experienced ACEs. Early childhood trauma is an attachment disturbance, which is an emotional disruption causing an inability to be calmed by adults. Sports, t'ai chi and any large-muscle activities that are multisensory; vocational skill-building; showing respect; animal therapies, such as equine and dog therapy; and using discharge planning in facilities are all methods that the CYFD employs at its facilities that can be helpful in counteracting the effects of ACEs.

A legislator said that prevention is the first step, and one of the challenges is getting home-visiting services to the right homes. The legislator said that experience shows that the people who sign up for home visiting are rarely the people who need it. There are good results with home visiting, but it is obvious that those who accept it are in families where the parents are more informed and more likely to accept and incorporate constructive criticism.

Dr. Davis said that the difficulty is not identifying those most in need of home visiting but to coerce those families into accepting the visits. This is especially the case where there is a need for ongoing visits. Solutions posed were tying cash assistance or Medicaid to home visits.

A legislator asked whether marijuana legalization might contribute to ACEs. Dr. Davis stated that this would be part of a larger picture. Where there is substance abuse in the home, there may be ACEs.

The discussion focused on lifestyle tips for improving the home life of children in New Mexico. Topics discussed include helping young mothers, providing books and toys to help with parenting, de-incentivizing divorce, providing cash assistance to single parents and treating substance abuse.

A member said that one way to break the familial incarceration cycle is to prevent recidivism by prohibiting a lack of criminal history to be used as a condition of employment. Another legal solution posed was to tie home visiting to early childhood development efforts so that it can be considered a medical home visit and be covered by Medicaid.

In response to a question about what types of probation violations are leading to incarceration, Mr. Chapel cited a report from a few years ago on what probation violations land people in jail. However, he said, a lack of uniformity in the data collection continues to be an obstacle. There are some uniform rules that are being implemented now that should help in the future.

A member mentioned Uniform Probation Code provisions that are being used in New Mexico and the need to teach parenting skills.

In closing, a legislator warned that, based on ACEs, there will be more women in the criminal justice system as more and more girls are being traumatized.

Sharpening Prescribing Practices for Pain Management

Michael Landen, M.D., state epidemiologist, DOH, told the committees that the prescription monitoring program is critical to sharpening the prescribing of pain medication to more effectively combat pain and not over-prescribe. (Please see handout under Item (20) for details and, on page 8, recommendations.) Dr. Landen cited a study that shows that the mortality rate among middle-aged White Americans is on the rise, in stark contradiction to comparable countries where the rate is going down. He attributed the difference to pain and pain medications. He said that more than one-half of the people who die of a prescription overdose have a prescription for the drug that caused it, but just under one-half do not. More than two-thirds of people who die of opioid overdose are on chronic opioid therapy.

Dr. Landen said that oversight, like that provided by the New Mexico Prescription Monitoring Program (PMP), if used effectively, can prevent overlapping prescriptions. However, there are still 3,000 to 6,000 patients in the state with overlapping prescriptions.

Discussing specific drugs, Dr. Landen said that hydrocodone was rescheduled in 2014, after which overdose deaths dropped precipitously. He also said that New Mexico is a leader in the use of Naloxone, an overdose medication.

Dr. Landen closed by saying that what is being done is not working, but work continues on the problem. For example, the chronic pain survey findings by the Prescription Drug Misuse and Overdose Prevention and Pain Management Advisory Council will be implemented in 2017.

Joanna Katzman, M.D., M.S.P.H., director, UNM Pain Center; and director, UNM Project ECHO Chronic Pain and Headache Program, said that the UNM Pain Center saw 8,000 patients last year suffering from an array of maladies. She said that most heroin addicts started with prescribed opioids given to them by a friend or relative. An important way to address this and other issues is to train everyone that can prescribe how to and how not to prescribe opioids. Dr. Katzman said the need is to train everyone, not just doctors and osteopaths, but nurse practitioners, physician assistants, etc. Currently, a five-hour training is now required for doctors at all federal clinics.

Demetrius Chapman, M.P.H., M.S.N.; R.N., executive director, Board of Nursing, provided a primer of advanced practice registered nursing. There are four types of advanced practice registered nurses (APRNs), three of which are regulated by the Board of Nursing: C.N.P., C.R.N.A. and C.N.S. Certified nurse-midwives are regulated by the DOH. APRNs in New Mexico have prescriptive authority that does not require physician oversight, while neighboring states have more limits to the prescriptive authority of APRNs. All APRNs are registered nurses with a bachelor's degree in nursing and either a master's degree or doctorate in advanced nursing.

APRNs include:

1. C.N.P.— (certified nurse practitioner), who provides primary care in community and acute-care settings, of whom New Mexico has 1,794;
2. C.R.N.A. — (certified registered nurse anesthetist), who provides anesthesia care or pain management, of whom New Mexico has 425; and
3. C.N.S.— (clinical nurse specialist), who has different training than a C.N.P. in that the C.N.S. is are more specialized in one population, disease process or anatomical system, such as the cardiovascular system, of whom New Mexico has 130.

Mr. Chapman provided an overview of recent federal law impacting the nurses' prescriptive authority and related training and said that the CDC guidelines for the prescribing of opioids for chronic pain are a nice synthesis of the current science that is available regarding the prescribing of opioids.

He said that the PMP has been a valuable tool for APRNs in determining treatment for patients with opioid prescriptions. Mr. Chapman discussed Suboxone and said that limited access and high need have resulted in a market on the street for the self-treatment of addiction.

He said the limited number of patients that a certified Suboxone prescriber can treat also creates a barrier to care because there are not enough providers to meet the needs of opioid-addicted patients. The limit was 30 and is now 100, but that will still not be enough.

Ben Kesner, executive director, Board of Pharmacy (BOP), introduced Shelley Bagwell, director, PMP, BOP, and Sarah Trujillo, licensing manager, BOP. Ms. Bagwell went through the steps of the PMP. She said the program has been responsible for lowering the number of doctor shoppers. To increase use of the program, doctors and providers are required to have a PMP file. To better gauge their own work, providers will now be able to stay informed on where they rank in the state and among similar specialists regarding prescribing medications.

Ms. Trujillo told the committees that there are 13 types of prescribing licenses that the BOP issues. She stated in response to a staff request that there are currently 950 custodial drug permits issued to boarding homes statewide.

Ralph McClish, executive director, New Mexico Osteopathic Medical Association, told the committees that the Board of Osteopathic Medicine is currently changing its rules partly to address opioid prescribing. He stated that opioids are physically and mentally addictive and that the public needs to know that. He stressed that patient education is a critical aspect of this discussion that is often ignored. He expressed his support for the use of abuse-deterrent opioids. "We had a small dip in opioid deaths" when there was more public messaging about the dangers of opioid use, he asserted. With less outreach and education, the numbers have again worsened.

Sondra Frank, J.D., executive director, New Mexico Medical Board, told the committees that until now, there has been a structural problem linking the PMP to the appropriate doctor. When someone enters data into the PMP but does not reference the right doctor, the doctor does not receive credit, and then it looks in the system as if the doctor was noncompliant or as if the doctor was not using the system enough or at all. When that happens, the doctor can end up on the high-risk prescriber list. Last year, there were 56 complaints filed about providers. Some of the confusion, Ms. Frank said, is that for some reason, cancer and hospice physicians thought they were exempt from the PMP, but they are not. Anyone with dispensing power, except veterinarians, must use the PMP. If a doctor needs retraining in pain medication prescribing, the New Mexico Medical Board sends the doctor to the Center for Personalized Education for Physicians in Denver. Ms. Frank said that New Mexico Medical Board investigations can be triggered by PMP irregularities.

In response to a question about why oxycodone use is so prevalent, Dr. Landen said that, often, oxycodone is the most appropriate thing to prescribe for pain. Dr. Landen said that among those people who die from opioids, 85% are dealing with chronic, not acute, pain.

When asked if there is a danger of overdose if the drugs are used as prescribed, Dr. Katzman said that in her opinion and in her experience, for the people who are taking their opioids responsibly, the risk of death is low.

A member forwarded the idea of using medical marijuana as an alternative to opioids. Mr. McClish said that there is a lack of cannabis training for doctors. He said that doctors want to prescribe cannabis, but they do not know how to go about it.

In response to the question of whether there is a problem mixing opioids and cannabis, several presenters explained that it is hard to know how to parse out what drug is having what effect and that there are many issues with cannabis, including the various legal issues. While the evidence for the benefits of cannabis for chronic pain is strong anecdotally, the evidence-based research is sparse because it is banned. In fact, a legislator said, cannabis research is a big reason to legalize. The possibilities for application seem very broad, and it can be paid for by diverting regulatory fees for cannabis to medical research.

A legislator expressed disappointment with the fact that there is little funding for training while providers attempt to treat pain appropriately. The legislator said that there is an unfunded mandate to train clinicians to treat pain adequately while not getting patients addicted.

Non-Pharmaceutical Treatment for Chronic Non-Cancer Pain

Michael Pridham, D.C.-A.P.C., N.R.C.M.E., member, executive board, New Mexico Chiropractic Association, explained the role of chiropractic treatment in the attempt to deal with the opioid epidemic. He said that a big challenge to these efforts is that in New Mexico, Medicaid does not reimburse providers for chiropractic treatment for opioid addiction, but there are 27 states that do. Dr. Pridham said that a patient's pharmaceutical costs are 85% lower when the patient seeks chiropractic treatment first.

Juliette Mulgrew, N.D., M.S.A.Y., vice president, New Mexico Association of Naturopathic Physicians, said that pain is a personalized experience. People with the same malady will experience different levels of pain and require differentiated treatment. Ms. Mulgrew said that pain is a symptom, not a diagnosis. In fact, many people who come to seek naturopathic pain treatment are already using opioids. She said that there is a six-month wait to get into a pain clinic, so other therapies are important and need recognition and support.

In response to a question, Dr. Pridham told the committees that the veterans' hospital in Albuquerque covers chiropractic treatment if the patient gets a referral from the patient's primary care physician to a qualifying chiropractor.

When asked what the legislature can do to help, Dr. Pridham said that chiropractors are legally prohibited from telling patients to stop using opioids and that it would be helpful to be able to do so if appropriate. He told the committees that some chiropractors would be seeking to change their scope of practice to permit this.

Medication-Assisted Treatment

Lindsay LaSalle, senior staff attorney, Drug Policy Alliance, said that New Mexico has been innovative and is credited with a lot of firsts in drug treatment and drug policy.

Eugenia Oviedo-Joekes, associate professor, School of Population and Public Health, University of British Columbia (UBC), discussed a study with Dilaudid that she published in *Psychology Today*. She said that by providing clean drugs, clean needles and a safe place to inject and having a person around in case of an overdose, deaths and the spread of disease went down. The study included more than 200,000 injections, and there were only 27 overdoses that required Narcan. Also notable in her work, she said, were better familial relationships for the addicts and significant savings in emergency room treatment costs and criminal justice costs because of an 80% retention rate in treatment.

Miriam Suzanne Komaromy, M.D., associate director, ECHO Institute; and associate professor of medicine, UNM, said that using technology allows front-line providers to access information via telemedicine. Dr. Komaromy said that the case-based treatment supported by the web-based database allows providers the ability to share best practices and to reduce disparities in the provision of health care. She said that opioid addiction is the most common disorder seen and that three-fourths of the physicians changed their treatment after working with the ECHO program. Dr. Komaromy said that the institute just got a grant from the United States Department of Health and Human Services' Health Resources and Services Administration to launch six opioid use disorder programs.

Andrew Hsi, M.D., principal investigator, FOCUS Programs at the Center for Developmental and Disability, UNM Health Sciences Center; principal investigator, Reflejos Familiares Project; professor of family and community medicine, discussed neonatal opioid withdrawal syndrome (NOWS) and said that since data started being collected, New Mexico is high on the list of NOWS per capita. He said that long-term outcomes of those who suffer NOWS are hard to predict. Dr. Hsi said that UNM pediatric clinics have become a significant provider, with about 120 families with young children receiving treatment, including a growing number of fathers. "We care for a very challenged population", he stated in response to a question about whether the adolescent wing at Turquoise Lodge is needed to provide detox services to adolescents. He spoke of administrative barriers that make it harder to serve people who desperately need assistance. He urged that health care administration be informed by medical expertise and not by "administrative fiat".

Dr. Komaromy stated that Turquoise Lodge is very important for reaching "highly at-risk" people. She also informed the committees that UNM was starting a post-detention clinic on an outpatient basis for children released from juvenile facilities. She stated that UNM would send case managers to homes to ensure compliance, and if there were issues at home, UNM would send a caregiver to help.

Responding to a legislator's question, Professor Oviedo-Joekes said that the use of opioid-assisted treatment is patient by patient and that treatment is meant to reach patients as they are and to go from there. Professor Oviedo-Joekes said that just starting this treatment is not a magic elixir that will put the patient back into the workforce right away. The treatment discussed in her

study is for the very poor, very addicted and not socially competent people who must come to the clinic three times a day.

Professor Oviedo-Joekes said that treatment varies country by country. In some places, clinics will allow the patient to take home a maintenance dose, which is rare, but that in her clinic, if anything is sent home with the patient, it would be methadone, which is much less popular than heroin. In fact, for the addict, Professor Oviedo-Joekes explained, opioids go from being a street drug to being a medication, and this provides the person with a great sense of pride. While the patients go to the clinic in Vancouver, British Columbia, for the medication, the staff is there to care for them as patients and provide them with an entire suite of social services. Another benefit to these clinics, Professor Oviedo-Joekes said, is that when heroin is offered for free at the clinic, the black market for heroin is undercut.

When asked about treatment for alcohol abuse and dependence, Professor Oviedo-Joekes stated that UBC has a small pilot project group in Vancouver that makes its own alcohol for consumption as a community. The project is showing that alcohol consumption is diminishing through the community work.

A legislator expressed frustration at the fact that the state is closing juvenile detoxification facilities, and the medical director of one facility does not believe in medical detoxification. Dr. Hsi said that the decision of whether or not to provide inpatient detoxification should be a medical one for the particular patient and not done by administrative fiat. Ms. LaSalle said that most people do not require inpatient detoxification, but facilities should prioritize treatment for the sickest rather than exclude those very patients.

Economic Burden of Prescription Opioid Abuse

Alan White, Ph.D. in economics, UBC; M. Litt. in economics and mathematics, and B.A. in economics and mathematics, University of Dublin, Trinity College; managing principal, Analysis Group, Inc., provided the members with a map of the United States showing the prevalence of prescription opioid abuse by zip code that indicates that large swathes of New Mexico are in the top 10%. He said that the medical cost associated with an opioid abuser is $20,000 above the average person. The total burden on the United States is $50 billion a year, he stated. That figure includes only diagnosed prescription opioid use, Dr. White explained, so it is likely a very low estimate. There are also associated costs that this estimate ignores, such as missed days of work, for example.

Dr. White mentioned two initiatives that may reduce opioid abuse and curb its costs. First is the use of tamper-resistant pills so that users cannot alter them to smoke or snort the drug. Second is interpreting claims data to identify patients at risk for abuse before treatment begins.

A legislator questioned the figure previously cited as a cost to the criminal justice system and said it is much more costly.

In response to a question by a member, Dr. White said that an opioid will typically be 20% of the cost of its equivalent abuse-deterrent opioid.

Public Comment

Nat Dean, disability advocate, said that at Express Scripts, the difference in price between an opioid and its equivalent abuse-deterrent opioid is $15.00 versus $90.00.

There being no further business before the committees, the meeting adjourned.