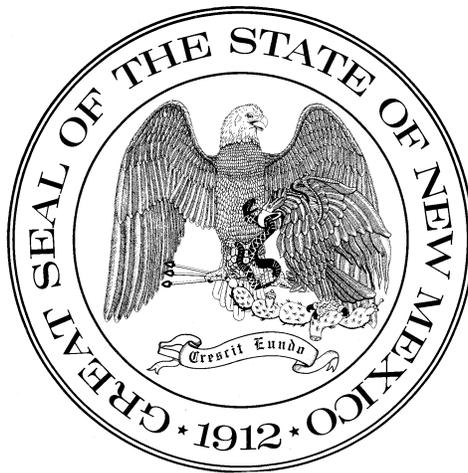


# **Legislative Health and Human Services Committee**

## **2012 INTERIM REPORT**



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

**2012 INTERIM REPORT  
LEGISLATIVE HEALTH AND  
HUMAN SERVICES COMMITTEE,  
INCLUDING  
THE DISABILITIES CONCERNS SUBCOMMITTEE AND  
THE BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE**

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## EXECUTIVE SUMMARY

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## SUMMARY

The Legislative Health and Human Services Committee (LHHS) devoted considerable attention to human services; substance abuse, misuse and dependence; health care work force; health information technology; hospitals; and Indian health. The committee continued its review of state law, programs and agencies related to the implementation of federal health care reform. At each of its meetings, the committee discussed the state's Medicaid program. The committee held hearings in Truth or Consequences, Farmington, Shiprock, Las Vegas and Santa Fe.

Regarding Medicaid, the LHHS received testimony from Human Services Department (HSD) leadership, local advocates and nationwide experts on the HSD's planned redesign of the state's Medicaid program, on the federal Patient Protection and Affordable Care Act's (PPACA) provision directing states to expand Medicaid eligibility and on other states' innovations in improving health care delivery while cutting Medicaid costs.

The HSD, having named its new Medicaid program "Centennial Care", laid out some details about Centennial Care and the status of the waiver application that the HSD submitted to the federal Centers for Medicare and Medicaid Services pursuant to Section 1115 of the federal Social Security Act.

In June 2012, the United States Supreme Court issued its decision on the constitutionality of the provisions of the PPACA. It upheld the requirement that nonexempt individuals obtain health insurance. It also held that the PPACA requirement that states expand Medicaid eligibility to cover adults with incomes under 138% of the federal poverty level was invalid and that Congress could not revoke states' participation in the Medicaid program, whether or not they chose to participate in expansion. The LHHS heard testimony from the HSD, Legislative Finance Committee (LFC) staff, local advocates and the public on whether or not the state should avail itself of the option to expand Medicaid eligibility. The testimony centered on economic factors and the effect upon state health care infrastructure and work force.

The committee heard testimony from nationwide experts on health care delivery models that emphasize care coordination, transitional care and the use of data to target high-risk patients for focused intervention.

A day of testimony focused on the state's options for obtaining and using health care data for a variety of purposes through an all payer claims database.

The committee heard extensive testimony on the HSD's New Mexico Office of Health Care Reform's efforts to establish a state health insurance exchange pursuant to the PPACA. It received testimony from the secretary of human services, local advocates and the public as to the functions, authority and time line for establishing an exchange.

The committee heard testimony on early childhood development and on supporting healthy development through supports such as home visiting programs.

The state's ongoing epidemic of the abuse of, misuse of and dependence on prescription drugs and other controlled substances was the subject of several hearings. The hearings focused on health professional licensure boards' new efforts at rulemaking to monitor and support best prescribing practices and on the causes of addiction, including childhood trauma. The committee heard testimony on therapeutic alternatives to opioid-based pain management.

The committee conducted hearings on a wide array of issues relating to health facilities, including hospitals and ambulatory surgical centers. There was testimony on peer review and credentialing; billing and collection practices; the potential effect of the PPACA's provisions relating to hospitals; and the role of information technology and infection control.

Health information technology, including telehealth and telemedicine, was the subject of several hearings. The committee heard testimony regarding the status of the state's broadband connectivity; on "meaningful use" of health information technology by health care providers in accordance with federal law; the University of New Mexico's Project Extension for Community Healthcare Outcomes (ECHO) telehealth program; the state health information exchange network; the HSD's Medicaid enrollment information technology system; and the potential for the use of telehealth to coordinate care in the state's Medicaid program.

Regarding human services, the committee heard testimony on efforts to address the incidence of domestic violence and sexual assault; to protect elders from abuse, exploitation and hunger; to provide early childhood services; to provide meaningful work opportunity to Temporary Assistance for Needy Families recipients; as well as testimony on energy assistance and on the application of federal community services block grant funds.

The committee held hearings on health care work force issues that included a proposal to create a licensure and scope of practice for dental therapists to work as mid-level dental health professionals in the state. There was discussion regarding the challenges of setting staffing standards for nurses.

On August 15, the committee met at the Shiprock Chapter House of the Navajo Nation, where it received updates on health care in the Navajo Nation, off-reservation health care and provisions of the PPACA that relate to Native Americans. The committee ended the day by touring the Navajo Regional Behavioral Health Centers in Shiprock.

#### Disabilities Concerns Subcommittee

The statutory Disabilities Concerns Subcommittee met twice in Santa Fe and once at the site of the Southwest Conference on Disability in Albuquerque.

Much of the subcommittee's work during this interim focused on long-term care. The developmental disabilities (DD) waiver program was the focus of much interest as its co-administrator, the Department of Health (DOH), issued new rules and undertook assessments regarding the way DD waiver participants' level of care is determined. The subcommittee heard testimony on money follows the person policy, relating to the transition of some institutional care

participants into community settings. Self-direction through Mi Via and proposed Medicaid Centennial Care programs was the focus of another hearing.

The subcommittee received an update on the medical cannabis program and the related fund that the DOH administers pursuant to the Lynn and Erin Compassionate Use Act. It also heard testimony on the rights of and opportunities for individuals living with disabilities in employment, in operating their own businesses and in living as protected persons under guardianships or conservatorships.

The subcommittee also heard testimony from the Governor's Commission on Disability on legislation relating to service animals and on the funding of disability programs through motor vehicle fees.

#### Behavioral Health Services Subcommittee

The New Mexico Legislative Council reauthorized the Behavioral Health Services Subcommittee for the 2012 interim. The subcommittee met in Gallup, Albuquerque and Las Cruces. A recurring theme of presentations to the subcommittee was concern over the state's decision to carve in behavioral health services with physical health services to implement the "coordinated care" strategy proposed in the Centennial Care Medicaid waiver. This discussion included the subcommittee's concern that Centennial Care managed care organizations deliver behavioral health care alongside physical health care without diluting the quality of behavioral health services or adding to the administrative burden for providers. The discussion also raised concern over how managed care organizations would apportion the responsibility for, and profit from, care coordination.

The subcommittee also heard several presentations that highlighted behavioral health disparities that are experienced by the Native American community. Presentations focused on the high rate of alcoholism, substance abuse and suicide, lack of adequate treatment resources and possibilities for funding additional treatment resources.

The subcommittee also discussed the importance of early intervention for children and adolescents in need of behavioral health services, the need for timely intervention and funding options for additional treatment resources. It also reviewed the behavioral health needs of children in treatment foster care.

Finally, the subcommittee heard a recommendation from the LFC that the Corrections Department fund only evidence-based behavioral health and treatment programs.

## WORK PLAN AND MEETING SCHEDULE

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**2012 APPROVED  
WORK PLAN AND MEETING SCHEDULE  
for the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**Members**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Nora Espinoza  
Sen. Gay G. Kernan

Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Advisory Members**

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena  
Sen. Cisco McSorley

Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Sen. John C. Ryan  
Sen. Bernadette M. Sanchez  
Rep. James E. Smith  
Rep. Mimi Stewart

**Disabilities Concerns Subcommittee:**

Rep. Antonio Lujan, Chair  
Sen. Nancy Rodriguez, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Sen. Mary Kay Papen  
Rep. Danice Picraux

**Behavioral Health Subcommittee:**

TBD

**Work Plan and Focus for 2012**

**Organizational Meeting**

The Legislative Health and Human Services Committee (LHHS) began its interim with an organizational meeting in which it received testimony from the Human Services Department (HSD) regarding the HSD's application to federal authorities for a waiver to implement its Medicaid redesign plan entitled Centennial Care. In addition, the LHHS heard testimony from representatives of Native American pueblos regarding the Centennial Care plan.

The committee also reviewed its work plan proposal and heard budget testimony on health and human service agencies from the Legislative Finance Committee staff.

**Focus for 2012**

The LHHS will continue its oversight of health and human services agencies and programs at state institutions of higher learning. The committee will also hear testimony on the following topics.

## Family Welfare

The welfare of children, parents and families is closely interrelated, and the committee will hear testimony on:

- child welfare, including proposed changes to the Children's Code; the incidence of child abuse and neglect in the state; and the return on investment for prenatal and early childhood home visiting and child care programs;
- domestic violence, including programs for prevention and to provide training for effective intervention;
- teen pregnancy rates and programs offering effective support for at-risk teens;
- the sharply rising rates of sexually transmitted diseases, especially among youth; and
- women's ability to earn a living wage and find adequate assistance for full participation in family support — including the effects of wage disparities, the availability of a "living wage", the cost and availability of child care and other factors.

## Medicaid

The LHHS will review the state's Medicaid program. This includes the Centennial Care plan, for which the HSD submitted a waiver application to the federal Centers for Medicare and Medicaid Services on April 25, 2012. The changes that the HSD proposes to institute include:

1. pursuant to the Patient Protection and Affordable Care Act (PPACA) mandate, covering all individuals, regardless of age, disability, resources or parental status, whose incomes fall below 138% of the federal poverty level (FPL);
2. collapsing all Medicaid programs currently governed by the state plan and several waivers under Sections 1115, 1915 and 1918 of the federal Social Security Act under one global 1115 waiver;
3. reintegrating behavioral health services with physical health services ("carving in");
4. removing three-month retroactive eligibility for applicants;
5. providing comprehensive care coordination to recipients;
6. streamlining care for Medicare/Medicaid "dual eligibles";
7. reducing the number of Medicaid managed care vendors to only two or three; these entities will be charged with providing behavioral, physical and long-term services across the span of recipients' lives or program participation;
8. increasing recipient health literacy and "responsibility" through the use of incentives and disincentives;

9. piloting payment reform, moving away from fee-for-service Medicaid; and instituting quality incentives;

10. instituting "benefits boundaries" for "moderate-to-high long-term services recipients" according to standards that are not yet defined;

11. making delivery system innovations such as requiring hospitals to invest in delivery system reform and improvement programs and restructuring sole community provider funding;

12. abandoning the state's participation in the Money Follows the Person community placement program;

13. creating a comprehensive community long-term care benefit that includes both personal care option services and the home- and community-based waiver services pursuant to which:

a. categorically eligible individuals will have no waiting list;

b. the medically eligible (138% FPL to 300% FPL) will be subject to a waiting list;  
and

c. slots will be divided into moderate-need and high-need slots;

14. addressing two major enrollment issues:

a. integrated enrollment with any health insurance exchange; and

b. outreach and enrollment in chronically underenrolled (but eligible) communities;

15. instituting health care delivery innovations: the committee proposes to hear testimony regarding the patient-centered medical home and chronic disease management and care coordination to achieve cost savings, including the North Carolina Community Care Program;

16. contending with Medicaid fraud: the committee will examine new federal regulations and initiatives to combat Medicaid fraud, including the use of information technology and data mining. The HSD has implemented most of the measures required by rule. The committee will request information from the HSD about the status of its implementation of federally required fraud provisions; and

17. addressing Native American Medicaid: members of the pueblo governments and the Navajo Nation have expressed concern about Centennial Care's auto-enrollment of Native Americans into managed care Medicaid. Also, the Navajo Nation is in discussions with the HSD regarding a possible Navajo Medicaid managed care organization. Those discussions are not yet at the formal stage, according to Navajo officials.

### **Behavioral Health Subcommittee**

At its June 27 meeting, the New Mexico Legislative Council (LC) re-created a behavioral health subcommittee to study and oversee the state of behavioral health services in the state. The subcommittee will hear testimony regarding ongoing concerns from behavioral health care service consumers, their families and the provider community and changes to publicly financed behavioral health services provided through the proposed Medicaid "carve-in" or the Interagency Behavioral Health Purchasing Collaborative (Collaborative). The subcommittee will also hear testimony regarding core service agencies, a central feature of the Collaborative's plan to provide comprehensive, intensive supports to high-need recipients.

The subcommittee will hold one hearing at the Los Lunas Substance Abuse Treatment and Training Center in Los Lunas and tour that facility.

The behavioral health subcommittee will hear testimony as to the status of behavioral health services for foster children.

The behavioral health subcommittee will review the statewide autism task force's report pursuant to House Memorial 41 (Representative Edward C. Sandoval, 2012); programs to increase work force development for individuals living with autism spectrum disorders; the discipline of autistic students in schools; and legislation to mandate autism coverage for individuals covered by public employee and retiree plans.

The LC allotted the behavioral health subcommittee three meeting days this interim.

### **The State Response to the PPACA**

The United States Supreme Court's decision on the challenges to the PPACA was issued on June 28, 2012. The Supreme Court upheld most of the PPACA. The committee will review the state's obligations and opportunities under the PPACA as determined by the Court's decision.

The committee will receive testimony from the New Mexico Office of Health Care Reform and entities with which it contracts, such as the Leavitt Group, to learn of its plans to implement a state health insurance exchange and meeting exchange requirements under federal law to share enrollment capabilities with the state's Medicaid program; to implement a navigator program to assist residents in enrolling in qualified health plans; and to offer cost-sharing subsidies, tax credits and insurance mandate exemptions. The committee will also continue to receive ongoing testimony from the New Mexico Office of Health Care Reform regarding federal grants that public and private entities receive pursuant to the PPACA.

The committee will hear testimony from the superintendent of insurance and the superintendent's staff regarding the recommendations of the Insurance Division of the Public Regulation Commission on changes to the New Mexico Insurance Code and on its implementation of federal rules relating to the "essential benefits" that the PPACA requires that any non-grandfathered comprehensive plan sold in the state offer to beneficiaries. The

committee will request testimony from the division on the implementation of new rate review rules, on the status of the division's ombudsman office and consumer assistance programs and the division's efforts to maintain accreditation by the National Association of Insurance Commissioners.

The committee will hear testimony on the development of a nonprofit cooperative health care coverage plan that local experts and employers have been working to establish through a corporation established pursuant to Section 501(c)(29) of the United States Internal Revenue Code to provide coverage to individuals and employers.

In addition to the PPACA's mandate that states expand public coverage through Medicaid, the PPACA proposes that states offer a basic health program for low-income individuals ineligible for Medicaid and offer attendant-care services through the Community First Choice (CFC) Program. If the state opted for the CFC Program, it would likely replace the state's current provision of services through the Personal Care Option offered to Medicaid recipients at the standard federal match in favor of the CFC option.

### **Delivery System Innovations**

The committee will hear testimony on the steps that public health coverage programs are taking to implement PPACA provisions on health care delivery and reimbursement. These include expansion of the medical home model, accountable care organizations, community care teams, the use of *promotoras*, or community health workers, and new long-term care delivery options.

### **Hospitals and Health Facilities**

There are a number of issues relating to hospitals and health facilities that the committee will review this interim:

1. billing and collection: the committee will receive testimony regarding the impact that new American Hospital Association guidelines might have in the state. The committee will also review guidelines and practices relating to financial arrangements for uninsured and underinsured patients;
2. credentialing: in 2011, there was a high-profile case in the state involving grave medical malpractice allegations that some contend arose partly due to lax physician peer credentialing. In response to Representative Terry McMillan's House Memorial 24, passed in the 2012 regular session, the committee will hear testimony by a panel that has been charged with reviewing hospital peer credentialing practices and intends to make recommendations; and
3. an important area of review that the committee will undertake is the status of efforts to reduce the incidence of health care-associated infections and challenges to patient safety. The New Mexico Healthcare-associated Infections Advisory Council, led by the Department of Health, is prepared to present a report to the committee. The committee will hear testimony

regarding infections arising from ambulatory surgical facilities. The committee will also hear testimony regarding a new patient bill of rights.

### **Incarceration Health Care**

The Corrections Department currently delivers physical health care and prescription drugs to individuals in its custody by contracting with a managed care entity, and it delivers behavioral health services through the Collaborative. The committee will examine:

- the funds that the state expends on corrections health care, high-risk and high-cost conditions and services such as those for pregnancy and childbirth, substance use and infectious diseases;
- a cost-benefit analysis regarding geriatric release programs; and
- whether to combine corrections health purchasing with that of other agencies, how to maximize federal and other funding through programs such as Medicaid and Medicare and how to use technology to increase efficiency.

### **Health Care Work Force**

The committee will continue its work in assessing the need and capacity for health care professionals statewide, including a review of:

- the capacity of state educational institutions to increase the supply of providers;
- registered nurse staffing guidelines pursuant to House Memorial 51 (Representative Brian F. Egolf, Jr., 2012) and American Hospital Association recommendations;
- licensure of nurses to perform ultrasound;
- health care professional retention: an examination of tax incentives and covenants not to compete and their effect upon the work force; and
- the prospects for and utility of a public health school in the state, pursuant to House Memorial 43 (Representative Joseph Cervantes, 2012).

### **Dental Health**

There is continued discussion of the possibility of using dental therapists and creating programs to train dental therapists in the state to address the shortage of dental services in many areas of the state.

### **Guardianships**

The committee will hear testimony pursuant to House Memorial 61 (Representative Gail Chasey, 2012), which requests the New Mexico Supreme Court and Administrative Office of the Courts to study and make recommendations for better monitoring of guardianship, conservator and elder abuse cases.

### **Alzheimer's Disease**

House Memorial 20 (Representative Picraux, 2012) requests that the Aging and Long-Term Services Department convene a multi-agency, multidisciplinary task force to study the causes and effects of Alzheimer's disease and report its findings to the committee.

### **Assisted Suicide**

A group of doctors have filed lawsuits to challenge state law on assisted suicide, seeking an interpretation that exempts physicians under certain circumstances involving terminally ill patients. The committee will examine other states' laws and receive testimony from all sides of this controversial issue.

### **Chronic Obstructive Pulmonary Disease (COPD)**

The committee will hear testimony from the Department of Health regarding its recommendations on COPD prevention and management pursuant to Senate Memorial 57 (Senator John M. Sapien, 2012).

### **Substance Abuse, Misuse and Dependence**

The epidemic of substance abuse, particularly prescription drug abuse, misuse and dependence, in the state continues to be a major focus of the committee. It will hear testimony on the state's efforts to monitor and enforce appropriate prescribing of prescription drugs, especially opioids; review efforts to prevent dependence and misuse; and the services available in the state for prevention and treatment of substance abuse.

The committee will also review the plans the respective state licensing boards for prescribers and dispensers have to address the state's substance abuse crisis.

### **Disabilities Concerns Subcommittee (DCS)**

The DCS will continue its examination of the status of programs and services for individuals living with disabilities. A major area of concern continues to be the Developmental Disabilities Waiver Program and changes to that program that have been implemented in the past year, especially as those changes relate to the assessment of need and the assignment of services.

The DCS will continue its review of the status of long-term services in the state and employment supports for individuals living with disabilities.

The DCS will receive testimony from the Governor's Commission on Disability on the services provided through that office and funding sources for its programs.

The DCS will hear testimony from the HSD and advocates regarding the HSD's decision not to pursue the Money Follows the Person Program to move individuals currently in institutional care to community settings.

The Mi Via Program allowing recipients to self-direct care received under home- and community-based waivers has been the object of many complaints by recipients and their advocates. The DCS will hear testimony on the Mi Via Program and self-direction of home- and community-based services under Centennial Care.

The committee will also review the role of family and community supports in providing care to individuals enrolled in Medicaid attendant-care or home- and community-based waiver services.

**Health Information Technology (IT)**

The committee will examine how health IT, including electronic health records, telehealth and telemedicine and the use of IT enrollment, technical assistance, data mining and fraud prevention strategies, can help the state in purchasing and effectively providing quality health care services.

**Legislative Health and Human Services Committee  
2012 Approved Meeting Schedule**

<u>Date</u>	<u>Location</u>
June 25	Santa Fe
July 9-10	Truth or Consequences
August 13-15	Farmington/Shiprock
September 10-12	Las Vegas
October 10-12	Santa Fe
November 26-27	Santa Fe

**Disabilities Concerns Subcommittee  
2012 Approved Meeting Schedule**

<u>Date</u>	<u>Location</u>
September 13	Santa Fe
October 9	Albuquerque
November 9	Santa Fe

**Behavioral Health Subcommittee  
2012 Approved Meeting Schedule**

<u>Date</u>	<u>Location</u>
August 16	Gallup
September 7	Albuquerque
October 18	Las Cruces



Revised: June 21, 2012

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

**June 25, 2012  
State Capitol, Room 307  
Santa Fe**

**Monday, June 25**

- 9:30 a.m.     **Call to Order**
- 9:35 a.m.     **Welcome and Introductions**  
—Senator Dede Feldman, Chair, Legislative Health and Human Services  
                  Committee
- 9:40 a.m.     **Review of 2012 Regular Session Health and Human Services Legislation**  
—Michael Hely, Staff Attorney, Legislative Council Service
- 10:00 a.m.    **Fiscal Reports**  
**Department of Health; Aging and Long-Term Services Department**  
—Ruby Ann Esquibel, Principal Analyst, Legislative Finance Committee (LFC)  
**Human Services Department (HSD)**  
—Greg Geisler, Senior Fiscal Analyst, LFC  
**Children, Youth and Families Department; Workforce Solutions Department**  
—Mimi Aledo, Senior Fiscal Analyst, LFC
- 11:00 a.m.    **Review of Work Plan and Meeting Schedule**
- 12:00 noon    **Lunch**
- 1:00 p.m.     **Medicaid Redesign: Centennial Care**  
—Sidonie Squier, Secretary, HSD  
—Julie Weinberg, Director, Medical Assistance Division, HSD  
—Brent Earnest, Deputy Secretary, HSD
- 2:00 p.m.     **Some Tribal Perspectives on Centennial Care**  
—Hon. Rex Lee Jim, Vice President, Navajo Nation  
—Hon. Joshua Madalena, Governor, Pueblo of Jemez  
—Joseph Ray, Executive Director, Native American Independent Living  
—Shelly Chimoni, Executive Director, All Indian Pueblo Council
- 3:00 p.m.     **Public Comment**
- 5:00 p.m.     **Adjourn**

Revised: July 5, 2012

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

**July 9-10, 2012  
Ralph Edwards Auditorium  
400 W. Fourth Street  
Truth or Consequences**

**Monday, July 9**

- 10:00 a.m.     **Call to Order**
- 10:05 a.m.     **Welcome and Introductions**  
—Senator Dede Feldman, Chair, Legislative Health and Human Services  
Committee
- 10:10 a.m.     **Project ECHO — Extension for Community Healthcare Outcomes**  
—Sanjeev Arora, M.D., Director, Project ECHO, Department of Internal  
Medicine, University of New Mexico (UNM)  
—Erika Harding, M.A., Education and Outreach Manager, Project ECHO, UNM  
Health Sciences Center
- 11:10 a.m.     **Human Services Department (HSD) Report on Insurance Exchange**  
—Sidonie Squier, Secretary, HSD  
—Dan Schuyler, Director, Leavitt Partners
- 12:10 p.m.     **Lunch**
- 1:30 p.m.     **Review of New Mexico Broadband Program and Health-Related  
Applications**  
—Gar Clarke, NM Geospatial Program Manager, New Mexico Broadband  
Program Manager, Agency Tribal Liaison, Department of Information  
Technology
- 2:30 p.m.     **Health Information Exchange Network**  
—Dale Alverson, M.D., Information Technology Medical Director, New Mexico  
Health Information Collaborative  
—Craig Hewitt, Chief Information Officer, LCF Research; New Mexico Health  
Information Collaborative
- 3:30 p.m.     **Molina Medicaid Managed Care Telehealth and Innovations in Coordinated  
Care**  
—Irene Krokos, M.D., Chief Medical Officer, Molina Healthcare

4:30 p.m.     **Public Comment**

5:00 p.m.     **Recess**

**Tuesday, July 10**

8:30 a.m.     **Call to Order**

8:35 a.m.     **Welcome and Introductions**

—Senator Dede Feldman, Chair, Legislative Health and Human Services  
Committee

8:40 a.m.     **Status of the Federal Patient Protection and Affordable Care Act (PPACA)**

—Michael Hely, Staff Attorney, Legislative Council Service

9:00 a.m.     **Consumer Perspectives on Health Care Reform**

—Kelsey McCowan Heilman, Staff Attorney, New Mexico Center on Law and  
Poverty

—Pamelya Herndon, Esq., Executive Director, Southwest Women's Law Center  
(SWLC)

—Kyle Marie Stock, Staff Attorney, SWLC

10:00 a.m.    **Katie Faith Martinez Patient Bill of Rights**

—Deborah and Melvin Martinez, Parents of Katie Faith Martinez

10:30 a.m.    **Tour of Appletree Educational Center (AEC)**

—Rebecca Dow, Chief Executive Officer, AEC

12:00 noon    **Lunch Tour of Sierra Vista Hospital**

—Domenica "D" Rush, Chief Executive Officer, Sierra Vista Hospital

1:30 p.m.     **Meaningful Use of Health Information Technology**

—Domenica "D" Rush, Chief Executive Officer, Sierra Vista Hospital

—Lindy Dittmer-Perry, Program Director, New Mexico Health Information  
Technology Regional Extension Center

2:00 p.m.     **Status Update: The Insurance Division and PPACA**

—John Franchini, Superintendent of Insurance, Public Regulation Commission

3:30 p.m.     **Public Comment**

4:00 p.m.     **Adjourn**

Revised: August 10, 2012

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

**August 13-14, 2012  
Room 9006, Henderson Performing Arts Center  
San Juan College  
4601 College Boulevard  
Farmington**

**August 15, 2012  
Shiprock Chapter House  
U.S. Highway 64  
Shiprock**

**Monday, August 13 — San Juan College**

- 10:00 a.m.     **Call to Order**
- 10:05 a.m.     **Welcome and Introductions; Approval of Minutes**  
—Senator Dede Feldman, Chair, Legislative Health and Human Services  
                  Committee (LHHS)  
—Toni Pendergrass, Ph.D., President, San Juan College  
—Rick Wallace, Chief Executive Officer, San Juan Regional Medical Center
- 10:20 a.m.     **Peer Review and Hospital Credentialing**  
—The Honorable Terry McMillan, M.D., New Mexico State Representative  
—David Johnson, Esq., Bannerman and Johnson Law Firm  
—Karen Dawson, B.S.N., C.P.H.Q., Director of Clinical Outcomes, Memorial  
                  Medical Center  
—Alan Rapaport, M.D., Physician Surveyor, Joint Commission
- 11:30 a.m.     **Working Lunch: Registered Nurse Staffing Guidelines**  
—Sharon Argenbright, M.S.N., R.N., C.C.R.N., Vice President, National Union of  
                  Hospital and Health Care Employees, District 1199 New Mexico  
—Suzanne Smith, Chief Nursing Officer, San Juan Regional Medical Center;  
                  Board Member, New Mexico Organization of Nurse Leaders  
—Jeff Dye, President, New Mexico Hospital Association  
—Laurie Lineweaver, Ph.D. (c), R.N., C.C.R.N.-C.S.C., Clinical Education  
                  Specialist/Clinical Coordinator, Presbyterian Healthcare Services; Member,  
                  New Mexico Nurses Association

- 1:00 p.m.     **Healthcare-associated Infections Advisory Committee Report**  
—Joan Baumbach, M.D., M.P.H., Infectious Disease Epidemiology Bureau Chief,  
Department of Health (DOH)  
—Lisa Bowdey, HAI Program Manager, Infectious Disease Epidemiology Bureau,  
DOH
- 2:00 p.m.     **Sole Community Provider and Disproportionate Share Hospital Funding**  
—Jeff Dye, President, New Mexico Hospital Association  
—Brent Earnest, Deputy Director, Human Services Department  
—Liza Gomez, Indigent Health Care Coordinator, San Juan County, New Mexico  
Association of Counties
- 3:00 p.m.     **Public Comment**
- 4:00 p.m.     **Recess**

**Tuesday, August 14 — San Juan College**

- 9:00 a.m.     **San Juan Regional Medical Center (SJRMC): Sole Community Provider  
Funding, Work Force Recruitment and Retention and Health Care Reform  
Implementation at a Rural Hospital**  
—Mike Philips, Chief Financial Officer, SJRMC
- 9:30 a.m.     **Infection Control at Ambulatory Surgical Centers**  
—Shawn Mathis, Staff Attorney, Legislative Council Service
- 10:30 a.m.    **Hospital Billing and Collection**  
—Jeff Dye, President, New Mexico Hospital Association  
—Mike Philips, Chief Financial Officer, SJRMC  
—Jesse Barnes, M.D., Casa de Salud/JAZZ for Health  
—The Honorable Eleanor Chavez, New Mexico State Representative
- 12:00 noon    **Lunch**
- 1:30 p.m.     **Domestic Violence**  
—Pamela Wiseman, Executive Director, New Mexico Coalition Against Domestic  
Violence  
—Susan Kimbler, Executive Director, Navajo United Methodist Center
- 2:30 p.m.     **Health Insurance Exchange — Navigators, Outreach, Enrollment**  
—Ellen Pinnes, J.D., Health Policy Consultant  
—Leah Steimel, Director, Office of Community Affairs, University of New  
Mexico Health Services Center  
—Jessica Kendall, Outreach Director, Enroll America

4:00 p.m.     **Low-Income Energy Assistance**  
—Ona Porter, Executive Director, Prosperity Works New Mexico

4:30 p.m.     **Public Comment**

5:00 p.m.     **Recess**

**Wednesday, August 15 — Shiprock Chapter House**

9:00 a.m.     **Welcome and Introductions**  
—Senator Dede Feldman, Chair, LHHS

9:05 a.m.     **Welcome to Shiprock Chapter House**  
—William Lee, Chapter President, Shiprock Chapter, Navajo Nation  
—Donald Benally, Vice President, Shiprock Chapter, Navajo Nation  
—Lula Jackson, Chapter Secretary/Treasurer, Shiprock Chapter, Navajo Nation  
—Russell Begaye, Navajo Council Delegate, Navajo Nation

9:30 a.m.     **Medicaid Enrollment and Expansion**  
—Quela Robinson, Staff Attorney, New Mexico Center on Law and Poverty  
—Sovereign Hager, Staff Attorney, DNA People's Legal Services  
—Mildred Bennally, New Mexico Resident  
—Stanford Washburn, New Mexico Resident

10:30 a.m.    **Medicaid Expansion — Perspectives from Association of Commerce and Industry of New Mexico (ACI/NM)**  
—David Foster, Chair, Health Care Committee, ACI/NM  
—Celia Ameline, Vice Chair, Health Care Committee, ACI/NM

11:00 a.m.    **Medicaid Enrollment and Expansion: The Impact on the State's Budget and New Mexico's Economy**  
—TBD, New Mexico Voices for Children  
—Jim Jackson, Executive Director, Disability Rights New Mexico

12:00 noon    **Lunch Presentation: Home for Women and Children, Inc. (HWC)**  
—Gloria Champion, L.I.S.W., Executive Director, HWC

1:00 p.m.     **Off-Reservation Native American Health Care and the Patient Protection and Affordable Care Act**  
—Roxane Spruce Bly, Director, Bernalillo County Off-Reservation Native American Health Commission

2:00 p.m.     **Navajo Nation: Health Care Update**  
—Roselyn Begay, Program Evaluation Manager, Office of Planning, Research and Evaluation, Navajo Division of Health, Navajo Nation  
—Gayle Diné Chacon, M.D., Surgeon General, Navajo Nation

3:00 p.m. **Tour of Navajo Regional Behavioral Health Center, Shiprock**

4:00 p.m. **Public Comment**

**Adjourn**

Revised: September 7, 2012

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

**September 10-12  
Kennedy Lounge  
New Mexico Highlands University  
905 University Avenue  
Las Vegas**

**Monday, September 10**

9:00 a.m.      **Call to Order**

9:05 a.m.      **Welcome and Introductions: Approval of Minutes**

—Senator Dede Feldman, Chair

—James Fries, Ph.D., President, New Mexico Highlands University

9:15 a.m.      **Attachment Disorders and Child Development**

—Shirley Crenshaw, M.S.W., L.C.S.W., Shirley Crenshaw, Inc.

—George Davis, M.D., Psychiatrist, Children, Youth and Families Department  
(CYFD)

—Diana McWilliams, Acting Chief Executive Officer, Interagency Behavioral  
Health Purchasing Collaborative

11:30 a.m.      **Public Comment**

12:00 noon      **Lunch**

1:00 p.m.      **Prescription Drug Prescribing, Monitoring and Management Board of  
Pharmacy Rulemaking on Prescription Drug Abuse**

—Larry Loring, R.Ph., Board of Pharmacy, Regulation and Licensing  
Department (RLD)

**Department of Health Rulemaking, Facilities and Services for Prescription  
Drug Abuse**

—Michael Landen, M.D., M.P.H., State Epidemiologist, Department of  
Health (DOH)

**New Mexico Medical Board Rulemaking on Prescription Drug Abuse**

—Lynn Hart, Executive Director, New Mexico Medical Board, RLD

—Bob Twillman, Ph.D., F.A.P.M., Director, Policy and Advocacy, American  
Academy of Pain Management

**Proposed Board of Nursing Rules for Management of Chronic Pain**

—Mike Wallace, M.S.N., F.N.P-B.C., Chair, Board of Nursing

4:00 p.m. **No Exceptions: The New Faces of Addiction**  
—Louella Duran, Heroin Awareness Committee

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

**Tuesday, September 11** — New Mexico Behavioral Health Institute (NMBHI)

9:00 a.m. **Introduction and Overview of NMBHI Programs**  
—Troy Jones, M.D., Executive Director, NMBHI, DOH  
—Brad McGrath, Chief Deputy Secretary, DOH

9:20 a.m. **Tour of NMBHI**  
—Troy Jones, M.D., Executive Director, NMBHI, DOH

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

1:00 p.m. **Sexual Assault Programs**  
—Kim Alaburda, Director, Coalition of Sexual Assault Programs

2:00 p.m. **Amendments to Immunization Act: Registry of Critical Patient Data**  
—Lance Chilton, M.D., Member, New Mexico Pediatrics Society

2:30 p.m. **Child Advocacy**  
—Shelly A. Bucher, L.M.S.W., School of Social Work, College of Health and Social Services, New Mexico State University (NMSU)  
—Esther Devall, Ph.D., Certified Family Life Educator, Family and Consumer Sciences Department, College of Agricultural, Consumer and Environmental Sciences, NMSU

3:30 p.m. **Alternative Pain Management**  
—Nityamo Lian, D.O.M., M.P.H., Director, Public Health Acupuncture of New Mexico  
—Laura Alonzo de Franklin, L.M.S.W., Board Member, La Plazita Institute

4:30 p.m. **Public Comment**

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

**Wednesday, September 12**

8:30 a.m. **Centennial Care: Updated Waiver Application**  
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department (HSD)

- 9:30 a.m.     **ASPEN: HSD's Enrollment Information Technology**  
—Charissa Saavedra, Deputy Secretary, HSD  
—Ted Roth, Director, Income Support Division (ISD), HSD  
—Sean Pearson, Chief Information Officer, HSD
- 10:30 a.m.     **Consumer Experience with the New Mexico Works/Temporary Aid for Needy Families Program**  
—Cynthia Trafton, Attorney, New Mexico Legal Aid — Las Cruces Office  
—Monica Dominguez, Paralegal, New Mexico Legal Aid — Albuquerque Office
- 11:00 a.m.     **Status Update: New Mexico Works**  
—Ted Roth, Acting Director, ISD, HSD  
—Lisa Roberts, Program Director, SL Start (New Mexico Works Vendor)
- 12:00 noon     **Lunch**
- 1:30 p.m.     **Supporting Health Development During a Child's First Three Years**  
—Andrew Hsi, M.D., Department of Pediatrics, University of New Mexico  
                  Health Sciences Center
- 2:30 p.m.     **Supporting Early Childhood Development**  
—Mimi Aledo-Sandoval, Senior Analyst, Legislative Finance Committee  
—Dan Haggard, Director, Early Childhood Services, CYFD
- 3:30 p.m.     **Attorney General of New Mexico's Informal Opinion on Creating a State Health Insurance Exchange**  
—Mark Reynolds, Esq., Assistant Attorney General, Office of the Attorney  
                  General
- 4:30 p.m.     **Public Comment**
- 5:00 p.m.     **Adjourn**

Revised: October 10, 2012

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

**October 10-12, 2012  
State Capitol, Room 322  
Santa Fe**

**Wednesday, October 10**

- 9:00 a.m.     **Welcome and Introductions**  
—Senator Dede Feldman, Chair, Legislative Health and Human Services  
Committee (LHHS)
- 9:05 a.m.     **Medicaid Innovations: North Carolina Community Care**  
—L. Allen Dobson, Jr., M.D., President and Chief Executive Officer, Community  
Care of North Carolina
- 10:35 a.m.    **Public Health Vision for New Mexico**  
—Robert G. Frank, President, University of New Mexico (UNM)
- 11:30 a.m.    **UNM Health Sciences Center Update and Statewide Role and Mission in New  
Mexico**  
—Paul Roth, M.D., Chancellor for Health Sciences; Dean, School of Medicine,  
UNM
- 12:00 noon    **Lunch**
- 1:30 p.m.     **New Mexico Health Connections (NMHC) — a Consumer-Operated and  
-Oriented Health Plan**  
—Nandini Kuehn, Ph.D., President, Board of Directors, NMHC  
—Martin Hickey, Ph.D., Chief Executive Officer, NMHC
- 2:30 p.m.     **Aging and Long-Term Services Department (ALTSD) Update**  
• **Elder Abuse and Data on Incidence; ALTSD's Role in Investigating**  
• **Continuing Care Act Rulemaking**  
• **Prescription Drug Dependence Among Elders**  
• **Hunger Programs for Seniors**  
—Retta Ward, Secretary, ALTSD
- 4:00 p.m.     **Public Comment**
- 4:30 p.m.     **Recess**

## **Thursday, October 11**

- 9:00 a.m.     **Hotspotting**  
—Jeffrey Brenner, M.D., Director, Institute for Urban Health at Cooper University Hospital; Executive Director, Camden Coalition of Healthcare Providers
- 11:00 a.m.     **Rural Care Coordination Innovations**  
—Charlie Alfero, Director, Center for Health Innovation, Hidalgo Medical Services
- 12:00 noon    **Lunch**
- 1:00 p.m.     **Tribal Consortium**  
—Ileen Sylvester, Vice President of Executive and Tribal Services, Nuka Institute Coordinator, Southcentral Foundation
- 2:30 p.m.     **Statewide Expansion of Cancer Clinical Trials**  
—Terri Stewart, M.S., Executive Director, New Mexico Cancer Care Alliance (NMCCA)  
—Cal Ridgeway, M.D., Co-Chair, NMCCA Board of Directors  
—Cheryl Willman, M.D., Co-Chair, NMCCA Board of Directors
- 3:30 p.m.     **Community Services Block Grant Update**  
—Ted Roth, Director, Income Support Division, Human Services Department
- 4:00 p.m.     **Public Comment**
- 4:30 p.m.     **Recess**

## **Friday, October 12**

- 9:00 a.m.     **Dental Therapists and Access to Dental Care in Rural and Tribal Areas**  
—Pamela K. Blackwell, J.D., Project Director, Oral Health Access, Health Action New Mexico  
—Daniel Kennedy, D.H.A.T., Dental Therapist, Alaska  
—Todd Hartsfield, D.D.S., Assistant Professor of Clinical Dentistry, Clinical Faculty in the Advanced Education in General Dentistry Residency Program at the Arizona School of Dentistry and Oral Health, Arizona  
—Don Weidemann, Administrator, Union County General Hospital, Clayton  
—Michael Bird, M.S.W., M.P.H., Pueblo of Kewa/Santo Domingo, Public Health Consultant
- 10:25 a.m.    **Approval of August Minutes**
- 10:30 a.m.    **Public Comment**

- 11:00 a.m.     **Report from the Task Force on Work-Life Balance**  
—Giovanna Rossi Pressley, President, Collective Action Strategies  
—Lee Reynis, Ph.D., Director, Bureau of Business and Economic Research,  
UNM
- 12:00 noon     **Working Lunch: Physician Aid in Dying**  
—Barak Wolff, M.P.H., Consultant  
—Steve Allen, J.D., American Civil Liberties Union of New Mexico  
—Katherine Morris, M.D., F.A.C.S., Surgical Oncologist, UNM Health Sciences  
Center (HSC)  
—Barbara Lee, P.A., F.N.P., J.D., President, Compassion and Choices
- 1:00 p.m.     **Nurse Advice New Mexico (NANM) and Health Care Delivery Innovations**  
—Connie Fiorenzo, Director, NANM  
—Robin Hunn, Consultant to NANM
- 1:30 p.m.     **Greater Albuquerque Medical Association (GAMA) Pre-Hospital Navigation  
Program**  
—H. Diane Snyder, Executive Director, GAMA  
—Kurt Krumperman, Executive Director, Albuquerque Ambulance Service  
—Darren Braude, M.D., M.P.H., E.M.T.-P., Professor, UNM HSC, Department  
of Emergency Medicine; Medical Director, Emergency Medical Services  
Academy, UNM HSC  
—Robert McDaniels, M.S., N.R.E.M.T.-P., Director, Emergency Medical  
Services Academy, UNM HSC
- 2:00 p.m.     **Essential Health Benefits**  
—John Franchini, Superintendent of Insurance, Public Regulation Commission
- 3:00 p.m.     **Adjourn**

Revised: November 21, 2012

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

**November 26-27, 2012  
State Capitol, Room 322  
Santa Fe**

**Monday, November 26**

- 9:00 a.m.     **Reinsurance and Risk Adjustment**  
—Debbie Armstrong, J.D., Executive Director, New Mexico Medical Insurance Pool
- 10:00 a.m.     **Aligning Forces for Quality (AF for Q)**  
—Patricia Montoya, Director, AF for Q, HealthInsight
- 10:30 a.m.     **Improving Quality Across Transitions of Care**  
—Sheila Conneen, Ph.D., M.P.H., M.S.N., A.N.P.-B.C., Project Director, Care Transitions, HealthInsight
- 11:00 a.m.     **All-Payer Claims Database**  
—Ross Winkelman, Wakely Consulting Group  
—Patricia Montoya, Director, AF for Q and Government Relations, HealthInsight
- 12:00 noon    **Working Lunch**
- 1:00 p.m.     **Prescription Drug Abuse and Dependence: Report on Medical Professional Associations' Collaborative Solutions**  
—Ralph McClish, Executive Director, New Mexico Osteopathic Medical Association (NMOMA)  
—Pilar Faulkner, Political Liaison, NMOMA
- 1:30 p.m.     **Report from the Senate Memorial 45 Harm Reduction Task Force**  
—Bill Weise, M.D.  
—Harris Silver, M.D.
- 2:30 p.m.     **Improving Outcomes for Pregnant Women and Infants Through Medicaid**  
—Pamela Galbraith, Program Evaluator, Legislative Finance Committee (LFC)
- 3:30 p.m.     **Public Comment**

4:00 p.m.     **Proposed Legislation for the 2013 Regular Session**  
—Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
—Shawn Mathis, Staff Attorney, LCS

5:00 p.m.     **Recess**

**Tuesday, November 27**

9:00 a.m.     **Update on Medicaid and the Federal Patient Protection and Affordable Care Act**  
—Greg Geisler, Senior Analyst, LFC

9:30 a.m.     **Medicaid Expansion and Basic Health Plan Report**  
—Lee Reynis, Ph.D., Director, Bureau of Business and Economic Research,  
University of New Mexico  
—Kelsey McLowan-Heilman, Staff Attorney, New Mexico Center on Law and  
Poverty

10:30 a.m.    **Medicaid Update; Health Insurance Exchange Advisory Group Report**  
—Sidonie Squier, Secretary, Human Services Department

11:30 a.m.    **Public Comment**

12:00 noon    **Lunch**

1:30 p.m.     **Proposed Legislation for the 2013 Regular Session**  
—Michael Hely, Staff Attorney, LCS  
—Shawn Mathis, Staff Attorney, LCS

5:00 p.m.     **Adjourn**



Revised: August 15, 2012

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

**August 16, 2012**

**Solarium, 3rd Floor, Rehoboth McKinley Christian Health Care Services (RMCHCS)  
1901 Red Rock Drive, Gallup**

**Thursday, August 16**

- 9:00 a.m.     **Call to Order, Welcome, Introduction**  
—Senator Mary Kay Papen, Vice Chair
- 9:15 a.m.     **Funding for Native American Treatment for Substance Dependence, Misuse  
and Abuse**  
—John (Jay) Azua, Programs Manager and Interim Executive Director,  
Na'Nizhoozhi Center, Inc.
- 10:15 a.m.    **A Rural Hospital's Perspective on Behavioral Health Services**  
—Gretchen Woods, Behavioral Health Services Nurse Manager, Advanced  
Practice Nurse, RMCHCS Behavioral Health Services
- 11:15 a.m.    **Comments on Centennial Care and on the Impact of State Behavioral Health  
Reform on Native Americans**  
—Cathleen E. Willging, Ph.D., Senior Scientist, Behavioral Health Services  
Research of the Southwest
- 12:15 p.m.    **Lunch (Provided)**
- 1:15 p.m.     **Medicaid Behavioral Health Services Through 2013 and Under Centennial  
Care**  
—Diana McWilliams, Acting Chief Executive Officer, Interagency Behavioral  
Health Purchasing Collaborative
- 2:15 p.m.     **Autism Issues/Senate Memorial 20 and House Memorial 44 Report**  
—Gay Finlayson, Education and Outreach Manager, Autism Programs, The  
Center for Development and Disability, University of New Mexico Health  
Sciences Center
- 3:15 p.m.     **Public Comment**
- 4:15 p.m.     **Adjourn**

Revised: August 30, 2012

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

**September 7, 2012**

**University of New Mexico Science and Technology Rotunda, Albuquerque**

**Friday, September 7**

- 8:00 a.m.     **Call to Order, Welcome, Introduction**  
—Representative Ray Begaye, Chair
- Welcoming Remarks**  
—Robert G. Frank, President, University of New Mexico (UNM)
- 8:30 a.m.     **Four Quadrant Clinical Intervention Model for Integrated Behavioral Health  
and Primary Care**  
—Steven Adelsheim, M.D., Director, UNM Center for Rural and Community  
Behavioral Health
- 9:30 a.m.     **Behavioral Health Care for the Chronically Mentally Ill — Now and Under  
Centennial Care**  
—Patsy Romero, State President, National Alliance for the Mentally Ill
- 10:30 a.m.    **Monitoring the Delivery of Behavioral Health Services**  
—Howard Dichter, M.D., D.F.A.P.A., Consulting Psychiatrist
- 11:30 a.m.    **Native American Suicide Prevention and Report on Statewide Clearinghouse  
for Native American Suicide Prevention (SB 417)**  
—Joseph B. Stone, Ph.D., Chief of Behavioral Health Services, Indian Health  
Service (IHS) Gallup Indian Medical Center  
—Sheri Lesensee, Program Manager, UNM Center for Rural and Community  
Behavioral Health, Native American Behavioral Program
- 12:30 p.m.    **Lunch (Provided)**
- 1:30 p.m.     **IHS Perspective on Behavioral Health Services Under Centennial Care**  
—Chris Fore, Ph.D., Director, IHS Tele-Behavioral Health Center of Excellence

- 2:00 p.m.     **Telehealth for Behavioral Health**  
—Chris Fore, Ph.D., Director, IHS Tele-Behavioral Health Center of Excellence  
—Avron Kriechman, M.D., Assistant Professor of Psychiatry, Department of  
Psychiatry, UNM School of Medicine, Professor, School of Social  
Work, New Mexico Highlands University
- 3:00 p.m.     **Early Intervention and Resources (EARLY and RAISE)**  
—Steven Adelsheim, M.D., Director, UNM Center for Rural and Community  
Behavioral Health
- 4:00 p.m.     **Public Comment**
- 4:30 p.m.     **Adjourn**

October 16, 2012

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

**October 18, 2012**

**Mesilla Valley Hospital, 3751 Del Ray Boulevard, North Gymnasium, Las Cruces**

**Thursday, October 18**

- 8:30 a.m.     **Call to Order, Welcome, Introduction**  
—Representative Ray Begaye, Chair
- 8:45 a.m.     **Behavioral Health Services Offered at Mesilla Valley Hospital**  
—Brian Hemmert, Chief Executive Officer, Mesilla Valley Hospital
- 9:00 a.m.     **New Mexico State University (NMSU) Community Mental Health and  
Wellness Clinic — Meeting the Needs of the Uninsured**  
—Esther Devall, Ph.D., Professor and Department Head, Family and Consumer  
Sciences, NMSU  
—David C. Holcomb, Ph.D., Licensed Psychologist, Assistant Professor, Family  
and Child Science, NMSU
- 10:00 a.m.    **School-Based Behavioral Health Panel**  
—Dr. Frank Mirabal, Vice President, Educational Support Division, Youth  
Development, Inc. (YDI)  
—Dr. Mary Ramos, Envision NM, University of New Mexico Department of  
Pediatrics  
—Jack Siamu, Senior Associate Director, Prevention, Intervention and Treatment  
Division, YDI
- 11:00 a.m.    **Connecting College Students to Behavioral Health Services**  
—Phillip Bustos, Vice President for Student Services, Central New Mexico  
Community College  
—Ann Lyn Hall, Executive Director, CNM Connect
- 12:00 noon    **Working Lunch Provided**

- 12:15 p.m.     **Behavioral Health for Children of Military Families**  
—Kourtney Vaillancourt, Ph.D., Licensed Marriage and Family Therapist,  
Assistant Professor and Clinical Director of Marriage and Family Therapy  
Program, Family and Child Science, NMSU  
— Merranda Marin, Ph.D., Licensed Psychologist, Assistant Professor, Family  
and Child Science, NMSU
- 1:15 p.m.     **Treatment Foster Care Panel**  
—Beverly R. Nomberg, L.I.S.W., Chief Executive Officer, La Familia-Namaste  
—Kate Banks, Former Treatment Foster Parent with La Familia
- 2:15 p.m.     **Report on Behavioral Health Programs for Children and Adolescents in the  
Child Welfare and Juvenile Justice Systems**  
—Yolanda Berumen-Deines, Secretary of Children, Youth and Families  
—Julia M. Kennedy, Psy.D., Clinical Psychologist, Juvenile Justice Facilities  
Behavioral Health Director, Children, Youth and Families Department  
(CYFD)  
—George Davis, M.D., Director for Psychiatry, CYFD
- 3:15 p.m.     **Review of Behavioral Health Services for Adult Offenders**  
—Jon R. Courtney, Ph.D., Program Evaluator, Legislative Finance Committee
- 4:15 p.m.     **Southern New Mexico Crisis Intervention**  
—Ron Gurley, Advocate and Executive Director, Forensic Intervention  
Consortium of Don Ana County
- 4:45 p.m.     **Public Comment**
- 5:15 p.m.     **Adjourn**

DISABILITIES CONCERNS SUBCOMMITTEE AGENDAS

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Revised: September 6, 2012

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

**September 13, 2012  
State Capitol, Room 321  
Santa Fe**

**Thursday, September 13**

- 9:00 a.m.     **Call to Order and Introductions**  
—Representative Antonio Lujan, Chair, Disabilities Concerns Subcommittee
- 9:05 a.m.     **Recipients, Providers and Advocates: Concerns About the Developmental Disabilities (DD) Waiver Program**  
—Anna Otero Hatanaka, Executive Director, Association of Developmental Disabilities Community Providers  
—Lisa Cisneros-Brow, M.S., Speech and Language Pathologist, Therapy Providers' Network  
—Peter Cubra, Attorney at Law  
—Joe Stone, Member, New Mexico Waiver Provider's Association
- 10:30 a.m.    **Public Comment**
- 11:30 a.m.    **Lunch**
- 1:00 p.m.     **Update: DD Waiver Program**  
—Catherine Torres, M.D., Secretary, Department of Health (DOH)  
—Cathy Stevenson, Director, Developmental Disabilities Supports Division, DOH
- 2:30 p.m.     **Money Follows the Person**  
—Nat Dean, Disability Advocate  
—Daniel Eckman, Disability Advocate  
—Adam Shand, Disability Advocate
- 3:30 p.m.     **Adjourn**

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

**October 9, 2012**  
**Albuquerque Convention Center, Jemez/Isleta Room**  
**Albuquerque**

**Tuesday, October 9**

- 9:00 a.m.     **Call to Order and Introductions**  
—Representative Antonio Lujan, Chair, Disabilities Concerns Subcommittee
- 9:05 a.m.     **Welcome to the Southwest Conference on Disability**  
—Anthony Cahill, Ph.D., Director of Disability and Health Policy, University of  
New Mexico School of Medicine
- 9:10 a.m.     **Home- and Community-Based Waiver Programs: Mi Via and Self Direction;  
Money Follows the Person**  
—Julie Weinberg, Director, Medical Assistance Division, Human Services  
Department
- 11:00 a.m.    **Advocates on Home- and Community-Based Waiver Programs: Self-  
Direction and Mi Via**  
—Ken Collins, Program Manager, San Juan Center for Independence-Gallup;  
Vice Chair, Statewide Independent Living Council
- 11:30 a.m.    **Public Comment**
- 12:00 noon    **Lunch**
- 1:30 p.m.     **Equity in Long-Term Services**  
—Jim Parker, Director, Governor's Commission on Disability (GCD)  
—Guy Surdi, Disability Specialist, GCD
- 2:00 p.m.     **Technical Assistance Program**  
—Jim Parker, Director, GCD  
—Guy Surdi, Disability Specialist, GCD

2:30 p.m.     **Voting Rights and Individuals Living with Disability**  
—Anthony Alarid, Architectural Specialist, GCD  
—Michael Hely, Staff Attorney, Legislative Council Service  
—Jim Jackson, Director, Disability Rights New Mexico

3:00 p.m.     **Public Comment**

3:30 p.m.     **Adjourn**

Revised: November 8, 2012

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

**November 9, 2012  
State Capitol, Room 321  
Santa Fe**

**Friday, November 9**

- 10:00 a.m.     **Call to Order and Introductions; Approval of October Minutes**  
—Senator Nancy Rodriguez, Vice Chair
- 10:05 a.m.     **Concerns Regarding the State Medical Cannabis Program**  
—Steven Jenison, M.D., Chair of the Medical Advisory Board to the New Mexico  
Medical Cannabis Program
- 10:35 a.m.     **Medical Cannabis Fund and Programming Status Update**  
—Ken Groggel, Medical Cannabis Program Manager, Department of Health
- 11:30 a.m.     **Public Comment**
- 12:00 noon     **Lunch**
- 1:00 p.m.     **Governor's Commission on Disability — Legislative Update**  
—Jim Parker, Director, Governor's Commission on Disability
- 1:30 p.m.     **State Use Act**  
—Nancy Bearce, Chief Operating Officer, Horizons of New Mexico
- 2:00 p.m.     **Microboards and Employment Initiatives for Individuals Living with  
Disabilities**  
—Nannie Sanchez, Disabilities Advocate  
—Rosemarie Sanchez, Disabilities Advocate
- 2:30 p.m.     **Employment for Blind Individuals and Individuals Living with Disabilities**  
—Ralph Vigil, Acting Director, Vocational Rehabilitation Division, Public  
Education Department  
—Greg Trapp, Executive Director, Commission for the Blind

- 3:00 p.m.     **Guardianships and Conservatorships**  
—Marsha Shasteen, Attorney, Senior Citizens' Law Office  
—Leonie Rosenstiel, Ph.D., M.P.H., Responsible Guardianship Advocate  
—Fern J. Goodman, General Counsel, Administrative Office of the Courts
- 4:00 p.m.     **Public Comment**
- 5:00 p.m.     **Adjourn**

# LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE MINUTES

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**2012 Interim Report  
Legislative Health and Human Services Committee**

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

**June 25, 2012  
Room 307, State Capitol  
Santa Fe**

The first meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, on June 25, 2012 at 9:41 a.m. in Room 307 of the State Capitol.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Nora Espinoza  
Sen. Gay G. Kernan  
Rep. Antonio Lujan

**Advisory Members**

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. Bernadette M. Sanchez  
Rep. James E. Smith  
Rep. Mimi Stewart

Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Sen. Sander Rue  
Sen. John C. Ryan

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Shawn Mathis, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Melissa Candelaria, Law School Intern, LCS

**Handouts**

Handouts are in the meeting file. They are listed at the back of the minutes.

**Monday, June 25**

**Welcome and Introductions**

The chair called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

**Review of 2012 Regular Session Health and Human Services Legislation**

The meeting's first order of business was a review of the fate of health and human services bills introduced in the previous legislative session (listed in handouts 5 and 6) by Mr. Hely. Mr. Hely also reviewed memorials passed in the 2012 legislative session, including one requesting the New Mexico Legislative Council (LC) to establish a behavioral health committee, and another requesting creation of a committee to oversee the implementation of health reform in the state.

Several members of the committee expressed their desire that the LC establish an interim subcommittee on behavioral health in light of last year's keen public interest in state behavioral health programs and resources. A discussion between the members of the committee resulted in a motion, approved unanimously, to request the LC to establish a standing behavioral health committee.

Mr. Hely closed his presentation with a reminder that the U.S. Supreme Court decision on challenges to the federal Patient Protection and Affordable Care Act (PPACA) was expected within the week.

**Fiscal Reports: Department of Health (DOH); Aging and Long-Term Services Department (ALTSD); Human Services Department (HSD); Children, Youth and Families Department (CYFD); Workforce Solutions Department (WSD)**

Greg Geisler, senior fiscal analyst for the Legislative Finance Committee (LFC), provided the committee with a fiscal year (FY) 2013 fiscal overview and outlook of New Mexico health and human services programs (see handout 7). He advised the committee that appropriations from the general fund to the HSD were on the increase for FY 2013 due to loss of federal American Recovery and Reinvestment Act of 2009 (ARRA) funding and characterized FY 2013 as a "transition year" for the HSD.

According to Mr. Geisler, since the HSD reduced provider rates, there has not been a notable increase in Medicaid enrollment or utilization; nevertheless, the department's request for a budget increase of \$48.9 million is all attributable to Medicaid. In total, the department received \$4.7 billion in appropriations, an increase of 5.8 percent from last year. Total general fund revenue for the department was approximately \$1 billion, representing an increase of 4.1 percent over FY 2012. Total Medicaid enrollment is projected to approach 527,000 by the end of June 2013. Of concern, enrollment of children has declined to 336,000 from a peak of 338,000 in March 2011.

For FY 2014, Mr. Geisler called the committee's attention to the coming need to replace funds from the tobacco litigation settlement funds that were temporarily diverted for appropriations to various health programs. Mr. Geisler reminded the committee that the legislative authority to divert money from the tobacco litigation settlement funds is due to expire. Further, assuming that health reform moves forward, the department projects it will need an additional \$10.6 million to \$16.6 million in the first six months of FY 2014 to fund activities associated with the anticipated increase in Medicaid enrollment. The department projects an increase in enrollment of between 106,000 and 137,000 recipients from the Medicaid expansion called for under health reform.

Mr. Geisler closed his presentation with a review of appropriations under the Temporary Assistance for Needy Families (TANF) program. Of note, the FY 2013 appropriation for direct TANF programs is slightly less than the FY 2012 operating budget, primarily due to fewer projected TANF cash assistance cases. According to Mr. Geisler, there has been an approximately 10 percent decline in the number of TANF cases from January 2011 to January 2012. Mr. Geisler reported that the HSD speculates that the decline is attributable to increased employment, while advocates for the needy attribute the decrease to a 15 percent reduction in benefits and changes in eligibility criteria implemented in FY 2011.

Mimi Aledo-Sandoval, senior fiscal analyst for the LFC, informed the committee about trends in appropriations to the CYFD. Pre-kindergarten (Pre-K) funding has remained a priority, with many early childhood programs and interventions in place that focus on healthy development of children from the prenatal stage to age three. In fact, the LFC held a hearing on early childhood development on June 15, 2012. An appropriation of \$9.2 million from the general fund was made to CYFD Pre-K programs in FY 2013.

Ms. Aledo-Sandoval reported that, in 2010, of the 27,793 births in New Mexico, approximately 71 percent were covered by Medicaid. Accordingly, Medicaid plays a major role in the health outcomes for many New Mexico children. From birth to the age of 15 months, Medicaid pays for six well-child doctor visits. Ms. Aledo-Sandoval explained that these visits are crucial to track developmental progress and to aggressively treat any health issues that could impair a child's proper development. However, for FY 2012, only 29 percent of children who qualify for these visits are getting them.

Ms. Aledo-Sandoval also reviewed trends for the state's juvenile facilities population. While the average daily population declined from FY 2006 through FY 2010, there is an increase in FY 2011. Ms. Sandoval reported that the state's juvenile facilities are operating at capacity. The CYFD's FY 2013 budget reflects the realignment of probation and parole services into the juvenile justice program. The FY 2013 budget includes a \$250,000 contract for continued training and support for the Cambiar New Mexico model.

Ms. Aledo-Sandoval next briefly covered the WSD fiscal overview and outlook (see page 15 of handout 7). Increased funding has been appropriated for unemployment support planning.

Since a high plateau from FY 2009 and FY 2010, unemployment benefits have been declining; however, since FY 2007, benefits paid have exceeded revenue paid into the Unemployment Compensation Fund by employers. Ms. Aledo-Sandoval reported that an ad hoc unemployment advisory council has been meeting to review the state's unemployment insurance system.

Ruby Ann Esquibel, principal analyst for the LFC, covered the FY 2013 fiscal overview and outlook for the DOH. For FY 2013, the department's appropriation from the general fund is \$292 million, with an increase of \$3.3 million (1.1 percent) over FY 2012. Funding above that requested by the department was appropriated for rural primary care services contracts (\$818,000), sexual assault programs (\$200,000), health care work force training (\$100,000), as requested by the LHHS, and nurse advice (\$29,000).

Ms. Esquibel advised the committee that the governor vetoed the use of the following FY 2013 performance measures for the department:

- preventing HIV/AIDS;
- conducting health emergency exercises;
- analyzing public threat samples;
- substantiating cases of abuse, neglect and exploitation in state facilities; and
- conducting compliance surveys of the state's private adult residential care and daycare facilities.

For this reason, the LFC's FY 2013 report card for the DOH will be abbreviated.

Funding for DOH health facilities remains at FY 2012 levels. There is increased funding for personnel, but the department continues to experience problems in filling a large number of job vacancies. According to Ms. Esquibel, the LFC has not identified the reason that available jobs are going unfilled, but there are concerns that the DOH is using the funds appropriated for hiring for other purposes.

The total appropriation for FY 2013 provides sufficient funding for maintaining direct patient care staffing levels and programmatic health care services and for paying \$4 million to lease the Fort Bayard Medical Center.

Ms. Esquibel next reviewed the Medicaid developmental disabilities (DD) waiver program. Currently, there are approximately 3,600 individuals receiving DD waiver services and 5,600 individuals are on the waiting list. In addition, there are 227 individuals receiving medically fragile waiver services. The DD waiver program's FY 2013 budget is \$96 million, with a \$2.7 million increase in general fund revenue over FY 2012. With this increase, the program will be able to provide services to an additional 150 clients. Ms. Esquibel pointed out that the number of clients served by the program has remained constant from FY 2008 through FY 2012, with a corresponding dramatic increase in the number of persons placed on the waiting list (see handout 7, page 21). The DOH recently issued new rates and standards for the DD waiver

program, but the LFC has not had sufficient time to analyze the impact of the new rates and standards.

Ms. Esquibel concluded the LFC's presentation with a report on the ALTSD. This department's FY 2013 total general fund appropriation is \$42.7 million, an increase of \$2 million over FY 2012. In addition, \$1.7 million was appropriated for home-delivered meals and other aging network programs, and \$537,000 was appropriated for the Aging and Disability Resource Center. Total FY 2013 general fund support for the aging network and area agencies is \$27.1 million, an increase of 6.6 percent over FY 2012. Ms. Esquibel informed the committee that the governor vetoed language in the appropriation to the aging network that directed the appropriation be used to expand home-delivered meals. Ms. Esquibel explained later that the governor had stated that she was not in favor of directing how these funds would be spent and preferred to give the agency flexibility in their use.

The LFC also provided the LHHS with handout 8, Third Quarter, Fiscal Year 2012 Performance Report Cards for the ALTSD, Interagency Behavioral Health Purchasing Collaborative (IBHPC), CYFD, DOH, HSD and WSD.

#### **Questions and Requests from Committee Members**

\* A committee member requested an annual report on the IBHPC.

Another member asked why rates of participation in Medicaid home visitation and follow-up are so low. Participation in this program is voluntary. Of the more than 20,000 children on New Mexico's Medicaid rolls, only about 600 children are taking advantage of this initiative. According to LFC presenters, the program's budget is very small, with only \$3.1 million allocated to the program. Furthermore, the program is not limited to children.

The member also asked why the rate of participation in Medicaid's well-child doctor visit benefit was so low, with only 29 percent of eligible recipients participating. Mr. Geisler advised that there is a two-month lag in reporting the well-child doctor visit data. According to Mr. Geisler, the department's target is 65 percent participation by the third quarter of 2012. He stated that the HSD expects to meet this target.

\* Several members requested further information regarding whether parents or providers are contributing to the failure to participate in the well-child doctor visits, or whether there are institutional barriers to participation.

\* A member requested a breakdown of categories of juvenile offenders. In the adult offender system, there has been an increase in violent offenders. The member wanted to know whether this is also a trend with the state's juvenile system.

A member expressed concern about the state's liability for unemployment insurance for retired state employees who are laid off by a subsequent private employer. In the member's

opinion, if an individual is already collecting a state pension, the state should not have to pay the same retired individual unemployment for loss of a post-retirement private sector job.

A member asked whether the DD waiver waiting list operated on a first in, first out (FIFO) basis. Ms. Esquibel confirmed that this is how the waiting list works, with exceptions for emergency cases. However, some people on the waiting list may receive some level of services while they are on the list. To obtain full benefits under the DD waiver, many people are waiting from eight to 10 years.

With regard to the 2014 expiration of authorization to divert a portion of the tobacco litigation settlement funds for health programs, a member asked whether there would be recurring replacement funding. David Abbey, director of the LFC, advised that replacement funding is included in the FY 2014 budget.

\*A member requested better information on the level of outreach taking place to ensure that those eligible for Medicaid are enrolled.

A discussion on the health care work force shortage took place. Ms. Esquibel responded that whether there is a sufficient primary care work force is "an open question" and suggested that in order to maintain a primary care safety net, many other types of practitioners would need to be used and provider rates would need to be supported. \*A member asked whether the LFC has any plans to analyze the health care work force as capacity is expanded. The discussion included mention of high school programs, the number of new medical schools and the use of programs to encourage medical school graduates to go into primary care.

Another member was curious about measures to reduce the DD waiver waiting list. The member questioned whether cost savings across the program could be achieved, thus enabling the DOH to increase enrollment. The member was also surprised that only 150 additional recipients could be added to the rolls as a result of the requested budget increase of \$2.7 million. \* The member requested that the LFC provide more information about the impact of cost savings on reducing the number of people on the waiting list. She also requested more information about a new A through F "grading" system that is being used to allocate or reduce DD waiver benefits to individuals.

\* A member requested information about the status of compliance with the Umbilical Cord Blood Banking Act and efforts required to educate pregnant women about the potential benefits of umbilical cord donations.

\* A member requested information regarding the level of hospital compliance with requirements for newborn genetic screening and the screening of newborns for hearing sensitivity. Ms. Esquibel stated that in FY 2011, approximately 30,000 newborns were screened for hearing sensitivity, which indicates that all newborns are being tested.

There was a discussion among members who questioned the governor's veto of certain performance measures for the DOH. Several members agreed that it is critical to consistently measure performance indicators over time and that changing the indicators from administration to administration makes it difficult to track trends.

A member asked the LFC team whether they had information about problems with providing appropriate shelter to foster children. Ms. Aledo-Sandoval responded that the CYFD has a 19.7 percent job vacancy rate for mental health counselors and social workers. A 2011 hiring freeze put a lot of pressure on existing CYFD social workers, leading to burnout and resignations. The CYFD's current staff is composed of either long-term or brand new employees. As a result of these developments, it will take time for the department to ramp up its behavioral health work force. There is also an increase in repeat maltreatment of foster kids. According to Ms. Aledo-Sandoval, the CYFD is presently more focused on children who have problems than on providing support to foster parents.

A member reported a rumor that foster kids in Bernalillo are staying in CYFD offices and asked that this be looked into. A member of the audience, Renada Galen, announced that she works for the CYFD and that this report is not correct. However, according to Ms. Galen, recruitment of foster families is a constant issue for the department.

A member questioned the \$4 million annual lease payment from the DOH to Grant County for the Fort Bayard Medical Center. Mr. Abbey stated that the deputy secretary of the DOH has been asked to explore restructuring the debt. Mr. Abbey stated that the New Mexico Finance Authority has taken the position that the debt cannot be restructured. While this facility was financed with bonds issued by Grant County, it was "a unique arrangement", according to Mr. Abbey.

One member questioned the LFC staff about the cost to New Mexico of new enrollees from 2014 through 2020 under the PPACA Medicaid expansion, referring to differing financial projections by the Lewin Group and by The Hilltop Institute. Mr. Geisler reported that the HSD is aware of these. He added that the HSD's calculations assume an increase of 162,000 recipients from the Medicaid expansion.

Another member commented on Item 8 on the IBHPC report card (handout 8) showing a target of only 37 percent of hospital inpatients to receive follow-up within seven days post-discharge. The member questioned whether this target was too low and whether it would lead to costly readmissions.

### **Presentation of Phil Lynch Legislative Award**

After the close of the period for questions, Senator Ortiz y Pino requested audience member Barack Wolff to step forward, whereupon Mr. Wolff announced that Senator Feldman is the 2012 recipient of the Phil Lynch Legislative Award given by the New Mexico Public Health Association and University of New Mexico National Health Disparities Center. This award is

given to a policymaker, advocate or legislator in any branch of government who has actively worked with communities to improve public health. According to Mr. Wolff, Senator Feldman received this award in recognition of her legislative record (350 bills introduced, 51 of which were signed into law, including the creation of the Brain Injury Services Fund in 1997) and of her "openness and inclusiveness" in the way she conducts the committees upon which she serves. This announcement was met with a standing ovation from all present.

### **Review of Work Plan and Meeting Schedule**

Mr. Hely reviewed the 2012 proposed work plan and meeting schedule for the committee (see handout 12). Mr. Hely called the members' attention to the absence of meetings on the work plan for the Behavioral Health Services Subcommittee, as the LC has yet to meet.

\* A member commented upon the ambitious work plan and suggested limiting time for presentations to ensure sufficient time for questions from the committee members. Presenters should be requested to streamline presentations to address areas of specific interest to the LHHS. It was suggested that the use of more detailed handouts be encouraged, and that these be emailed to committee members in advance of the meetings.

\* A member requested including autism coverage for state employees on the work plan. Another member suggested that this be included in the Behavioral Health Services Subcommittee's work plan. According to the member, there is already a work group on this topic, and he would like a report from it.

\* A member requested more information on medical schools and programs to increase providers.

\* Several members were opposed to having the Disabilities Concerns Subcommittee (DCS) meet concurrently with the October 9-12, 2012 Southwest Conference on Disability in Albuquerque. Last year, subcommittee members were not able to attend the conference because of the subcommittee meeting. In addition, conference attendees had to choose between attending the conference and attending the subcommittee meeting. Members would prefer to have the DCS meeting on a different day. A member also requested that the DCS meet an additional day.

\* Several members urged greater strategic focus to champion LHHS initiatives before the legislature. A member requested copies of fiscal impact reports (FIRs) for bills that did or did not pass in the last legislative session. The member wants to address concerns raised in the FIRs to improve the chance that future legislation recommended by the LHHS will pass muster with the LFC. Another member suggested that, since budgets are key, the LHHS needs to focus its efforts on programs for which budget requirements are known, taking into account start-up costs.

\* With regard to topics for the Behavioral Health Services Subcommittee, a member suggested narrowing down the work plan. The member is interested in plans for the Los Lunas facility and would like to tour it. The member would also like to hear from the New Mexico Medical Society and New Mexico Medical Board regarding prescription drug abuse and overdose

issues that the LHHS has been following. The member also requested review of mental health services for children in foster care if they are medicated. Committee members agreed that the Behavioral Health Services Subcommittee should meet a minimum of three days.

\* A member requested the LHHS to look into the impact of non-compete clauses in health care professional services contracts on the number of physicians who practice in health care work force shortage or rural areas. This is included in the LHHS's review of health care work force issues included in the LHHS work plan.

Incorporating the requests and suggestions of members listed above, the work plan was approved without opposition.

### **Medicaid Redesign: Centennial Care**

Sidonie Squier, secretary of human services, gave a presentation on the HSD's redesign of Medicaid, which the department has coined "Centennial Care", and on the Section 1115 Centennial Care waiver request.

Secretary Squier began her presentation with an explanation of recent events regarding the Section 1115 waiver request that the HSD submitted to the Centers for Medicare and Medicaid Services (CMS) on April 25, 2012. [The waiver request was withdrawn on May 29, 2012.] According to Secretary Squier, the HSD completed all "necessary" public hearings and Native American consultations required for the waiver. However, the department did not provide the Indian Health Service (IHS) with 30 days' notice and a 30-day comment period before submitting the waiver request to CMS, as provided for by New Mexico's state plan tribal consultation process. While the secretary believes that the IHS had actual notice of the HSD's plans for the waiver through meetings with the department, formal notice has now been given. As a result, there is now a 60-day delay before the waiver may be resubmitted, during which time the department is accepting public comments.

Next, the secretary proceeded to cover information set forth in handout 10, "Centennial Care". As of FY 2013, the HSD projects that Medicaid will make up 20 percent of the state budget. Further, if the Medicaid expansion called for in the PPACA is upheld, the department anticipates greater enrollment, at a greater cost. Secretary Squier gave examples of both federal and state measures to trim Medicaid budgets, a goal of Centennial Care. The secretary next explained the four principles of Centennial Care:

- comprehensive service delivery system;
- personal responsibility;
- payment reform; and
- administrative simplicity.

According to Secretary Squier, two-thirds of Centennial Care is "care coordination". Centennial Care is centered around care coordination "from newborn to nursing home". Care

coordination is also the reason behind the department's decision to include behavioral health services in Centennial Care.

Next, Julie Weinberg, director, Medical Assistance Division, HSD, explained the mechanics of "care coordination". A managed care organization under contract with the state receives an enrollment file, completes a health risk assessment in 10 days and assigns the Medicaid recipient a care coordination designation of Level 1, 2 or 3. A Level 1 recipient needs the least amount of care coordination and will be reassessed at least quarterly, with health risk assessments performed annually. A typical Level 2 recipient has chronic diseases such as obesity and uncontrolled diabetes. A Level 2 recipient would receive care coordination that enlists a team of health care providers who each receive a copy of the care plan. A Level 2 recipient will have ongoing face-to-face contact with the care coordinator, who provides "education and advocacy". A Level 3 recipient requires care at the level of a nursing facility. A determination of needs for home- and community-based services is made. Next, a care plan is developed and reviewed with the recipient. This care plan will be provided to a team of health care providers, and the Level 3 recipient will have ongoing face-to-face contact with the care coordinator, who provides "education and advocacy".

Ms. Weinberg gave an example of behavioral health Level 3 care coordination. Here, the managed care organization completes a health risk assessment in 10 days. If the recipient is identified as a schizophrenic who is not receiving psychiatric care and lacks permanent housing, the recipient is evaluated for referral to a core service agency or health home. If this option is viable, a referral is made. Face-to-face contact takes place and a comprehensive level of care assessment is made. The recipient selects a primary care provider within 30 days of the health risk assessment. Information is obtained from all members of the recipient's care planning team. A care plan is completed with the recipient and, if approved by the managed care organization, is provided to all care plan team members. Services are initiated, with ongoing contact accompanied by "education and advocacy". Ms. Weinberg characterized this as a "high touch process". Secretary Squier interjected that she has issued a directive that Medicaid behavioral health decisions will be made jointly by Ms. Weinberg and the chief executive officer of the IBHPC.

With regard to Native American participation in Centennial Care, Secretary Squier acknowledged that there is apprehension in the Native American community over managed care. She stated that the HSD wants to promote and encourage greater involvement by and with the Native American community. To this end, the department is requiring managed care organizations to contract with tribes to provide on-reservation case management. Her directive is not to interfere with measures that are working on reservations. Further, the department is requiring providers to offer culturally appropriate services. The department wants to have government-to-government collaboration with the Native American communities. For example, the department would support a Native American community that wants to contract directly with the federal government for mini-block grants to provide services to their members. The department will require managed care organizations to offer contracts to tribal health care entities at federal Office of Management and Budget (OMB) rates, to pay clean claims from IHS providers

and to pay OMB rates to out-of-network IHS providers who do not want to contract with managed care organizations. Department contracts will require preferential hiring of Native American care coordinators and cultural diversity training for all care coordination staff. Further, each managed care organization is required to have at least two tribal representatives in its management structure.

With respect to "personal responsibility", the second core principle of Centennial Care, the secretary explained that co-pays (also referred to as "cost sharing") are important to make both the patient and provider mindful of the cost of care. Patients who present at the emergency room for non-emergent conditions will be advised by the hospital that there will be a co-pay for non-emergent care. According to Secretary Squier, the hospital is supposed to refer the patient to available non-emergent services. In addition to this financial disincentive to use the emergency room for non-emergent care, recipients will be rewarded for engaging in healthy behaviors with gift and debit cards.

With respect to payment reform, the third core principle of Centennial Care, the HSD will reward plans and providers that practice cost-effective medicine, "targeted at outcomes rather than process". The HSD plans to establish pilot programs on adult diabetes and pediatric asthma to improved patient outcomes. Bundled payments will be made for inpatient hospital care for pneumonia and congestive heart failure. Under this rate structure, a hospital will not be paid if the patient is readmitted for the same condition within 30 days. Payment reform will also use peer-to-peer physician effectiveness reporting.

Secretary Squier explained the fourth core principle of Centennial Care — administrative simplicity. Currently, New Mexico has 12 Medicaid waivers. Except for the DD waiver, the HSD proposes to combine all current waivers into a single Section 1115 waiver. According to Secretary Squier, this would give New Mexico the flexibility to fashion "programs that work here". In addition, the HSD hopes that reducing the number of managed care organizations with which the state contracts will reduce costs and simplify oversight by the HSD. The updated Section 1115 waiver will be submitted by August 2012. From September through December, the HSD will be going through its procurement and award process. The HSD will use calendar year 2013 to transition to Centennial Care, with the goal of "going live" in 2014. Secretary Squier closed her presentation with assurances that program eligibility and provider payments would not be cut. She also announced additional public meetings on the Section 1115 waiver to be held in Albuquerque on June 26, in Las Vegas on June 27 and in Las Cruces on July 16.

### **Questions and Requests from Committee Members**

When pressed by a member of the committee, Secretary Squier confirmed that scheduled public meetings meet the public notice and comment requirements under current federal regulations for changes to state Medicaid waiver programs.

Another member questioned a statement made by Secretary Squier that it would cost the state an additional \$320 million to \$500 million for the Medicaid expansion as a result of the

PPACA. The secretary was asked how this estimate squared with projections by The Hilltop Institute (estimated net increase of \$40 million between 2012 and 2020) and The Lewin Group (estimated increase of 0.4 percent for 2014 through 2019). Brent Earnest, deputy secretary, HSD, clarified that the figures given by the secretary referred to the aggregate cost of the state's Medicaid program (the existing program and as expanded by the PPACA). Responding to further questioning, Deputy Secretary Earnest advised that, controlling for baseline costs (i.e., the cost of the existing program), "there is not much difference" between The Hilltop Institute's estimate and that of the HSD. He also clarified that statements about a dramatic rise in the state's Medicaid bills referred to the number of enrollees and estimated cost per person. To "bend the cost curve" will require a systemic change, according to Deputy Secretary Earnest.

Ms. Weinberg was asked to explain what "needed services" mean within the context of care coordination. She defined "needed services" as "those needed to support or maintain health". She was asked whether this means "least expensive and most convenient". According to Ms. Weinberg, coordinated care focuses on "most effective" and "best outcomes". She stated, "managed care organizations will not be telling physicians what pills to prescribe". When asked who would measure a physician's success, Ms. Weinberg indicated that physicians would be measured by standard quality performance measures, such as hospital readmissions within 30 days of discharge. Ms. Weinberg was also asked about the role a patient's family would play in treatment decisions. Ms. Weinberg indicated that part of the care coordinator's job is to involve the recipient's support system.

Another member asked whether there are any changes in eligibility for any of the waivers (see handout 9). Ms. Weinberg explained that the waiver proposal was developed assuming that the PPACA would be upheld, which means that some of those on the Medicaid waiver rolls would qualify for health insurance through the insurance exchange required by the PPACA. This change in policy would only affect persons applying for Medicaid for the first time; it would not apply to persons who have applied for disability and have had to wait for a determination (which can take years) or to persons whose eligibility has lapsed and who are "re-certifying".

\* A member requested information regarding the way the HSD generated its estimated increased enrollment, since it appears that there is a disparity between the LFC's estimates and those of the HSD. The LFC predicts between 106,000 and 137,000 new enrollees while the HSD predicts 162,000 additional enrollees.

\* A member wanted to know the cause of limited Medicaid enrollment for children. Ms. Weinberg stated that the HSD believes the cause is out-migration. She added that the HSD was surprised that growth in Medicaid enrollment of children did not increase during the recession.

A member asked whether the proposed waiver would affect the current practice of providing retroactive coverage for first-time enrollees; otherwise, service providers may not get paid for services rendered. According to Ms. Weinberg, there would be no change; however, by 2014, patients will be able to apply for Medicaid when they present at a hospital emergency department.

The HSD anticipates that Medicaid eligibility determinations will be made quickly and will not result in cost shifting to the providers.

A member asked why, in light of the withdrawal of the 1115 waiver submission for failing to conduct required tribal consultation, the three additional public hearings do not include any to be held on tribal lands. Secretary Squier replied that the department did conduct tribal consultation but that the glitch was a technicality about notice to the IHS. According to the secretary, Ms. Weinberg personally visited reservations.

A member asked how medical records would be shared across providers. Ms. Weinberg indicated that sharing of medical records would be governed by medical confidentiality laws.

Another member applauded the department's attempt to design an innovative program. The member confirmed that the HSD had conducted meetings at which many legislators were invited, and the member took issue with those who allege that the HSD made an end-run around stakeholders and the public.

A member requested clarification about the way the capitated rate paid to a managed care organization would be determined. The member asked whether capitation rates would be based on different segments of the covered population. The member also asked whether incorporating behavioral health services into care coordination would increase costs. Ms. Weinberg replied that capitation rates will be risk-adjusted. Currently, the HSD does not pay the same rate for each recipient, e.g., those in nursing homes, children and women in childbearing years.

A member expressed concern that, by utilizing outcomes measures, the HSD would penalize providers if recipients do not take care of themselves. The member used the example of a diabetic who goes home and eats an entire birthday cake, or of a patient with substance abuse problems. Secretary Squier replied that she expects physicians will be compensated, for the most part, for the care they provide.

A member asked whether the HSD would be able to work with what has already been implemented as part of health care reform at great cost, regardless of the outcome of the U.S. Supreme Court decision on the PPACA. Secretary Squier gave her opinion that the decision would not interfere with measures that are working. Further, she believes that Centennial Care "is a good idea regardless" of the outcome of the court decision; care coordination makes sense and many insurance companies have announced that they will continue certain initiatives that were mandated by the PPACA.

Next, a member questioned the transparency of the HSD's tribal consultation process. \* The member asked for specifics on the number of tribes consulted. The secretary reiterated that Ms. Weinberg met with many tribal representatives face-to-face. \*Following up on the secretary's response, the member asked whether Secretary Squier was aware of SB 196 requirements for

tribal consultation and asked whether this law was followed. Secretary Squier insisted that even small one-to-one meetings constitute tribal consultation.

Another member asked whether care coordination will cut behavioral health patients off from their current providers. Linda Roebuck-Homer, chief executive officer of the IBHPC, answered that patients can choose their providers. Next, the member asked about alternatives to core services agencies in rural areas that are not served by these organizations. Ms. Roebuck-Homer acknowledged that some mechanics of the waiver have not yet been sorted out. For example, there are plans to utilize telehealth and three services for behavioral health in rural areas: peer-to-peer support, respite and family support for seriously disturbed children. In using telehealth to expand mental health services, she anticipates greater use of allied health professionals such as psychiatric nurses.

A member of the committee responded to statements by the HSD about the anticipated increase in Medicaid enrollment in the next few years, urging that the rate of increase "should not be driving panic". The member expressed concern about changing eligibility for long-term care services from 250 percent to 138 percent of the federal poverty level. According to the member, reducing eligibility of some recipients merely results in cost-shifting. His constituents have called to complain that Centennial Care's changes to the state's Medicaid program will be "devastating".

### **Some Tribal Perspectives on Centennial Care**

The Honorable Rex Lee Jim, vice president of the Navajo Nation, gave the Navajo Nation's formal comments on the Section 1115 research and demonstration waiver request for Centennial Care (handout 13). Vice President Jim prefaced these with a brief overview of the Navajo Nation, the largest federally recognized Indian tribe in the United States.

The Navajo Nation encompasses a land base of nearly 27,000 square miles of mostly rural and geographically remote terrain, incorporating parts of 13 contiguous counties in northeast Arizona, northwest New Mexico and southeast Utah. In 2010, approximately 10 percent of New Mexico's total state population was Navajo. Unemployment among the Navajo is over 50 percent, a rate 10 times higher than that of New Mexico as a whole. In 2007, approximately 37 percent of Navajos were living below the poverty level, compared to 18 percent for New Mexico as a whole. A factor that may contribute to difficulty in accessing health care is the language barrier, as Navajo is widely spoken by tribal members in their homes.

Vice President Jim next described the Navajo health care system. The system includes the Navajo Nation's Divisions of Health, Social Services and Public Safety, the IHS, 638 tribal organizations and Native American traditional healing. In conjunction with several of the 638 tribal organizations located in the tribal area, the Navajo Area IHS provides primary care services to 246,000 individuals, with 16,000 hospital admissions and over one million outpatient visits annually. The IHS spends \$1,600 per person per year for health services, approximately 50 percent less per person than private and public health insurance plans. The Navajo Area IHS receives federal funding that meets only 55 percent of the health care needs of the tribal

population served; due to severe underfunding, the IHS must rely on third-party revenues to support its system.

Vice President Jim gave statistics comparing the much higher rates of illness and injury of American Indians and Alaska Natives to those of other Americans to illustrate the "daunting" challenge of providing health care services to tribal members.

Vice President Jim also stated that, in preparation for the Navajo Nation's input on the Centennial Care plan, Medical Assistance Division officials were invited to meet in Window Rock, Arizona, on March 13, 2012.

The Navajo Nation's formal comments on Centennial Care are as follows.

- The Navajo Nation requests that the state do no harm to Native American Medicaid beneficiaries.
- The Section 1115 waiver request proposes mandatory enrollment of Native Americans in Medicaid managed care, while guaranteeing Native Americans the right to choose an Indian health care provider. However, the proposal does not define "Indian health care provider". The Navajo Nation requests New Mexico to include the IHS, tribal operated facilities pursuant to the Indian Self-Determination and Education Assistance Act and urban Indian organizations in the definition of "Indian health care provider".
- The Navajo Nation requests New Mexico to explicitly require the Medicaid managed care organizations to contract with Indian health care providers as a provider network and to reimburse these providers at the Medicaid all inclusive rate or OMB rate.
- Consulting with the IHS is not collaboration with tribes. The Centennial Care plan had been finalized by the time it was presented to the Navajo Nation, with limited opportunity for additional input into the development of the plan. Additional tribal consultation in accordance with the State-Tribal Collaboration Act (SB 196) is requested before the waiver proposal is resubmitted to the CMS.
- The Navajo Nation requests the HSD to include a tribal representative on the RFP Finalization Team and Proposal Review Team as a voting member in the selection of managed care organizations.
- Native American culturally relevant holistic care is missing from the waiver request. The Navajo Nation requests establishment of a system of care that includes culturally appropriate comprehensive behavioral health services that comports with requirements of the Indian Health Care Improvement Act of 2010 and the Tribal Law and Order Act.
- The Navajo Nation has had problems with the managed care organizations administering the state's coordination of long-term services program. The managed care organizations have required "outrageous justification" for claims submitted for payment, failed to reimburse the IHS and other Native American providers in a timely manner and failed to coordinate care. The Navajo Nation urges the HSD not to repeat past managed care mistakes.
- With regard to proposed payment reform, the Navajo Nation is concerned about ensuring that compensation will be paid to providers who provide services to chronically ill

patients residing in rural or geographically remote areas who may require readmission for the same diagnosis in 30 days.

- The Navajo Nation would like to contract directly with the state for a pilot chronic disease health home project.
- The Navajo Nation supports provisions of Centennial Care that exempt Native Americans from co-pays.

The next speaker was the Honorable Joshua Madalena, governor of the Pueblo of Jemez. Governor Madalena started his presentation by questioning information provided by the HSD regarding the health status of tribal members. According to the governor, the Pueblo of Jemez has an accredited ambulatory care facility that services a population of over 2,600 tribal members, 28 percent of whom are Medicaid eligible. Accordingly, Medicaid revenue constitutes 70 percent of the facility's total revenues. Further, the facility meets or exceeds several clinical standards under the federal Government Performance and Results Act of 1993 (GPRA). The GPRA is the tool used by the IHS to report to Congress on the quality of care provided to Native American patients. The GPRA measures include clinical, quality of care and infrastructure standards. In addition, as part of the facility's recent accreditation survey, the facility was commended as a rural community medical home model.

Governor Madalena takes issue with the state's assertion that tribal consultation took place as Centennial Care was developed. He referred to the State-Tribal Collaboration Act and stated that tribal consultation is not a "technicality" but a federal mandate. Furthermore, consultation is of paramount importance in this case, because the Pueblo of Jemez has exercised its right under federal law to contract for health care funds that would have been spent by the IHS to provide health care for the pueblo's population. Without consultation, the state has decided to pull the pueblo's large Medicaid population into a managed care organization that is not a part of the pueblo's sovereign health system. To add insult to injury, according to the governor, the state plans to pay these managed care organizations a robust capitated rate for assuming the risk of caring for Native Americans.

Governor Madalena maintained that the state has a bad track record with managed care organizations. There continue to be large waiting lists for services. Managed care outreach and education in rural areas have been insufficient and ineffective, with access to managed care providers in rural and tribal communities a continuing concern. Existing managed care organizations have failed to coordinate care, such that the brunt of care coordination and associated costs falls upon the tribes. Nevertheless, the managed care organization receives a capitated rate for Native Americans while failing to take care of them. The governor was also critical of the state's lack of oversight of managed care organizations.

According to the governor, Centennial Care will also affect the economy of the pueblo. The Pueblo of Jemez is a rurally located non-gaming tribe. The pueblo relies upon Medicaid and other third-party reimbursement to supplement the cost of care for its tribal patients. An interruption or

reduction in this revenue stream would negatively impact the pueblo's health system and its ability to maintain current levels of service. Health care on the pueblo is also a job creator.

The governor concluded his remarks by saying that the Pueblo of Jemez has no confidence in the state to properly take care of its Native American population. Further, based on tribal sovereignty, the PPACA and other provisions of law, Native Americans cannot be compelled to enroll in managed care, nor will they suffer a penalty if they do not purchase health insurance.

On behalf of the pueblo and other tribes, the governor requests:

- direct communication with Governor Martinez to discuss the waiver and Native American concerns;
- a joint meeting with the CMS and the Medical Assistance Division of the HSD to discuss the waiver and its impact on the Native American Medicaid population;
- that the waiver expressly state that fee-for-service reimbursement for tribal health care services will be maintained and that cost-sharing will not be imposed;
- tribal consultation as required by federal and state law;
- disclosure of tribal health outcomes data under existing managed care organizations, including fee-for-service data from managed care providers; and
- retention of retroactive coverage to avoid increasing uncompensated care for Native Americans and very low-income individuals who are exempt from the individual mandate.

Shelly Chimoni, executive director of the All Indian Pueblo Council, provided additional information about the Centennial Care tribal consultation process. She indicated that the All Indian Pueblo Council serves as a single point of contact and that she is currently working with Ms. Weinberg's office. According to Ms. Chimoni, the appendix to the Centennial Care waiver request only reflects "consultation" with six of the 22 tribes. The 2009 State-Tribal Collaboration Act defined what tribal consultation is. The tribes have since given feedback on Centennial Care at an event attended by a representative of the CMS. She requested that a process to document tribal consultation be utilized, requiring the signature of each tribal governor. Ms. Chimoni also acknowledged that Native American tribes and pueblos could do a better job of publicizing their accomplishments in health care. She noted that many tribes have health care pilot projects under way and should be looked to as mentors for other tribes. She pointed out that revenues from these projects expand existing facilities and invest in tribal lands.

Joseph Ray, executive director of Native American Independent Living from the Pueblo of Laguna, spoke next. His organization works to improve the quality of life of pueblo people with disabilities by empowering them with attitudes, knowledge, skills and practices to live independently. The organization empowers its "consumers" to go on with their lives. Among the services the organization provides are home- and community-based services that allow aging at home in the community. Mr. Ray urged that any new fees or co-payments under Centennial Care should be waived for people with disabilities. He explained that people with disabilities do not have primary care options available after hours or on the weekend and that, often, the hospital

emergency department is their only alternative. Many people do not even have access to a vehicle, with the nearest provider an hour away. He also encouraged the HSD to retain retroactive coverage, as cutting this feature would put more families in debt.

Governor Phillip A. Perez from the Pueblo of Nambe and First Lieutenant Governor Harry Antonio, Jr., from the Pueblo of Laguna were in the audience and recognized by the committee.

### **Questions and Requests from Committee Members**

At the conclusion of this portion of the program, a member requested confirmation from the secretary of human services that there will be no co-payments for Native Americans. Secretary Squier so stated.

\* A member also requested further information regarding the problems reported regarding existing managed care organizations, such as "unreasonable" demands for claims documentation and the extra burden on Native American care coordinators.

### **Public Comment**

Nat Dean identified herself as a survivor of traumatic brain injury who lives in Santa Fe. She requested greater legislative action to mandate access for assistance dogs in public facilities.

Linda Milanese identified herself as the executive director of Assistance Dogs of the West. She supports greater access for assistance dogs in public facilities and expressed concern that dogs were being taken from a shelter by the U.S. Army to be trained as service dogs without being properly evaluated for temperament.

Ken Collins, who stated that he is a member of the Governor's State Independent Living Council, spoke regarding the Mi Via self-directed waiver. He is concerned that independent living centers have been left out of any planning processes. According to Mr. Collins, the managed care organizations are not doing a good job, and independent living centers have to do a lot of work that the managed care organizations are supposed to be doing.

Jim Jackson from Disability Rights of New Mexico complained about the lack of consultation in the development of the Section 1115 waiver. He asked the committee to serve as a "Board of Directors" to exert as much oversight as possible over changes proposed in Centennial Care. He noted that changes in eligibility would penalize and discourage persons with disabilities who make an effort to seek gainful employment.

Dr. Harris Silver, a retired surgeon, drug policy advocate and patient, weighed in on the HSD's plan to establish a pilot program for pediatric asthma. According to Dr. Silver, 40 percent of children with asthma live in homes infested with cockroaches. Dr. Silver stated that there is no proposed HSD intervention that will address the core issue of poverty. He believes that these asthmatic children need to be seen by a physician. He believes that co-payments are a disincentive for parents getting asthmatic children to the emergency room. He also volunteered

that most adult Medicaid patients need pain management and that a better way to manage pain needs to be found.

Dick Mason, with the New Mexico Alliance of Health Councils, testified that cuts in funding to health councils have had serious health effects and have cost more than they have saved. He indicated that national organizations are impressed with the unique structure of health councils in New Mexico and that the state alliance is in final negotiations for a national source of funding. Mr. Mason also requested that presentations on health councils be added to the committee's work plan.

Sharon Argenbright identified herself as a nurse speaking on behalf of 1,199 New Mexico health care workers. They support House Memorial 51, which calls for a study showing the relationship between staffing levels and outcomes. According to Ms. Argenbright, inconsistent staffing impacts patient care, causing falls, urinary tract infections and bedsores. These preventable conditions would be addressed by proper staffing.

Brenda Parker, the executive director of the San Juan Center for Independent Living, testified that her clients are located in areas so rural that even the use of telehealth is not workable. She questioned giving incentives to Medicaid recipients to get care when there is a shortage of physicians available to some Medicaid patients. Her agency has a primary care office program that is self-directed. This organization handles all the paperwork for self-directed care. Centennial Care would eliminate this type of agency, and her patients would end up in nursing homes.

Ellen Pinnes, with the Disability Coalition, echoed Mr. Jackson's observations that there are both good and bad provisions in Centennial Care, but she complained about the lack of opportunity to review it in advance. She disputes Secretary Squier's characterization of the federal Medicaid program as "one size fits all". Beyond some basic requirements, the federal Medicaid program provides considerable flexibility to states. In fact, every state has a unique Medicaid plan. In its Centennial Care waiver request, New Mexico is requesting an exemption from basic minimum federal requirements.

Dave Schmidt, from the Drug Policy Alliance of New Mexico, requested that the work plan on substance abuse be expanded and indicated that he would like to present a study regarding the impact of appropriate legal sanctions for possession of specified quantities of controlled substances.

Quela Robinson, with the New Mexico Center on Law and Poverty, requested a 12-month continuation of eligibility for Medicaid. Centennial Care proposes to reduce Medicaid eligibility for the working disabled and for those needing family planning and pregnancy services on the assumption that they will be covered through an insurance exchange. She added that Indian Country is not the only place where access to medical services is limited. Further, she advocated

in favor of legislation providing for the discharge of debts for past medical care in bankruptcy. She also urged further tribal consultation.

Penelope Foran testified about the intersection between poverty and health care. She stated that she has become poor since becoming disabled and is an example of the working disabled. If she is removed from Medicaid eligibility, it means a loss of \$1,300 a year to her. Mi Via is impacted by the proposed Centennial Care waiver. She wanted to know who would police the managed care organizations, stating that delays in receiving authorization for needed care are common.

Stevie Bath identified herself as the parent of an adult daughter who has been in the Mi Via program for five years. She likes this program, testifying that self-direction works. But the Centennial Care proposal appears to do away with self-direction. Family support does not appear to be incorporated into the managed care template. She reminded members of the committee that services of friends and family are free contributions to the state. She urged that the Mi Via waiver be kept.

Mary Vivian identified herself as the parent of an adult daughter who participates in Mi Via. She opposes including the self-directed waiver in the Centennial Care waiver. Mi Via works for her daughter: she does not get sick, has not been hospitalized and decides who her caregivers will be. The Mi Via waiver is working well and should not be changed.

Saskia van Hecke works for the Center for Health Innovation in Silver City. She is critical of Centennial Care because it fails to specify who will be coordinating care. If the care coordinators will be managed care organization employees, it will not work. Care coordination has to be done locally. Local care coordinators must be developed and integrated into the care team. There is also a lack of information regarding behavioral health homes. There are already many such centers that should be integrated into Centennial Care. Ms. van Hecke opposes co-payments and supports keeping retroactive payments.

Dr. Michael Prudhomme is a chiropractor from Albuquerque. He advocates including chiropractic care in Medicaid for pain management. This is a benefit in every private insurance policy in New Mexico. There are evidence-based studies showing positive outcomes.

Yvonne Hart is an independent consultant for community support. She is a former director of the Office of Disability and Health at the DOH. She has read the Centennial Care waiver application and concept paper and has great concerns. Centennial Care evidences no appreciation of what it means to be a disabled person who works in the community. The focus on outcome measures is not appropriate for evaluating care for the disabled community. For a disabled person, a positive outcome is not getting worse, or being able to function on a daily basis. She also noted the greater use of medications by the disabled. She requested leave to submit a copy of her testimony to the committee.

Nick Estes, from New Mexico Voices for Children, also spoke on behalf of the New Mexico Academy of Family Physicians. This group urges greater efforts to enroll eligible children in Medicaid. (See written public comments.) At present, the HSD requires children to be re-enrolled in Medicaid at age one, and as a result, many drop off the Medicaid rolls. There is no reason to require this re-enrollment. Mr. Estes also pointed out that differences in the estimated cost of the Medicaid expansion depend on whether they reflect savings from discontinuing the SCI program.

Ed Keller stated that he was "blown away" by Secretary Squier's cavalier attitude about the impact of Centennial Care on some recipients. He has two traumatic brain injuries. He is in Mi Via and suffers from severe pain. His physicians have considered institutional nursing care for him, but this means the loss of all daily decisions if he is institutionalized. The best outcome for him is the ability to live independently and interact with his community.

Gay Findlayson spoke on behalf of the autism community. There were 285 children born with autism in 2011. Funding for autism is insufficient. She hopes that in the updates for the Section 1115 waiver, an innovative health home for autism will be included.

Sandy Skaar spoke on behalf of a Mi Via participant. Under Centennial Care, rural residents need adjustments for higher costs. For example, a cell phone costs \$600 per year in rural New Mexico. Rural health clinics are only open on Tuesdays and Thursdays. It takes one-and-a-half-hours to drive to the nearest hospital if a recipient is ill on other days. She helps people on Mi Via get out of nursing homes. As of last fall, she had assisted 112 people with developmental disabilities. One of those was just discharged.

Rebecca Shuman, a Mi Via consultant, said that CMS rules and guidelines for self-directed waiver programs have specific requirements such as plans and budgeting. None of these requirements is found in the Centennial Care waiver application because the state does not plan to follow the CMS self-direction process. She believes that the state will call whatever it decides to do "self-direction". She urged either excluding the Mi Via waiver from the Centennial Care waiver or ensuring that the state follows CMS self-directed guidelines.

Jill Kennan is a Mi Via participant. She has a brain injury. To reconnect with life, she has used some unique services to help her. Medicaid does pay for chiropractic care if one is in Mi Via. This is an important aspect of self-direction.

David Murley, an AAA participant and Mi Via consultant, wants to see continuation of self-directed services. He doubts that Centennial Care will improve on existing self-directed services and urges greater stakeholder input.

Nannie Sanchez was recently given a "B" level assessment and therefore no longer receives services through a waiver. She cannot live independently and is now expected to move out of her

mother's house. She stated that inmates in prison receive better treatment than the disabled. She also complained that she has been separated from her friends with Down syndrome.

Tess Velasquez is a family living provider within the DD waiver. She has problems with proposed changes to the waiver. She is a caregiver for her son who is 41 years old. Long-term services will be capped and the state has not said what the cap will be.

Bruce Evans is the former co-chair of the IBHPC and is familiar with funding, implementation, coordination of care, management and oversight of managed care organizations. He cited a history of high turnover at OptumHealth. While he finds that Centennial Care has some good provisions, some are questionable or "not good at all". He stated that the local collaborative met earlier in the day. There are many open questions regarding the Medicaid redesign, and there has not been enough public input. The other ongoing concern is underenrollment, primarily in urban areas.

Clarissa Hoover, a parent and patient advocate, weighed in on home-based versus managed care organization care coordination. Her daughter has had a health home for the last seven years. Relationships are very important. Communication and trust between the health care providers are essential to the medical health home. A care coordinator who is not part of a team, or who becomes a rationer, is not helpful.

Hank Hughes, New Mexico Coalition to End Homelessness, cautioned that co-payments for emergency room visits may discourage people from going for care when they really need it.

Doris Husted, ARC of New Mexico, is also the parent of a daughter with a disability. She also questioned whether the family as caregiver is included in the Centennial Care plan. Furthermore, she does not want managed care organizations arranging care for the disabled population as part of Centennial Care.

\* At the conclusion of public comment, a committee member requested that the health planning councils be included in the committee's work plan.

### **Adjournment**

There being no further business, the committee adjourned.

## Handouts

1. Meeting Notice (May 24, 2012)
2. Memorandum from Raúl E. Burciaga re: Interim Committee Reminders — 2012 (June 5, 2012)
3. Draft Calendar for Legislative Committee Meetings (rev. 6/15/2012)
4. Tentative Agenda for the First Meeting of the Legislative Health and Human Services Committee (rev. June 21, 2012)
5. 2012 Health & Human Services Legislation (6/22/2012)
6. Legislative Health and Human Services Committee — Status of Endorsed Bills
7. NM Health and Human Services Programs: FY13 Fiscal Overview and Outlook (June 25, 2012)
8. Third Quarter, Fiscal Year 2012 Performance Report Cards for:
  - Aging and Long-Term Services Department;
  - New Mexico Behavioral Health Collaborative;
  - Children, Youth & Families Department;
  - Department of Health;
  - Human Services Department; and
  - Workforce Solutions Department.
9. Excerpt from Section 1115 Centennial Care Waiver Request (submission to CMS April 25, 2012)
10. Centennial Care, Human Services Department (June 25, 2012)
11. Money Follows the Person in New Mexico Act Fact Sheet (June 2012)
12. 2012 Proposed Work Plan and Meeting Schedule for the Legislative Health and Human Services Committee
13. Prepared Statement for Vice President Rex Lee Jim
14. Pueblo of Jemez State of New Mexico Centennial Care Position Statement (May 2012)
15. Pueblo of Jemez Position Statement Presented by Governor Joshua Madalena to the Legislative Health and Human Services Committee (June 25, 2012)
16. Navajo Nation Comments to New Mexico Human Services Department on the Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond (April 2012)
17. Certificate of Recognition for Pug Burge, Chief Administrator of the University of New Mexico Health Sciences Center

## **Written Public Comment**

Statement of Nat Dean, Advocate for Public Assistance Dogs (June 25, 2012)

Resolution of the Board of Directors of the New Mexico Academy of Family Physicians

(April 21, 2012)

Statement of Laurence Shandler, MD, FAAP (June 25, 2012)

Statement of Ken Collins and Attachments

Email Correspondence from Jill Kennan

Statement of Tess Velasquez (6/25/2012)

Statement of Ernestine Morales (6/25/2012)

Handwritten Statement of "Monique's Mother"

Statement of Art Tarro

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

**July 9-10, 2012  
Ralph Edwards Auditorium  
400 W. Fourth Street  
Truth or Consequences**

The second meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on July 9, 2012 at 10:07 a.m.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Nora Espinoza  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan (July 9)  
Sen. Gerald Ortiz y Pino

**Absent**

**Advisory Members**

Sen. Rod Adair (July 9)  
Rep. Ray Begaye (July 9)  
Sen. Stephen H. Fischmann (July 10)  
Rep. Miguel P. Garcia  
Sen. Cisco McSorley (July 9)  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. John C. Ryan (July 9)  
Sen. Bernadette M. Sanchez  
Rep. Mimi Stewart

Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez  
Rep. James Roger Madalena  
Sen. Sander Rue  
Rep. James E. Smith

**Guest Legislator**

Rep. Dianne Miller Hamilton (July 9)

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

Additional guests are recorded on the guest list in the committee file.

## **Staff**

Michael Hely, Legislative Council Service (LCS)

Shawn Mathis, LCS

Rebecca Griego, LCS

Melissa Candelaria, LCS

## **Handouts**

The following handouts are in the meeting file:

1. ECHO project — Extension for Community Healthcare Outcomes;
2. Project ECHO Map;
3. Project ECHO Center for Medicare & Medicaid Innovation Project Abstract;
4. New Mexico CHW/CHR Scope of Practice: Roles and Related Tasks;
5. Josh Ewing, State Legislator Magazine, *Rural Rx: A program developed in New Mexico may change how health care is delivered in rural America* (May 2012);
6. Leavitt Partners, New Mexico Legislative Health and Human Services Committee (July 9, 2012);
7. New Mexico Department of Information Technology, *New Mexico Broadband Program Health Initiatives*;
8. NMHIC Handout;
9. Molina Medicaid Managed Care: Telehealth and Innovations in Coordinated Care;
10. New Mexico Legislative Council Service Information Bulletin (July 6, 2012);
11. Chart of Changes to New Mexico Law as a Result of PPACA;
12. The Lewin Group, *The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending*;
13. Buettgens, Dorn and Carroll, *Consider Savings as Well as Costs — State Governments Would Spend at Least \$90 Billion Less With the ACA than Without It from 2014 to 2019*;
14. Southwest Women's Law Center, *Understanding the Affordable Care Act: Consumer Protections for Insured New Mexicans*;
15. Senator Jeff Bingaman Health Reform 2012, *Health Reform Two Years Later: Benefits to New Mexico*;
16. Domenica D. Rush, *Meeting Meaningful Use at SVH*; and
17. NM HITREC Presentation.

## **Monday, July 9**

### **Welcome and Introductions**

Senator Feldman called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

### **Project ECHO — Extension for Community Healthcare Outcomes**

Dr. Sanjeev Arora, professor of medicine (gastroenterology/hepatology), Department of Medicine, University of New Mexico Health Sciences Center, and director of Project ECHO, and Erika Harding, the education and outreach manager of Project ECHO, gave an update on this

innovative and internationally recognized model for expanding access to the medically underserved. Dr. Arora explained that, while Project ECHO originally focused on training rural health practitioners to treat and manage hepatitis C, the model has now been expanded to address 19 separate disease areas, including: cardiac risk reduction, asthma, prevention of teenage suicide, palliative care, rheumatology, chronic pain, substance abuse, high-risk pregnancy, complex care, HIV, geriatrics/dementia, Prison Peer Educator Program, childhood obesity and antibiotic stewardship.

The Project ECHO model uses multipoint video conferencing and internet technology to leverage scarce health care resources. Patient outcomes are improved by reducing variation in care, as rural practitioners attending weekly video clinics learn "best practices" through co-management of patients with a team of University of New Mexico Health Sciences Center specialists. Patient outcomes are monitored via a federal Health Insurance Portability and Accountability Act-compliant web-based database that provides data to monitor both outcomes and program effectiveness.

In addition to benefiting patients, Project ECHO benefits participating rural clinicians by providing no-cost continuing medical and nursing education required to maintain professional credentials. Further, it addresses the most common complaint of rural providers: professional isolation. Through Project ECHO, rural clinicians regularly consult and collaborate with similarly situated peers and a multidisciplinary team of medical and behavioral health specialists. This, in turn, creates "knowledge networks".

Dr. Arora described Project ECHO as "building bridges" among the University of New Mexico Health Sciences Center, the Department of Health (DOH), private practitioners and community health centers. Using existing community clinicians, it is a force multiplier. Currently, Project ECHO has over 400 points of contact throughout New Mexico. The Project ECHO model has been successfully replicated in the federal Veterans' Health Administration (chronic pain, diabetes, congestive heart failure and hepatitis C), in the United States Department of Defense (chronic pain), the University of Chicago (difficult to treat hypertension), in other states and in several foreign countries.

Importantly, a peer-reviewed study published in the *New England Journal of Medicine* found that treatment outcomes for Project ECHO hepatitis C patients are as good as those of patients who are treated in person at the University of New Mexico Health Sciences Center. Additional findings were that outcomes for Project ECHO patients exceeded national success rates. According to Dr. Arora, an important factor in these favorable outcomes is eliminating the need for the patient to travel outside the patient's community for treatment. Furthermore, the savings associated with reducing patient travel are significant. Most recently, Project ECHO received a grant from the Center for Medicare and Medicaid Innovation (CMMI) for a complex disease pilot study to improve the quality of care for 5,000 of two states' (Washington and New Mexico) most expensive Medicaid patients while achieving an estimated cost savings of 10%.

Next, Ms. Harding told the committee about the use of the Project ECHO model to train paraprofessionals, also referred to as "community health workers" or "promotores" or "community health representatives". This "emerging work force" is composed of persons already embedded in medical care settings in local communities. Project ECHO trains these embedded health care workers to provide social support and advocacy for patients with diabetes and complex medical conditions. This training is currently offered for free, via short face-to-face and telehealth training over a period of six months. The goal of the program is to train teams, not just individuals. It requires ongoing participation and training, and trainees are tested. Community health workers in the diabetes program are predominantly Native American, Hispanic and African American. To date, Project ECHO has trained nearly 100 community health workers in 32 New Mexico communities. Project ECHO also conducts similar programs on prisoner health (to address hepatitis C and HIV prevention in the prison population) and retinopathy screening.

Dr. Arora reminded the committee that, during the economic downturn, Project ECHO's state funding suffered a "massive cut". He noted that, while Project ECHO is compensated for consulting with other states and countries to build programs based on the Project ECHO model, it lacks sufficient funding to keep its work going in New Mexico.

#### **Questions and Requests from Committee Members**

\*In response to a question from a committee member, Dr. Arora requested restoration of Project ECHO's pre-2008 annual appropriation of \$2.5 million. A motion that the committee endorse the restoration of, or an increase over, Project ECHO's pre-2008 funding carried.

A member asked Dr. Arora whether Project ECHO is having difficulty accessing non-state funding sources. Dr. Arora indicated that all New Mexico programs had been put on hold, with expansion slowed. When available, Project ECHO attempts to obtain charitable foundation funding and was able to replace recent cuts in state funding with funds from the Robert Wood Johnson Foundation. However, this funding will end in Fall 2012, and it is not expected to be renewed. According to Dr. Arora, most Project ECHO private funding now comes from outside the United States; he expressed concern that Project ECHO not become a strictly international phenomenon.

A member asked how the Patient Protection and Affordable Care Act (PPACA) will impact Project ECHO. Dr. Arora stated that the federal government is very interested in the Project ECHO model with respect to the expansion of Medicaid. Dr. Arora predicts a dire shortage of primary care practitioners. He stated that chronic disease management is a "team sport", so training paraprofessionals will be critical. Project ECHO can play a key role in expanding the state's capacity to train these health workers.

A member requested more information about the CMMI grant. Dr. Arora explained that the total award is \$8.5 million, of which \$1.5 million will go to Project ECHO. The pilot is expected to save \$300 million over three years.

A member asked about challenges unique to the Native American community. Dr. Arora explained that, while the federally qualified health center system has good broadband coverage, connectivity is a problem for the Indian Health Service and Native American health clinics. He assured committee members that, if state funding is restored, Project ECHO would "go all out" to engage with Native American health services. This would include offering medical education to Indian Health Service providers.

A member complimented Dr. Arora on Project ECHO's success, recommending that those who have benefited from its programs be encouraged to contact their state legislators to remind them of the cost savings, continuing education provided, providers helped and consultations made. The member also urged Project ECHO to seek legislative support to expand its training to high school students.

Another member asked about Project ECHO collaborating with community colleges. Dr. Arora stated that many community colleges do train community health workers, but that funding has also been a challenge for these institutions. Further, Project ECHO's focus is training community health workers who are in communities that are too small to have a community college. Dr. Arora added that there needs to be reimbursement for services provided by community health workers.

\*A member requested more information about community health worker training programs available at community colleges around the state to ensure that these programs receive support.

### **Human Services Department Report on the Health Insurance Exchange**

Sidonie Squier, secretary of the Human Services Department, and Dan Schuyler, director of Leavitt Partners, appeared before the committee to report on the state's plan to establish a health insurance exchange under the PPACA. According to Secretary Squier, the administration has decided that federal election year uncertainty combined with forecasts for a shrinking federal budget make reliance upon the federal government to operate an insurance exchange "dicey". Since New Mexico has the second-highest uninsured rate in the country, the administration intends to act decisively by establishing an insurance marketplace for consumers to access vital health insurance information. Insurance companies will offer products and compete on the basis of price and quality.

Secretary Squier advised that New Mexico's exchange will operate differently than a federal exchange. The state's approach will be to build component parts of the exchange on a phased basis, for one-stop shopping. Phase I will build the four core components of the exchange to comply with federal requirements. She emphasized that the exchange will not be created in a vacuum; it is part of overall health reform. The exchange will increase transparency, improving the payment and delivery system. Over the next six to eight months, the department plans to engage stakeholders in more meaningful ways. A New Mexico Health Insurance Exchange Task Force has been established. The New Mexico Health Insurance Alliance should remain central to the planning. It will be an exchange designed by New Mexico, for New Mexico.

Leavitt Partners has been hired by the department to assist in setting up the state-based exchange. Mr. Schuyler provided some details regarding the proposed exchange. It will work like online travel retailers Travelocity or Priceline. It will be open to all insurance carriers licensed in New Mexico. Leavitt Partners deliverables include: 1) program integration and cost allocation (April 2013); 2) stakeholder consultation (April 2013); 3) health insurance market reforms (April 2013); 4) establishment of a grant application plan (June 2013); and 5) technology procurement assistance (September 2013).

### **Questions and Requests from Committee Members**

\*A member asked Secretary Squier several questions in an effort to find out how many uninsured New Mexicans would qualify for and use a state-based insurance exchange. Secretary Squier stated that state and federal employees, and those covered by Medicaid, would not qualify for the exchange. The member expressed concern that the expense to establish a state-based exchange might not be justified given the number of end users.

The member asked Secretary Squier how much it would cost to build the exchange. Secretary Squier stated that estimates are from \$25 million to \$40 million to build in all the PPACA requirements and \$100 million to build the exchange "from the ground up".

The member also asked how many people a day would be using the exchange. Mr. Schuyler stated that under a limited or soft launch, several thousand persons a day would use the exchange. He stated that there would be "a question of resources" on the customer service side.

The member asked how many people per day would be using the exchange once it is built. Mr. Schuyler stated that it would depend on how well the state advertises the exchange. Qualified consumers would check into their plan, so this could add up to several million transactions.

The member criticized the department for going forward with a state-based exchange before making a determination of how many New Mexicans will actually qualify for, and use, the exchange. The member stated that he does not believe that participating in the federal exchange is ill-advised if more than half of the state is already participating in federal health insurance programs (Medicaid, Medicare and federal workers). Secretary Squier stated that the information on the number of end users and encounters with the system will be available once the core components of the exchange are built.

Another member stated that her constituents who participate in federal health care programs are satisfied, and if so, why would it not be reasonable to participate in the federal insurance exchange? Secretary Squier replied that the state is "already overwhelmed" by the federal government and that the state "needs to keep some autonomy".

A member asked whether insurance companies that choose not to be listed on the exchange will essentially be out of business. Mr. Schuyler confirmed that federal insurance premium subsidies would only be available for coverage purchased through the exchange.

A member asked how much federal grant money the state has already received to establish the state-based exchange. Secretary Squier stated that New Mexico has received \$34 million, most of which has not been spent yet.

A member asked how much Leavitt Partners is being paid. Secretary Squier said that she thinks the Leavitt contract is for \$1 million.

In response to a member's question about who would operate the exchange, Secretary Squier stated that the New Mexico Health Insurance Alliance would be the site of the state exchange. She stated that she does not envision a large staff for the exchange.

A member noted that, after receipt of the \$34 million federal grant, contracts were on the verge of being let, then withdrawn. The member wanted to know whether the contracts are being rewritten. Secretary Squier confirmed that the contracts are being rewritten because the original request for proposals (RFP) did not fit New Mexico's needs, so Leavitt Partners is rewriting a New Mexico-specific RFP.

Another member stated that the former director of the New Mexico Office of Health Care Reform, Dr. Daniel Derksen, is from New Mexico, that he worked for U.S. Senator Jeff Bingaman and that Dr. Derksen was on leave from the University of New Mexico, yet a Utah consultant [Leavitt Partners] has been hired to create a "New Mexico" RFP. The member stated that he is "astounded" by the secretary's response to the question about the RFP. Secretary Squier responded that Dr. Derksen "had no experience working on an exchange and Leavitt does".

A member commented that it is disingenuous for the administration to continue to take the position that the federal government had not provided sufficient information about the exchange to go forward. According to the member, this same proposal was heard two years ago, so it is apparent that the administration will continue to drag its feet. The state was prepared to advance to level 2 in the establishment of the exchange months ago.

Secretary Squier was also questioned at length by committee members about the department's decision not to include any legislators on the New Mexico Health Insurance Exchange Task Force and the fact that the department has not engaged in any consultation with the legislature regarding the exchange. The observation was made that the legislature had spent a year studying the exchange with input from stakeholders as well as from the administration. Secretary Squier was specifically requested to give legislators a formal role in the task force. A member commented that the failure to consult with the legislature on the exchange could present a constitutional problem. Another member noted that if any legislation is necessary to implement the exchange, there would have to be a special session to pass it if the exchange must be up and running on January 1, 2014.

In response to questions, Secretary Squier stated that she thought that legislation would be necessary to establish the exchange. However, she had no details as to what that legislation

should entail and had not discussed this matter with the governor's office. \*A request was made by the committee that the administration provide an answer as to its position on the question of legislation.

When asked how the administration would meet the November 2012 deadline for an exchange "blueprint" or readiness plan as required by federal regulations, Secretary Squier stated that "we will meet it". When asked how requisite legislation to create an exchange would be achieved before November, Secretary Squier stated that while legislation may not be achieved by November, there might be consultation with legislators before November.

A member inquired whether the state exchange would provide plans on both the individual and small-group markets. Mr. Schuyler replied that the exchange would first establish the small-group or "SHOP" exchange because it is "low-hanging fruit". Less technology would be needed to implement this component because the subsidy and individual eligibility and Medicaid interface systems would not need to be in place for the SHOP to operate. The individual market would be established "months later" than the SHOP, according to Mr. Schuyler.

A member asked the panel how much the state would have to pay to operate the exchange. Mr. Schuyler stated that the federal Consumer Information and Insurance Oversight Agency could not provide the state with an answer to that question.

A member asked what role the Insurance Division of the Public Regulation Commission (PRC) is playing in the exchange. Mr. Schuyler indicated that the department is working in partnership with the Insurance Division.

### **Review of New Mexico Broadband Program and Health-Related Applications**

Gar Clarke, New Mexico Geospatial Program manager, New Mexico Broadband Program manager and agency tribal liaison for the Department of Information Technology, reported on the status of the state's broadband strategy. According to Mr. Clarke, the goal of the program is broadband availability and adoption for every New Mexican. This is achieved through: defining service areas and technologies; identifying barriers to adoption such as socioeconomic factors, education and markets; and implementation of steps to increase adoption. The department is in the process of mapping broadband availability and has several maps available on its web site. Building capacity for health care is one of the department's areas of focus. For health care, community anchor sites include health facilities and schools. Currently, there are 57 hospitals, eight nursing homes, 39 urgent care centers, 53 school-based health care centers and 150 federally qualified health centers with broadband in the state.

To enhance telehealth services throughout the state, Mr. Clarke recommends a collaborative quasi-governmental entity to serve as a trusted intermediary between the government and the private sector. This approach has been adopted by other states. This entity would function as a central hub and clearinghouse for technology grants and would track grant funding. The projected

date for completion of the state's broadband initiative is February 2014, but the health care portion of the system should be complete in December 2012.

### **Questions and Requests from Committee Members**

A member asked about broadband progress in tribal areas. Mr. Clarke stated that the department is interviewing stakeholders in pueblo and tribal areas before expanding into those areas. This survey should be complete by the end of July 2012, with a report published in August 2012.

### **Health Information Exchange Network**

Craig Hewitt, chief information officer for LCF Research and the New Mexico Health Information Collaborative (NMHIC), and Dale Alverson, M.D., NMHIC information technology director, reported on the status of the New Mexico Health Information Exchange (HIE). This exchange links patient records for 1.3 million New Mexico patients. All patient data are encrypted in motion and at rest. Every provider that participates in the HIE is required to sign a network subscription agreement that addresses security and privacy protections. Access to the patient data requires user authorization and is password protected. Furthermore, the NMHIC keeps audit logs of all access transactions.

Mr. Hewitt and Dr. Alverson explained that a patient must give written consent to give specific providers access to the patient's records and has the right to opt out. The only exception to the requirement that a patient consent to give a specific provider access to the patient's medical records would be in case of emergency; in such a case, an emergency department physician would be able to "break the glass" and access the patient's records linked through the HIE. The DOH has access to patient data, but only for public health conditions that must be reported by statute and for the state immunization registry. With patient authorization, the NMHIC also provides patient health data to the federal Social Security Administration to facilitate, and shorten the time for, disability determinations.

The presenters stated that, perhaps more than anyone, University of New Mexico emergency department physicians appreciate and are enthusiastic about the benefits of central access to patient records through the HIE because it: 1) improves care coordination; 2) provides for superior triage and evaluation in emergencies; 3) provides more comprehensive data for diagnosis and patient management; 4) reduces unnecessary duplication of tests; and 5) avoids unnecessary admissions and reduces readmissions.

Dr. Alverson, a noted telehealth expert, stated that telehealth and the HIE should be closely linked as a means to improve access to care, to achieve the best health outcomes and to reduce costs. He explained that the convergence of technology could address "the perfect storm" created by health care reform, an aging population, a critical shortage of health care providers and disparities in access to health care. With respect to rural New Mexico, gaps in access to health services exist for hepatitis C, behavioral health, diabetes, asthma, cancer, oral health and cardiac and stroke care. According to Dr. Alverson, only three out of 33 counties exceed the national

average of physicians per 100,000 population. Sixty-four percent of New Mexico's physicians practice in three counties. These same three counties are home to only 39% of New Mexico's population.

Dr. Alverson identified three entities working to broaden the use of telehealth to meet the state's health needs:

- the Center for Telehealth and Cybermedicine Research at the University of New Mexico Health Sciences Center develops new programs and provides technical, operational, business and evaluation planning;
- the Southwest Telehealth Access Grid is a "network of networks" that can support both telehealth and the HIE. It connects 11 New Mexico hospital and health system telehealth providers, Arizona's Telemed Program, providers in Phoenix and Tucson and the Navajo Nation with three regional "backbone" providers building-out broadband networks for health care; and
- the New Mexico Telehealth Alliance is a 501(c)(3) consortium of public and private health care stakeholders.

Dr. Alverson reminded the committee that various telehealth programs are funded by grants and do not have sustainable funding.

Dr. Alverson requested the committee's support for the following:

1. maintaining the NMHIC as the state's designated HIE entity;
2. legislation that allows point-of-service patient consent and authorization to disclose patient medical records;
3. funding for the NMHIC to demonstrate the effectiveness of the HIE and to establish a sustainable funding model;
4. legislation to provide reimbursement for telehealth encounters (reintroduction of House Bill 591 from 2011); and
5. legislation establishing the New Mexico Telehealth Alliance as the state's designated telehealth resource center.

### **Questions and Requests from Committee Members**

A member asked about coordination with health care providers in West Texas, specifically El Paso, Lubbock and Midland. The member stated an interest in a less Albuquerque-centric approach to regional health care. The member brought up an incident in which testing at the M.D.

Anderson Cancer Center had to be repeated in New Mexico because of an impediment to the exchange of patient medical records. The member stated that patients cross state boundaries for medical care all the time and that there needs to be a national HIE. The member added that he would be glad to support funding for access to out-of-state patient records. Maggie Gunter, the president and executive director of LCF Research, responded that the NMHIC is in contact with West Texas providers, and she added that the HIE is part of a nationwide network.

Several members asked questions about the consent and authorization process and about protections for confidential and private patient medical information. Dr. Alverson clarified that a patient would have to present to a physician for treatment and then consent to the disclosure of medical records to that physician before the physician would be granted access to the patient's medical records. A member was concerned about correctly matching medical records to the patient. The presenters explained that the HIE system is designed to provide each patient with a unique patient identifier. According to Dr. Alverson, hospitals use sophisticated systems for patient verification, but no system is perfect. He added that locating the correct record digitally takes less time than finding the right paper record. A member was concerned about DOH access to records through the HIE. Dr. Alverson explained that for reportable conditions, the DOH has access to patient medical records (whether electronic or hardcopy) by law. \*The member requested a list of reportable conditions.

Another member asked whether the HIE system is linked with the Board of Pharmacy's prescription database. Ms. Gunther stated that the NMHIC would be interested in this. Dr. Alverson commented that this demonstrated the need for a central body to coordinate the information-gathering technology. \*The member requested that the NMHIC contact the Board of Pharmacy about its prescription drug monitoring database and link it to the HIE. \*Another member requested that the HIE include adverse drug events in its database.

A member questioned Dr. Alverson about the availability of broadband in rural areas. Dr. Alverson confirmed that there are "gaps" and that the HIE for Native Americans is just beginning. The main barrier is the lack of adequate high-speed connectivity.

A member asked how long it would be before a physician in any emergency room in the state could access a patient's medical records. Mr. Hewitt analogized HIE access to the use of automated teller machines (ATMs). According to Mr. Hewitt, expanding the use of ATMs was a standards issue. He estimates that it could take two to three years to achieve universal access to HIE. In Dr. Alverson's opinion, much progress could be made in two to three years, but it may take five years for the HIE to be ubiquitous in New Mexico. He observed that, if the public perceives value, adoption of technology takes place more rapidly. He pointed to the spread of the use of cellphones, and now tablets, as examples of this phenomenon.

A committee member asked whether a patient could refuse to consent to the disclosure of medical information. Dr. Alverson confirmed that no patient can be compelled to consent to the disclosure of confidential medical information and that there is no penalty for this.

The NMHIC presenters were asked about the exchange of patient medical information with the Social Security Administration. \*A member was interested in seeing a copy of the agreement between the NMHIC and the Social Security Administration.

### **Molina Medicaid Managed Care Telehealth and Innovations in Coordinated Care**

Irene Krokos, M.D., chief medical officer for Molina Healthcare of New Mexico, spoke to the committee about a changing paradigm in the delivery of health services. She explained that Molina was founded by an emergency room physician who saw too many patients in the emergency room for non-emergent conditions. These patients were low-income and had low health literacy. As a result, he decided to open primary care clinics in California. Molina is now a managed care organization operating across the country. This organization is now a "medical home" that reduces unnecessary use of the emergency room. In New Mexico, Molina participates in the Salud! and State Coverage Insurance (SCI) programs, and is a third-party administrator for Personal Care Option and the Mi Via self-directed waiver.

Dr. Krokos explained that, as a practitioner, she treats patients with several factors that impact health status: chronic disease, behavioral health and mental illness and social determinants such as early childhood development, lifestyle and working conditions. In addition, one-half of the adult population in the United States has difficulty understanding and acting upon health information. Integrated health management addresses physical, behavioral and social factors.

Molina is leveraging technology, such as Project ECHO, to promote quality and best practice care in rural and underserved areas through telemedicine. As Dr. Krokos explained, there are patients who cannot be served in a 15-minute appointment and who require a more intensive treatment approach for chronic conditions. The Project ECHO model provides an "outpatient ICU". Project ECHO is the hub that supports primary practices around it, with outpatient intensive care unit (ICU) teams embedded in the primary care clinic. The goal of the model is same-day triage by the team. This is a transformation in the model of care.

### **Questions and Requests from Committee Members**

Several members were surprised by the incidence of mental illness cited by Dr. Krokos in her materials. According to the Centers for Disease Control and Prevention, 25% of all U.S. adults have a mental illness, and nearly 50% of U.S. adults will develop at least one mental illness during their lifetime. Dr. Krokos explained that "mental illness" was defined using clinical definitions according to DSM IV criteria.

Another member asked Dr. Krokos about the role of electronic medical records in the outpatient ICU model. Dr. Krokos replied that access to electronic medical records is vital to track a patient after discharge and to follow care over time.

**Tuesday, July 10**

The meeting reconvened at 8:57 a.m.

### **Status of the PPACA**

Mr. Hely briefed the committee on the recent United States Supreme Court decision on the PPACA. First, the Court upheld the PPACA's individual mandate requiring certain uninsured individuals to obtain health insurance or be subject to a monetary penalty. Second, the Court held that Congress cannot penalize states for not participating in the PPACA's Medicaid expansion. However, Congress may provide incentives to states that choose to expand their Medicaid programs. Finally, the Court upheld the other parts of the PPACA, including the insurance coverage provisions, innovation grants and programs and the health insurance exchange.

Committee members inquired about the positive and negative economic impacts of the PPACA on the state. The members expressed concern about the penalty to be imposed on New Mexicans without health insurance by 2014. Committee members asked whether uninsured residents and businesses can qualify for tax credits or subsidies to purchase health insurance. It was noted that New Mexico's uninsured rate is the second highest in the country.

Committee members requested information on the amount of federal grant funding received by the state since 2010 to implement the PPACA, including grants for the development of a health insurance exchange. According to the Human Services Department's web site, the amount received is more than \$120 million. Mr. Hely mentioned that the Legislative Finance Committee will be studying the tax implications of the PPACA at its August meeting and may provide a list of total funding received to date.

### **Consumer Perspectives on Health Care Reform**

Pamelya P. Herndon, executive director, Southwest Women's Law Center (SWLC), provided an overview of some of the new benefits to women under the PPACA. She stated that more than 50% of the New Mexico population are women. Women and children can now receive preventative services without cost-sharing under the PPACA. Some of these preventative services include cancer screening, immunizations, domestic violence screening and counseling. Ms. Herndon explained that the PPACA also establishes women's health coordinating centers and a network of supportive services to help mothers and pregnant women to complete secondary education. She emphasized that the PPACA allows the extension of parents' health insurance coverage to children under the age of 26. Ms. Herndon said that older women will benefit from the PPACA provision that eliminates co-pays for prescription drugs.

Kyle Marie Stock, staff attorney, SWLC, focused on consumer protections for insured New Mexicans under the PPACA. She highlighted five key points: 1) New Mexicans with health insurance already meet the PPACA's individual mandate requirement; 2) consumers stay healthy because they can access preventative health services without cost-sharing; 3) consumers have access to more health care services when they need them; 4) consumers can get health insurance even if they have pre-existing conditions; and 5) the law creates more transparency and helps to control costs for consumers. Ms. Stock pointed out that the new health care law affords

consumers an appeals process when they are denied coverage for a treatment or service and ensures that health insurance premium rates are fair according to the rate review and medical loss ratios.

Kelsey McCowan Heilman, staff attorney, New Mexico Center on Law and Poverty, views the PPACA as an opportunity to reduce the state's uninsured rate from 25% to 5%. She underscored that expanding Medicaid is critical to provide health care to low-income working families and adults under 138% of the federal poverty level. She said expanding Medicaid to 200,000 more New Mexicans will save hundreds of millions of dollars each year in uncompensated care costs. She explained that the state will leverage significantly more federal dollars from its small investment in expanding Medicaid, thus providing a major boost to New Mexico's economy and jobs. Ms. Heilman pointed out that even if New Mexico does not expand its Medicaid program, New Mexico's federal tax dollars will nonetheless go to other states that do participate in the Medicaid expansion. She recommended that the committee ask the governor to make a public commitment to implementing the Medicaid expansion under the PPACA and that the committee introduce legislation and appropriate funds to that end.

Committee members asked what the new eligibility requirements would be under a Medicaid expansion. The panel answered that it would be up to each state to determine its eligibility requirements. The committee requested information regarding long-term cost savings associated with expanded coverage, what extra money would come to the state and what a Medicaid expansion would mean for urban and rural hospitals under the PPACA. Committee members inquired as to which states have requested waivers to establish a single-payer system similar to Vermont's proposal. It was noted that states can submit waivers beginning in 2017.

### **Katie Faith Martinez Patient Bill of Rights**

Tyler Atkins, an attorney with McGinn, Carpenter, Montoya and Love, P.A., who represents the parents of Katie Faith Martinez, explained that House Memorial 80 from the 2011 regular legislative session requested the creation of a task force to study the rights of health care patients and the manner in which state health care facilities consider patients' rights in the delivery of health care, among other purposes. The New Mexico Health Policy Commission was charged with convening the task force; however, the commission was de-funded and the task force was not established. Mr. Atkins asked that the committee endorse the legislation in the upcoming 60-day session.

Deborah and Melvin Martinez, Katie's parents, shared the story of how their daughter had been misdiagnosed by hospital staff who were not doctors. Katie was eventually admitted to the hospital with pneumonia. The last physician to treat her was a locum tenens "substitute" physician from a temporary agency who was unable to resuscitate Katie after complications from a procedure due to his lack of familiarity with the hospital facility. Mr. and Mrs. Martinez said their proposed legislation would make hospitals fully accountable for any physicians they provide onsite to treat patients who present at the hospital. The proposed legislation is based on a Vermont statute that requires each hospital to have a policy that protects the patients' rights to

receive information about their health care that will allow them to make informed decisions about their care.

Committee members asked whether the family had taken any action against the doctor or the hospital. Mr. and Mrs. Martinez stated that their case was settled without a trial. Committee members were interested in whether hospitals frequently use temporary agencies to hire physicians. The committee said it will look at the proposed patient bill of rights legislation at its final meeting when it considers bills to endorse.

### **Tour of Appletree Educational Center (AEC)**

Rebecca Dow, chief executive officer, AEC, gave a tour of the educational facility serving children and youth from pre-kindergarten through ninth grade. She complained of what she characterized as too much regulation by the Children, Youth and Families Department (CYFD). She alleged that the CYFD retaliated when she complained of CYFD rules and enforcement.

### **Tour of the Sierra Vista Hospital**

Domenica "D" Rush, chief executive officer, Sierra Vista Hospital, gave a tour of the community-operated, 25-bed critical access hospital.

### **Meaningful Use of Health Information Technology**

Lindy Dittmer-Perry, program director, New Mexico Health Information Technology Regional Extension Center (NM HITREC), explained that the NM HITREC is a consortium of three nonprofit organizations — LCF Research, HealthInsight New Mexico and the New Mexico Primary Care Association — working together with the goal of assisting priority primary care providers to reach "meaningful use" of electronic health records to improve patient care. Eligible providers that achieve meaningful use of electronic health records can obtain Medicare and Medicaid incentives. For example, Medicare provides up to \$44,000 over five years in incentive payments, and Medicaid pays up to \$63,750 over six years, including assistance to providers in the first year to adopt, implement or upgrade electronic health records.

NM HITREC's service areas include: Albuquerque, Santa Fe, Farmington, Gallup, Zuni, Clovis, Roswell, Las Cruces and Carlsbad. Of the 1,500 eligible primary care providers within these service areas, NM HITREC hopes to reach 1,035 providers, including doctors, osteopathic physicians, physician assistants and nurse practitioners, among others. Ms. Dittmer-Perry further stated that primary care providers have the unprecedented opportunity to update their electronic health records, as exemplified by Sierra Vista Hospital. This hospital was nominated and selected to attend a White House meeting to share its experience in implementing electronic medical records.

Ms. Rush detailed Sierra Vista Hospital's efforts to upgrade and implement an electronic records system, including the challenges of using electronic health records. Some of these challenges involve the ongoing need for staff orientation and training and the high cost to fully implement, maintain and troubleshoot the software system. Ms. Rush emphasized the

administrative burden on the hospital to meet all federal standards regarding the sharing of protected patient health information. She thanked the NM HITREC for helping to modernize Sierra Vista Hospital with the electronic medical records and believes her hospital will achieve Medicaid meaningful use status in the near future. Ms. Rush's recommendations to other hospitals interested in upgrading their electronic medical systems are to apply for grants and loans, to hire a good team to train facility personnel to use the system and to work with a reputable and responsive electronic records system vendor.

Committee members were interested to learn that Midland College in Midland, Texas, received a grant to provide online training to New Mexico's primary care providers in using electronic records technology. Committee members agreed that it is important that physicians and medical staff understand the electronic medical records and data collection technology. The committee inquired about the costs for purchase, implementation and training to use the technology.

#### **Status Update: The Insurance Division and the PPACA**

John Franchini, superintendent of insurance, Insurance Division, PRC, reviewed the procedures that the division has implemented pursuant to legislation (SB 208 from the 2011 regular legislative session) intended to improve the health insurance rate review process. The rate review law mandates that specific factors be considered when reviewing proposed rate increases from health insurance companies.

Superintendent Franchini mentioned that Blue Cross Blue Shield of New Mexico (BCBS) requested a 9.9% rate increase, which was approved prior to SB 208 becoming effective. Subsequently, the Insurance Division reexamined the 9.9% rate increase under the parameters of the new law and decided that it was too high. BCBS sued the Insurance Division and eventually accepted a 6.9% rate increase that accounted for medical inflation and BCBS's rural service area. Presbyterian was approved for a 4.7% increase, and Lovelace received a 6.9% increase. Superintendent Franchini stated that this is the first time that health insurance companies have not received double-digit increases, partly due to the new rate review requirements under SB 208 and mandates under the PPACA.

Superintendent Franchini reported that the Insurance Division received a federal grant to hire a new actuarial firm to audit the division and hire new staff to join the rate review team, resulting in better overall performance of the division. He added that in 2011, the division's Life and Health Bureau and the Managed Care Bureau conducted external rate reviews as required under the PPACA and closed 3,212 claims. Superintendent Franchini announced that the division has received several grants totaling more than \$4.2 million, and he hopes to receive a grant from the SWLC to conduct outreach to rural communities.

Superintendent Franchini said that SB 290 (introduced in the 2012 regular legislative session) requires an amendment to make the New Mexico Insurance Code compliant with the PPACA. Superintendent Franchini explained that the amendment would cover medical loss

ratios, children and gender rating, among other provisions. He ended his presentation by announcing that New Mexico has been recognized in a national article as one of 10 successful states in implementing health insurance reform under the PPACA.

Committee members asked how many New Mexicans are covered by insurance plans and the number of health insurance companies under the division's purview. Superintendent Franchini answered that 400,000 New Mexicans are covered by some type of health insurance. The division handles seven companies that write individual health plans. Additionally, there are other limited medical plans, accident plans and small group plans under the division's purview. The committee asked whether the insurance companies can appeal the division's rate increase decisions. Superintendent Franchini explained that SB 208 allows an appeals process with the PRC and that the new approved rate increases for BCBS, Presbyterian and Lovelace have not been appealed. According to Superintendent Franchini, Presbyterian has the highest number of enrollees. BCBS is the biggest rural provider and enrolls the second-highest number of people. Lovelace has the fewest enrollees — 75,000.

The committee questioned whether existing insurance companies are committed to serving rural areas of the state and, if they are not, how the state plans to fill the void. Superintendent Franchini believes that none of the state's existing insurance companies will pull out of the state. He also said that there is a new nonprofit health insurance co-op interested in serving rural New Mexico. Committee members would like a presentation on the new co-op at a future committee meeting.

Committee members wondered whether the division is involved in setting up the health care exchange under the PPACA and requested information regarding the exchange's potential impact on the division's workload. Superintendent Franchini replied that the division already has in place the medical loss ratio, external review, web site and a federal team to assist with outreach. He also stated that with his team of financial examiners, actuaries and ombudsmen and support from the PRC commissioners, the Insurance Division is prepared for any increased workload resulting from the PPACA. He added that the division will focus on outreach to people currently without health insurance. He confirmed that he was recently asked by the Human Services Department to join the advisory board working on the exchange and that he had offered the assistance of his staff as well.

Committee members wanted to know what progress has been made on defining an essential benefits package to be offered under the exchange. Superintendent Franchini responded that at the end of last year, his division requested insurance companies to send in their health benefit plans. Of the plans submitted, the division picked the three most common plans, which were different from the federal government's chosen plan. He said the issue of the conflicting plans should be resolved in the near future before the implementation of the exchange.

## **Public Comment**

Jim Jackson, executive director, Disability Rights New Mexico, explained that under the PPACA, insurance companies cannot deny coverage based on disability or pre-existing conditions. The PPACA also requires that the essential benefits package include mental health, behavioral health, rehabilitation and habilitation services, which are important needs of people with disabilities. Mr. Jackson detailed the ways a Medicaid expansion will help cover adults with disabilities who do not qualify for Supplemental Security Income. He disagreed with the Human Services Department that a Medicaid expansion would be challenging or unsustainable and urged the committee to support Medicaid expansion.

Ellen Pinnes, health policy consultant with the Disabilities Coalition, added that it makes moral sense for New Mexico to participate in the Medicaid expansion and urged legislators to support the expansion. She said that without the expansion, the most vulnerable population will be without health care.

### **Adjournment**

Committee members thanked the mayor and the City of Truth or Consequences for hosting the meeting. There being no further business, the committee adjourned at 3:27 p.m.

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

**August 13-14, 2012  
Henderson Performing Arts Center  
San Juan College  
Farmington**

**August 15, 2012  
Shiprock Chapter House  
U.S. Highway 64  
Shiprock**

The third meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on August 13, 2012 at 10:30 a.m.

**Present**

Sen. Dede Feldman, Chair  
Rep. Nora Espinoza (August 13)  
Sen. Gay G. Kernan (August 13 and 14)  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez (August 13 and 14)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Danice Picraux, Vice Chair

**Advisory Members**

Sen. Rod Adair (August 14)  
Sen. Sue Wilson Beffort (August 13 and 14)  
Rep. Ray Begaye  
Rep. Eleanor Chavez (August 13 and 14)  
Rep. Miguel P. Garcia (August 14 and 15)  
Rep. James Roger Madalena  
Sen. Cisco McSorley (August 13 and 14)  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen (August 14 and 15)  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. Mimi Stewart

Sen. Stephen H. Fischmann  
Sen. John C. Ryan  
Sen. Bernadette M. Sanchez  
Rep. James E. Smith

### **Guest Legislators**

Rep. Brian F. Egolf, Jr. (August 13)

Rep. Terry McMillan (August 13)

Rep. Thomas C. Taylor (August 14)

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

### **Staff**

Michael Hely, Legislative Council Service (LCS)

Shawn Mathis, LCS

Rebecca Griego, LCS

Theresa Rogers, LCS

### **Handouts**

The following handouts are in the meeting file:

1. Statement by Alan Rapport, M.D., M.B.A., Physician Surveyor, The Joint Commission, before the New Mexico Health and Human Services Committee (August 13, 2012);
2. Medical Staff Credentialing, Privileging and Peer Review (August 20, 2012);
3. Registered Nurse Staffing Guidelines (August 13, 2012);
4. New Mexico Hospital Association and New Mexico Organization of Nurse Executives, Guidelines: Registered Nurse Staffing;
5. Evidence-Based Nurse Staffing: Another Perspective to Staffing Conversations;
6. California's Historic RN-To-Patient Hospital Staffing Ratios Upgraded Again With New Year;
7. Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Satisfaction;
8. Implications of the California Nurse Staffing Mandate for Other States;
9. Nurse Staffing and Inpatient Hospital Mortality;
10. Headlines from the Hill, The RN Safe Staffing Act and What It Means for You;
11. American Journal of Infection Control, Nurse Staffing, Burnout and Healthcare-Associated Infection;
12. Presbyterian Presentation on Nurse Staffing Ratios;

13. Wisdom at Work: The Importance of the Older and Experienced Nurse in the Workplace;
14. New Mexico Healthcare-Associated Infections (HAI) Initiative;
15. New Mexico Healthcare-Associated Infections Report (August 10, 2012);
16. Medicaid to Stop Paying for Hospital Mistakes (including some infections);
17. Sole Community Provider Program — Quick Fact Sheet;
18. New Mexico Hospital Association, Sole Community Provider (SCP) and Disproportionate Share Hospital (DSH) Funding;
19. Human Services Department, Supplemental Payments to Hospitals — Impacts of Centennial Care and the Patient Protection and Affordable Care Act (August 13, 2012);
20. Comments of Mike Philips, Chief Strategy Officer, San Juan Regional Medical Center;
21. Section 501(r) Proposed Regulations;
22. New Mexico Hospital Association, Hospital Billing and Collection Practices;
23. Handouts from NMCAD;
24. The New Mexico Coalition Against Domestic Violence, *Speaking Out*, July 2011;
25. Robert F. Anda, MD, MS; *Overview of the Adverse Childhood Experiences (ACE) Study*;
26. Ellen Pinnes, *Navigators: Connecting People to Coverage in the Health Insurance Exchange*;
27. National Conference of State Legislatures, *Role of Navigators in State Health Insurance Exchanges (State Legislation)*;
28. Written Statement of Sara Kaynor;
29. House Joint Memorial 13;

30. New Mexico Center on Law and Poverty, *Close the Healthcare Gap for Adults, Close the Healthcare Gap for Children, How to Close the Healthcare Gap in New Mexico*;
31. Disability Rights New Mexico, *Health Care Reform and Medicaid Expansion: A Different Look at Projected Costs*;
32. New Mexico Voices for Children, *The Economic Benefits of Health Care Reform in New Mexico*, updated July 2012;
33. New Mexico Voices for Children, *The Tax Revenue Benefits of Health Care Reform in New Mexico*, updated August 2012;
34. July 17, 2012 letter to Governor Susana Martinez from organizations representing New Mexicans to implement the Medicaid expansion;
35. Bernalillo County Off-Reservation Native American Health Commission, *The Affordable Care Act and Off-Reservation Native Americans*;
36. Navajo Area Indian Health Service Health Profile 2012; and
37. New Mexico Department of Health, *Racial and Ethnic Health Disparities Report Card*, August 2010.

### **Monday, August 13 — San Juan College**

#### **Welcome and Introductions**

Senator Feldman called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

Dr. Toni Pendergrass, the new president of San Juan College, welcomed the committee and provided demographic information about the college's student body: the majority of its 11,500 students are female; 30% of the student body is Native American; 40% is Latino; the average age of students is 36; and a large percentage are the first generation of their family to attend a university.

Rick Wallace, chief executive officer of San Juan Regional Medical Center (SJRM), joined in welcoming the committee. He explained that the SJRM's service area extends north from Albuquerque, and that the population it serves is rural with a high concentration of Medicare patients. Accordingly, the SJRM depends heavily upon sole community provider (SCP) and disproportionate share hospital (DSH) funding. He emphasized that these funding sources are "critical" to small rural hospitals.

## **Peer Review and Hospital Credentialing**

Representative McMillan, M.D., posed the question of whether there is a need for legislation to address conditions that made it possible for two physicians on the medical staff of Gerald Champion Regional Medical Center (GCRMC) to perform unorthodox operations outside their scope of practice. The GCRMC has recently filed for bankruptcy protection in the wake of lawsuits filed by former patients allegedly harmed by injections of Plexiglas-like bone cement. In a state that is as heavily rural as New Mexico, Representative McMillan believes that the current procedure of having the medical staff of a hospital police (through credentialing, privileging or peer review) one of their neighbors and colleagues is problematic.

David Johnson, an attorney with the Bannerman and Johnson Law Firm, is a nurse practitioner and legal expert on credentialing, privileging and peer review of physicians. He explained that credentialing is the process by which a hospital confirms that a physician is qualified by education and experience. Privileging is the hospital's decision regarding the scope of the physician's practice at the facility. Peer review is the hospital's periodic and ongoing review of the physician's performance. He explained that in a small rural community, physicians on a hospital staff may lack objectivity or have a conflict of interest when evaluating other staff physicians. Under federal and state law, the board of directors assumes overall responsibility for what happens in a hospital; the decision process for credentialing, privileging and peer review of physicians rests with the medical staff.

Karen Dawson, B.S.N., C.P.H.Q., director of clinical outcomes, Memorial Medical Center, walked the committee through the processes of credentialing, privileging and peer review. Jennifer Hoppe, associate director, state and external relations, Joint Commission, described how credentialing and privileging are incorporated into the process for accrediting hospitals. Joint Commission accreditation requirements serve as a foundation for objective, evidence-based decisions regarding appointment to a hospital medical staff, and recommendations to grant or deny initial and renewed privileges to physicians. There are also data collection requirements to support ongoing professional practice evaluation that should promptly identify performance problems.

Mr. Johnson provided a review of both state and federal laws and regulations that address the duties and responsibilities of the hospital's governing body and its medical staff to oversee staff physicians. He highlighted New Mexico's Review Organization Immunity Act, which limits the liability of medical staff organizations and their members who gather information to evaluate and improve the quality of care and authorizes, limits, suspends or revokes privileges. The act also limits the liability of persons providing information to medical staff organizations and makes documents and opinions created in the review process confidential.

## **Questions and Requests from Committee Members**

Several committee members were interested in the opinions of the presenters as to the root cause of the failure at the GCRMC. Acknowledging that he was not privy to details about the

situation at the GCRMC that gave rise to litigation, Mr. Johnson believes that it was not due to lack of regulatory oversight; rather, there was a failure of "execution".

A member asked about the role of the New Mexico Medical Board (NMMB) in policing physicians. Mr. Johnson stated that the NMMB takes an active role in identifying and weeding out physicians who should not be practicing. A complaint to the NMMB initiates an investigation, which is conducted by a panel of experts. According to Mr. Johnson, if a complaint about the physicians at the GCRMC had been made, the NMMB would have had the authority to respond. \*A member requested staff to contact the NMMB to ask whether it has played any role in credentialing or would be interested in playing a role in credentialing.

\*Several committee members expressed an interest in utilizing third parties to credential, privilege or peer review physicians in order to minimize financial conflicts of interest on the part of the hospital or personality conflicts between medical staff physicians. Catherine Torres, secretary of health, was present in the audience and added that peer review may be outsourced and would be of particular value to small hospitals. One member suggested streamlining and centralizing the credentialing process to reduce duplication of effort. \*A member requested staff to research the number of state hospitals that use third parties to credential physicians.

In response to questions from members, panelists advised that physicians who have received their medical education abroad go through a credentialing process and, in addition, are required to pass a test to apply for a medical license in the United States. Emergency room services physicians or hospitalists who are typically independent contractors go through the same credentialing process as physicians who are employees of the hospital.

A member stated that she was impressed by the Joint Commission's accreditation process. Responding to a question, Ms. Hoppe confirmed that only 38 New Mexico hospitals are accredited by the Joint Commission and that not every hospital in the state is accredited by the Joint Commission. The member observed that if a hospital adhered to Joint Commission standards, legislative action would not be necessary.

A discussion took place between members and the panelists regarding the function and composition of a hospital's governing body.

### **Registered Nurse Staffing Guidelines**

Sharon Argenbright, M.S.N., R.N., C.C.R.N., vice president of the National Union of Hospital and Health Care Employees, District 1199, appeared before the committee to argue for safe nurse staffing legislation. She urged the collection of data from all New Mexico hospitals on the nurse-to-patient ratio. Ms. Argenbright provided the committee with research from the Center for Health Outcomes and Policy Research and other materials linking patient outcomes with nurse staffing ratios. She remarked that job dissatisfaction as a result of low staffing ratios contributed to burnout and high turnover. She requested the committee to support House Memorial 51 (2012).

Jeff Dye, president of the New Mexico Hospital Association, differed with Ms. Argenbright on the cause of high turnover in the nursing field. According to Mr. Dye, health reform has spawned much change; the general health care work force shortage has created opportunities for nurses to pursue careers in positions that do not involve direct clinical care. Since there is a cost associated with turnover, hospitals are motivated to improve the workplace environment to retain staff. Mr. Dye indicated that the New Mexico Hospital Association has three initiatives directed to this end.

Suzanne Smith, chief nursing officer, SJRMC, and board member of the New Mexico Association of Nurse Leaders, advocated for sufficient support staffing for tasks that do not require a person with a nurse's training.

Laurie Lineweaver, a researcher and the clinical coordinator for Presbyterian Healthcare Services, advocated against staffing ratios because they stifle innovation. According to Ms. Lineweaver, Presbyterian is successfully using a real time workload intensity index to meet its Rio Rancho hospital's staffing needs. Outcome measures using this approach are very good, with readmissions reduced to 10% or less. This model has been replicated at other hospitals.

#### **Questions and Requests from Committee Members**

Representative Chavez asked Secretary Torres when the Department of Health (DOH) would report on House Memorial 51, which requested a study of staffing ratios. The secretary stated that she hopes to present the department's findings in January.

In response to questions from committee members about California's mandated staffing ratios, Ms. Lineweaver stated that research on the effects of changing staffing ratios is "inconclusive". Further, she pointed out that nurse turnover is not necessarily indicative of inappropriate staffing, since a nurse's move from one hospital department to another is included in turnover statistics. Also, there are no data to correlate patient outcomes with nurse turnover.

\*A member requested nurse data from the NDIE database and data on best staffing practices.

#### **Healthcare-Associated Infections (HAI) Advisory Committee Report**

Joan Baumbach, Infectious Disease Epidemiology Bureau chief, DOH, and Lisa Bowdey, the bureau's HAI program manager, updated the committee on developments in the state's HAI initiative. The August 10, 2012 HAI Advisory Committee Report is posted among the handouts for this meeting on the legislature's web site.

#### **Questions and Requests from Committee Members**

A member expressed concern that, despite progress made, the state is not mandating reporting on HAI from every hospital in the state, is only collecting data on certain infections and has not made this data readily available to the public for each hospital.

### **Sole Community Provider and Disproportionate Share Hospital Funding**

The next panel addressed concerns about changes in two Medicaid funding programs: DSH and SCP. Hospitals that serve a disproportionate share of Medicaid patients have traditionally received additional funding from the federal government. SCP hospital payments are made to hospitals that function as the only hospital in rural or less populated areas. The SCP program is funded in the first instance by counties, which in turn receive matching federal funds through the state's Medicaid program.

Mr. Dye explained that most of New Mexico's total annual DSH payment of approximately \$35 million goes to the University of New Mexico Health Sciences Center. In contrast, annual SCP funding amounts to \$300 million, which is distributed to 28 rural hospitals. According to Mr. Dye, the SCP funding makes up most of each rural hospital's revenue and is critical to keeping its doors open.

The DSH payment is justified by a hospital's provision of uncompensated care. If, as a result of the insurance mandate under the federal Patient Protection and Affordable Care Act (PPACA), more New Mexicans have health insurance, this will reduce the DSH payment to the state. Brent Earnest, deputy director for the Human Services Department (HSD), explained that if there are fewer uninsured New Mexicans, there will be less need for uncompensated care.

Unrelated to the PPACA, but resulting from the HSD's changes to the state's Medicaid plan, the SCP payment is now at risk. According to Mr. Dye, since the services under the state's Medicaid plan will be provided as managed care under a capitated rate, the basis upon which previous SCP payments were made will no longer exist. According to Mr. Earnest, the state is seeking a waiver from the federal government to allow the state to put the SCP funds into two pools: one to be used to reimburse uncompensated care and the other to pay for delivery system reforms. Mr. Earnest explained that the SCP funds diverted from indigent care would be used for infrastructure, information technology or community access programs.

### **Questions and Requests from Committee Members**

In response to questions from committee members, Mr. Dye stated that a change in the current SCP funding stream is of concern to rural hospitals.

One committee member questioned why nearly the entire DSH payment went to the University of New Mexico Health Sciences Center.

Another member pointed out that, while the DSH might be reduced, hospitals would be getting paid for care provided to formerly uninsured patients.

### **Public Comment**

Three local child care facility owners appeared in support of the Children, Youth and Families Department.

The president of District 1199 of the National Union of Hospital Healthcare Employees appeared to voice support for nurse staffing legislation in New Mexico.

A representative of the New Mexico Hospital Workers Union appeared in support of a study of health care staffing. She urged collection of staffing data from every hospital in the state.

### **Tuesday, August 14 — San Juan College**

#### **SJRM: SCP Funding, Work Force Recruitment and Retention and Health Care Reform**

Mike Philips, chief strategy officer of the SJRM, began his presentation with statistics about the facility's operations. Of note, 57% of its patients are covered by Medicare or Medicaid. The SJRM is also the largest employer in San Juan County, contributing \$100 million annually to the local economy.

Mr. Philips expressed concern that Centennial Care was not developed with input from the legislature or from the hospital industry and could therefore have unintended consequences. Programs that currently fund rural hospitals make it possible to provide services. He explained that historically, Medicaid reimbursement has not covered the cost of care, with the SCP payment making up the difference. SCP funding is essential to the SJRM as a rural hospital. Mr. Philips also noted that payment reforms will reduce reimbursement under Medicare.

The entire text of Mr. Philips' remarks has been posted on the legislature's web site.

#### **Questions and Requests from Committee Members**

Members discussed New Mexico's Medicaid and Medicare rates. A member stated that the state's hospital rate for Medicaid may be lower than the rate for private insurance and for Medicare. \*A member requested committee staff to determine whether the PPACA brings Medicaid reimbursement rates into alignment with Medicare rates.

Committee and audience members commented that the PPACA's expansion of Medicaid and an increase in the number of privately insured patients would reduce the hospital's financial burden to provide uncompensated care. Nevertheless, Mr. Philips is concerned that patients will continue to show up in the emergency room because of the health care work force shortage. He indicated that the SJRM is conducting community health needs planning and recruiting of physicians years before they graduate.

#### **Infection Control in Ambulatory Surgical Centers**

Ms. Mathis informed the committee that inadequate infection control in ambulatory surgical centers (ASCs) is a national industry-wide concern. While nearly 75% of all surgeries and procedures now occur in ASCs instead of hospitals, ASCs have been subject to far less regulatory oversight than hospitals. She advised the committee that New Mexico's ASCs are inspected infrequently according to records provided by the DOH. Her remarks are posted among the meeting handouts on the legislature's web site.

## **Questions and Requests from Committee Members**

\*A member advocated legislation to fund more frequent DOH inspections of the state's ASCs.

\*Other members support development of an online infection control program for periodic refresher training of licensed health care professionals and others who work in ASCs.

## **Hospital Billing and Collection**

Mr. Dye advised members about a change in the Internal Revenue Code that was enacted as part of the PPACA. New Section 501(r) of the Internal Revenue Code requires hospitals that claim tax-exempt status as charitable organizations to: 1) conduct a community health needs assessment every three years; 2) adopt a written financial assistance policy and a policy relating to emergency medical care; 3) limit the amount of charges to individuals eligible for financial assistance for emergency or other medically necessary care; and 4) limit the use of extraordinary collection actions before making reasonable efforts to determine a patient's eligibility for financial assistance. Mr. Dye indicated that this provision would apply to 15 tax-exempt hospitals in New Mexico. According to Mr. Dye, the average amount of hospital gross revenues claimed as "community benefit" by 12 of the 15 nonprofit hospitals is 5%. The American Hospital Association's objections to provisions of this federal law are posted on the legislature's web site.

Mr. Philips told members that his hospital's guidelines provide for charitable care to persons earning up to 400% of the federal poverty level; however, patients are expected to take the initiative to apply for this benefit.

Representative Chavez requested members to reconsider passage of House Bill 16 (2012), which she sponsored to condition hospital licensure upon the hospital's agreement not to charge an uninsured patient more than 115% of the applicable Medicare rate for emergency and general health care services and to utilize a sliding scale to assess charges to uninsured patients whose gross household income is less than 500% of the federal poverty level.

Dr. Jesse Barnes, who practices at Casa de Salud in Albuquerque's South Valley, told committee members that medical debt is a huge problem for patients. In his opinion, a patient without insurance should be charged "a fair price". He explained that hospital rates do not typically reflect the actual cost of services; instead, they are inflated for negotiations with health insurance companies. He recommends standard policies for what an uninsured patient will be charged.

## **Questions and Comments from Committee Members**

Several members of the committee expressed opposition to the practice of charging self-pay patients more than insured patients and urged hospitals to provide greater transparency in rates charged.

## **Domestic Violence**

Pamela Wiseman, executive director of the New Mexico Coalition Against Domestic Violence, spoke of the connection between trauma and domestic violence on the nation's health and well-being.

Susan Kimbler, executive director of New Beginnings at the Navajo United Methodist Center in Farmington, told the committee that intimate partner violence is higher among Native American women in New Mexico than for Hispanics or non-Hispanic whites. Providing shelter for this population is critical.

Michael Patch, Family Crisis Center in Farmington, explained that San Juan County experiences family violence at three times the national average. His organization runs two facilities for children who have witnessed abuse.

### **Questions and Comments from Committee Members**

Ms. Wiseman told the committee that funding for statewide programs had been severely cut. She would like a return to the 2007 funding level of \$4 million and requested a direct appropriation to the coalition. The chair directed Ms. Wiseman to come back to the committee with a specific funding request to be considered by the committee at the end of the interim.

### **Health Insurance Exchange — Navigators, Outreach, Enrollment**

Ellen Pinnes, a health policy consultant, presented an overview of the role of navigators for a contemplated state health insurance exchange under the PPACA. She explained that the approximately 300,000 persons expected to qualify for insurance on the exchange will need assistance from navigators. Also present was Jessica Kendall, outreach director of Enroll America, a 501(c)(3) organization whose mission is to help the public enroll in health insurance through the exchange. According to Ms. Kendall, approximately 417,000 non-elderly uninsured New Mexicans are likely to enroll through the exchange. Leah Stimel, director of the University of New Mexico Health Sciences Center's Office of Community Affairs, also appeared to discuss connecting vulnerable adults to coverage in Bernalillo County and rural New Mexico.

Presentation handouts are posted on the legislature's web site.

### **Questions and Comments from Committee Members**

Several committee members expressed concern regarding the lack of both detail and transparency from the state's executive branch regarding the exchange; several members complained about the lack of legislative oversight or opportunity for legislative input.

Another member was critical of establishing a state exchange when no one appears to be able to provide any projections of the cost. The member questioned whether it would be more cost-effective for the state to participate in a federal exchange.

In response to a question, Ms. Stimel indicated that it costs \$800,000 per year to fund a program to connect 1,688 adult clients with extensive services, including home health care, housing and food security programs.

A member noted that there are deadlines to apply for federal funds to establish state exchanges and stated that he fears the state would not qualify for such funding because of the delay in creating the exchange.

### **Low-Income Energy Assistance**

Sarah Kaynor, executive director of ECHO, Inc., is a board member of Prosperity Works. She appeared before the committee in support of House Joint Memorial 13 (2012) that requests the New Mexico Legislative Council to appoint an interim legislative low-income energy assistance task force to study ways to provide additional energy assistance to low-income customers. Copies of her remarks and HJM 13 are posted on the legislature's web site.

### **Questions and Comments from Committee Members**

The chair requested Ms. Kaynor to come back with proposed legislation for the committee at the end of the interim.

### **Public Comment**

Ms. Argenbright spoke in favor of health reform.

Senator Ortiz y Pino recognized Ms. Pinnes for her op-ed piece supporting the expansion of Medicaid that appeared in the Las Cruces newspaper.

### **Wednesday, August 15 — Shiprock Chapter House**

Proceedings were translated by Paul George, Navajo court interpreter.

### **Welcome and Introductions**

The committee was welcomed by the following officials of the Shiprock Chapter of the Navajo Nation: William Lee, president; Donald Benally, vice president; and Lula Jackson, secretary/treasurer. Russell Begaye, Navajo Council delegate of the Navajo Nation, identified himself as a member of Representative Begaye's clan. He gave the committee a brief overview of the importance of Shiprock within the Navajo Nation, including its industrial and agricultural history. He reminded the committee that radiation and mercury contamination are the legacy of uranium mining in the area. Phillip Harrison, an advocate for uranium workers, told the committee about onerous provisions of federal programs established to compensate these "cold war patriots".

Representative Begaye welcomed audience members in Navajo.

### **Medicaid Enrollment and Expansion**

Quela Robinson, staff attorney for the New Mexico Center on Law and Poverty, urged the committee to reduce the administrative burden for those who already qualify for Medicaid. According to Ms. Robinson, the HSD ended outreach efforts in 2009, despite the fact that there are 50,000 children in New Mexico who presently qualify for Medicaid but are not enrolled. With regard to the proposed Medicaid expansion, she advised that 200,000 low-wage New Mexico workers would become eligible if the state expanded eligibility to 138% of the federal poverty level. Handouts are posted on the legislature's web site.

Sovereign Hager, staff attorney for DNA People's Legal Resources, works in a legal medical partnership to assist those with legal problems impacting their health. Her client, Stanford Washburn, was too ill to attend the meeting. However, Ms. Hager told the committee about Mr. Washburn's difficulties in obtaining medical care because he lacks transportation, which would be provided by Medicaid but is not provided by the Indian Health Service (IHS). Mildred Bennally, who was accompanied by her son, is another of Ms. Hager's clients. Mrs. Bennally requested assistance because she no longer qualifies for home health services she was receiving under Supplemental Security Income. Mrs. Bennally lives in a remote area of the reservation and her son has had to move back home to take care of her. Both Mr. Washburn and Mrs. Bennally's circumstances illustrate how gaps in services under various governmental health programs lead to unintended consequences.

#### **Questions and Comments from Committee Members**

In response to questions, committee members were advised that:

- the HSD has been asked by public interest groups about outreach to those who already qualify for Medicaid, but the department has not included outreach in Centennial Care;
- Medicaid provides transportation services;
- there are many Navajo-owned medical transportation companies in the community;
- the only way for Mrs. Bennally to qualify for Medicaid would be for her to enter a nursing home; and
- there are 17,000 persons on the waiting list for the Medicaid medically fragile waiver.

#### **Medicaid Expansion — Perspectives from the Association of Commerce and Industry of New Mexico (ACI/NM)**

David Foster, chair of the Health Care Committee of the ACI/NM, requested legislative support for: 1) sufficient funds to provide access to health care; 2) adequate reimbursement rates for providers; and 3) relief from regulations in the form of an Administrative Procedures Act. Mr. Foster explained that providers in the health care community struggle with regulations and laws that are contradictory, and the ACI/NM advocates for state rules and regulations that are consistent with federal rules and regulations. In addition, the ACI/NM encourages the development of infrastructure that will direct those who are eligible for government health programs to take advantage of them and to provide for audits of providers. Finally, the organization is concerned about the period of transition while provisions of the PPACA are being implemented and requests the legislature to push state agencies to develop transition plans.

Celia Ameline, vice chair of the Health Care Committee for the ACI/NM, told the committee that the organization supports the Medicaid expansion. The ACI/NM sees the expansion as an opportunity to increase access to care and create jobs. The expansion will relieve both large and small employers from many health care costs. According to Ms. Ameline, even many Walmart employees would qualify for Medicaid coverage or the health insurance exchange. Ms. Ameline was appointed by Governor Martinez to the New Mexico Health Insurance Alliance.

### **Medicaid Enrollment and Expansion: The Impact on the State's Budget and New Mexico's Economy**

Jim Jackson, executive director of Disability Rights New Mexico, presented an analysis of the impact of health care reform and the Medicaid expansion on the state budget. According to Mr. Jackson, the HSD has been overstating the cost of expansion. He explained that, should Medicaid be expanded, there will actually be a net savings because of the decrease in State Coverage Insurance. He reminded the committee that in addition to providing increased access to health care, dollars spent on health reform and the Medicaid expansion would have a multiplier effect on the state's economy. A copy of Mr. Jackson's report is posted on the legislature's web site.

### **Questions and Comments from Committee Members**

Members and presenters discussed the discrepancy in provider rates under Medicaid and Medicare, and enhanced rates called for under the Medicaid expansion. \*A member requested information on the rates that primary care providers will be paid for the first two years of the Medicaid expansion.

Mr. Jackson stated that New Mexico's Medicaid rate is in the top 10 in the country. In general, New Mexico pays a better rate than other states. However, those who have insurance pay more to cover uncompensated care provided to the uninsured. Nick Estes, New Mexico Voices for Children, advised that a Hilltop Institute study commissioned by the HSD estimated a \$2.5 billion savings in uncompensated care to providers under the Medicaid expansion.

In response to questions, Ms. Ameline stated that when New Mexico receives federal dollars, they are taxed through insurance premiums and gross receipts taxes. She noted that the PPACA reduces the federal deficit by \$1 trillion over the next 20 years.

A member expressed concern that purported benefits of the expansion to the state treasury were overly optimistic.

### **Public Comment**

Nancy Evans, who works for Navajo Social Services, spoke in her individual capacity. She stated that she works with New Mexico, Arizona and Utah and that New Mexico has the best Medicaid services. In her opinion, in-home services for those who live in remote areas are the

best and most cost-effective. She also advocates using local workers and placing more focus on prevention.

Dolores Hardin is the parent of two disabled children. She is concerned that families of disabled children are not aware of changes in programs for these children. She also advised the committee that she had to travel to Albuquerque to obtain dental care for her disabled children because no dental providers in Farmington accept Medicaid.

An elderly Navajo lady spoke through a translator, explaining that she also lacks transportation to a dialysis facility. She is almost 80 years old and requests more home care programs.

Another member of the audience was concerned about the rising cost of private insurance. He was also concerned about the danger of patients becoming addicted to prescribed drugs.

Mr. Begaye requested the committee to consider: 1) the impact that liquor dealers located on the border of the reservation have on rates of alcoholism; 2) the delay in receipt of health services; 3) the limited number of health facilities in remote areas and the need for more outpatient clinics; 4) how medical debt discourages individuals from seeking needed medical treatment; 5) including traditional healing as a covered service; 6) a Navajo-owned health company; 7) the need for clean water for agriculture and livestock, including assistance with the drilling of water wells; 8) attention to veterans needing psychiatric assistance; 9) more enforcement against illegal dumping of medical waste and establishment of proper disposal sites; 10) regularly providing the tribes and nations with information about programs and funding available to them; and 11) more local services.

### **Home for Women and Children, Inc. (HWC)**

Gloria Champion, executive director of the HWC, thanked the committee for its support and provided a snapshot of its staff and what the organization does. The HWC is the largest shelter on the Navajo Nation. The HWC's work includes providing counseling to men under court supervision for domestic violence, working with children in schools, assisting clients to apply for assistance such as Temporary Assistance for Needy Families and Medicaid, and legal advocacy. The center's primary focus is to strengthen families in the community through Navajo language and traditional culture. Ms. Champion advised that statistics show that 85% of women return to their perpetrators 11 times.

### **Questions and Comments from Committee Members**

A discussion took place regarding providing reimbursement to the shelter.

\*Representative Begaye requested Greg Geisler, Legislative Finance Committee, to determine whether Medicaid would reimburse the shelter.

Another member suggested that the state's health family budget might provide for financial support or payments to the shelter.

Another member recalled that there may be funding for removing batterers from the home.

### **Off-Reservation Native American Health Care and the PPACA**

Roxane Spruce Bly, director of the Bernalillo County Off-Reservation Native American Health Commission, explained that the commission is funded by the state. It conducts outreach advocacy for Native Americans, regardless of where they live. She pointed out that provisions in the PPACA that apply to Native Americans are not based upon place of residence. While Native Americans are exempt from the PPACA mandate to obtain insurance, she urges them to purchase health insurance because it will strengthen the Indian health system. Further, the Indian Health Care Improvement Act was permanently reauthorized as part of the PPACA and provides funding for Native Americans to purchase insurance.

Medicaid is financed differently for Native Americans. Native American health services provided by the IHS or a tribal 638 provider are paid 100% by the federal government. Further, providers of services to Native Americans are allowed to charge a higher rate. In 2009, the state received \$65.9 million in federal funds for services provided to Native Americans.

She pointed out that the IHS is not insurance, it is a discretionary program funded at the will of Congress, typically funded at 50% of the actual need. This means that Native Americans are essentially uninsured. Further, the IHS typically denies two-thirds of claims for payment for contract services.

### **Navajo Nation: Health Care Update**

Gayle Diné Chacon, M.D., surgeon general of the Navajo Nation, spoke to the committee about the lack of data on Native American health status and care. According to Dr. Chacon, health data gathered by states are not tribe-specific. Further, agreements between states and tribes do not address Native Americans who live off-reservation. She advised the committee that the Navajo Nation is considering becoming a "state" for purposes of Medicaid to assume responsibilities for its people. A copy of the Navajo Area IHS Health Profile 2012 is posted on the legislature's web site. Dr. Chacon also supports incentives to providers who decrease health disparities.

Roselyn Begay, program evaluation manager, Office of Planning, Research and Evaluation for the Navajo Division of Health of the Navajo Nation, spoke regarding the impact of the Medicaid expansion on the Navajo Nation. Ms. Begay advised the committee that 170,000 people live on the Navajo Nation, with 38% living below the poverty level and an unemployment rate of 50%. According to Ms. Begay, 10% of New Mexico's population is Native American.

Ms. Begay stated that the age group between 15 and 45 years old will be impacted by health reform. Currently, for men between the ages of 19 and 65 with chronic diseases, no

government programs provide health care. The Medicaid expansion would be 100% federally funded for the first three years and would go far in closing the gap in health disparities for Native Americans. A racial and ethnic disparities report card is posted on the legislature's web site.

### **Questions and Comments from Committee Members**

The committee also heard about communication and coordination challenges in public health emergency preparedness for the Navajo Nation and the several states that it borders.

In response to a question, Ms. Begay stated that she opposed mandatory enrollment of Native Americans in Centennial Care, as there is a record of failure with managed care. Nevertheless, she believes that the Medicaid expansion is critical to addressing the needs of off-reservation Native Americans.

Ms. Begay elaborated on the Navajo Nation's study to evaluate whether it can become a certified Medicaid agency. The study was made possible through the reauthorization of the Indian Health Care Improvement Act, and a report is due to Secretary of Health and Human Services Kathleen Sebelius and Congress by the end of the year. She also volunteered that the Navajo Nation self-insures health coverage for its 6,000 employees and for 16 Navajo enterprises with 24,000 beneficiaries.

In response to a question, Ms. Begay indicated that the Navajo Nation has not taken a position on the expansion of Medicaid in New Mexico.

### **Tour of the Navajo Regional Behavioral Health Center**

Members of the committee adjourned to tour the Navajo Regional Behavioral Health Center.

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

**September 10-12, 2012  
Kennedy Lounge  
New Mexico Highlands University  
905 University Avenue  
Las Vegas**

The fourth meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on September 10, 2012 at 9:15 a.m.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Nora Espinoza

**Advisory Members**

Rep. Ray Begaye (9/10)  
Rep. Miguel P. Garcia (9/11 and 9/12)  
Rep. James Roger Madalena  
Sen. Cisco McSorley (9/10 and 9/12)  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. Sander Rue (9/11)  
Sen. Bernadette M. Sanchez (9/10 and 9/11)  
Rep. Mimi Stewart

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez  
Sen. Steven H. Fischmann  
Sen. John C. Ryan  
Rep. James E. Smith

**Guest Legislator**

Sen. Clinton D. Harden, Jr. (9/11 and 9/12)

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

**Handouts**

Meeting handouts are posted on the legislative web site.

**Monday, September 10**

**Welcome and Introductions**

Senator Feldman called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

The committee was welcomed by Dr. James Fries, president of New Mexico Highlands University. He used the opportunity to advocate in favor of a higher education funding formula that rewards improvement based on outcomes measures. Representative Stewart noted that the university's college of education is rated first in the state for teaching of reading.

**Attachment Disorders and Child Development**

Shirley Crenshaw, M.S.W., L.C.S.W., explained how acts of omission have a greater negative impact on children than acts of commission. Multiple caregivers, institutionalization, drug-addicted or alcoholic parents, environmental stressors such as poverty, and parents with their own unresolved traumas create what could be described as developmental traumas disorder. This condition is characterized by lack of trust and lack of belief in the existence of a reliable parent, which creates anxiety. A child's fear becomes defiance, and the child's terror becomes aggression.

Dr. George Davis, a psychiatrist with the Children, Youth and Families Department (CYFD), advised that there is a high rate of misdiagnosis of children with attachment disorder. He told the committee that the CYFD has early childhood trauma programs, and research is underway. According to Dr. Davis, childhood experiences studies conducted by the Kaiser Foundation and the Centers for Disease Control and Prevention reveal that over one-third of all adults were sexually abused as children. These studies showed long-term physical effects over the course of a lifetime for those with adverse childhood experiences. This trauma is pre-verbal. It is a lack of neural development that changes brain chemistry and anatomy and cannot be addressed with medication.

Diana McWilliams, the acting chief executive officer of the Interagency Behavioral Health Purchasing Collaborative, stated that the first task is to map trauma-based services across the state. According to Ms. McWilliams, New Mexico's Centennial Care Medicaid program includes family support services.

On questioning, the presenters and the committee members addressed the following concerns and topics:

*Early intervention and prevention.* Trauma is generational. A committee member suggested that the legislature should be concentrating on home visitation regardless of marital or economic status. There should be more funding for the healthy families initiative. The paradigm is shifting — in order to help the child, the parents must be trained.

*Concern about the emphasis on reunification of the family at all costs.* Several members have received complaints from constituents about state agencies that have removed children from safe care settings and put children back into harm's way to accomplish reunification with the child's family of origin.

*Overmedication of children to control behavior.* Several committee members expressed concern about the tendency to medicate children. Panel members explained that training parents, teachers and caregivers to closely supervise and regulate the behavior of a child whose brain has not developed a working hippocampus is the appropriate approach to address childhood trauma, not medication. Close and constant supervision is required.

*Better treatment and services for foster parents.* Foster parents should receive better training, and state agencies should be better at handover and in providing support to foster parents. Several committee members have received reports that state agencies treat foster parents poorly. Even worse, when foster parents adopt, they lose all services.

### **Prescription Drug Abuse**

The afternoon was dedicated to presentations on prescription drug abuse and the opioid addiction epidemic from: Bill Weese of the Robert Wood Johnson Foundation; Larry Loring, president of the Board of Pharmacy; Dr. Michael Landen, the Department of Health's chief epidemiologist; Lynn Hart, the executive director of the New Mexico Medical Board; Bob Twillman, director of policy and advocacy for the American Academy of Pain Management; Mike Wallace, chair of the Board of Nursing; and Luella Duran of the Heroin Awareness Committee.

On questioning, presenters and committee members addressed the following concerns and topics:

*Virtually all diverted drugs are legally prescribed.* The increase in the availability and prescribing of opioids is matched by an increase in accidental overdose deaths. Prescriptions of opioids continue to increase, with opioids more readily available in New Mexico than in the rest of the country. Unfortunately, what began as a law to penalize a physician for undertreating pain appears to have resulted in overprescribing of opioids. It is hoped that a recent amendment to the Pain Relief Act requiring physicians and others who prescribe certain pain medications to attend continuing education on pain management will heighten prescriber awareness.

*The prescription monitoring program.* The Board of Pharmacy's prescription monitoring program is a powerful tool for prescribers to track patients that doctor-shop to seek drugs and for regulators to identify physicians who are overprescribing opioids. The Board of Pharmacy, the New Mexico Medical Board and the Board of Nursing have adopted or are adopting rules to require their respective licensees to refer to and use the prescription monitoring program. Other boards that license other health professionals, such as dentists and osteopaths, are expected to follow.

*The lack of inpatient treatment beds.* Several committee members expressed concern that outpatient treatment alone is ineffective and that the state has a dire shortage of inpatient treatment beds.

*Red tape that makes disposal of pain medications problematic.* Federal law enforcement and environmental laws are barriers to setting up drug take-back programs or incinerators. As a result, there are currently only a few drug take-back options available to New Mexicans.

*Pharmaceutical companies and drug education.* One of the presenters noted that drug education for medical professionals is done by the pharmaceutical companies and that this creates an inherent conflict of interest. Committee members were told that the pharmaceutical companies are participating in drug awareness campaigns, but representatives of the pharmaceutical industry declined the committee's invitation to appear.

*Opioids are a gateway drug to heroin.* Ms. Duran stated that her organization receives 64 to 85 heroin overdose calls per month in Albuquerque. Ms. Duran told the committee members that it only took one oxycontin shared between five young people at a party to start her son's heroin addiction.

## **Tuesday, September 11**

### **Introduction, Overview and Tour of New Mexico Behavioral Health Institute (NMBHI)**

The morning began with a tour of the NMBHI. Dr. Troy Jones, executive director, led the tour of the 300-acre campus, which includes an adult psychiatric hospital, a forensic division, a nursing home and a sex-offender unit. The NMBHI also operates an off-campus outpatient community mental health center. Dr. Jones took the opportunity to request an additional \$75 million to \$81 million in capital outlay funding for both a nursing home and additional psychiatric housing.

On questioning, Dr. Jones and committee members discussed the following concerns and topics:

*Lack of licensing and regulation of adult residential care facilities.* Boarding homes for the mentally ill are not licensed or regulated in New Mexico. Several committee members suggested looking to laws of other states as templates for future legislation.

*The need to update the mental health code.* According to Dr. Jones, the mental health code is "antiquated" and needs updating. One member suggested that there should be a task force charged with updating the code every few years. Another suggested revisiting legal requirements and procedures for civil commitment.

*Legislation to expand the scope of practice for non-physician health care workers when a physician is not available.* Dr. Jones explained that patients are often admitted after hours when a

physician is not on the premises. He believes that legislative changes are warranted to permit emergency prescribing of psychotropic drugs by psychologists and psychiatric nurses and to authorize non-physician employees to evaluate and admit psychiatric patients after hours. This is important in light of the health care work force shortage throughout the state and the challenge of attracting and retaining psychiatrists and other health care professionals.

### **Sexual Assault Programs**

Kim Alaburda, director of the Coalition of Sexual Assault Programs, gave some startling annual rape statistics for New Mexico. Sixty-seven percent of those raped are children; of those, 44 percent are under the age of 12. Nearly all of these children are raped by someone they know, and 38 percent are raped by a family member. According to Ms. Alaburda, these statistics show that rape prevention efforts focusing on rapes by strangers do not address the root causes of most of the cases of sexual assault of children.

One million dollars in annual Department of Health funding has more than doubled the number of rape crisis centers in the state since 2004. There has also been an increase in sexual assault nurse examiner (SANE) units. In the last nine years, more than 11,000 SANE exams have been performed.

On questioning, the following concerns and topics were raised:

*Men make up a significant percentage of victims of rape.* Nationally, one of six men is a victim of rape. Men are now seeking help from rape crisis centers.

*Accreditation of rape crisis centers ensures use of best practices.*

*The new paradigm in rape prevention is working with offenders.* The most effective treatment programs are those for adolescents.

*Rape crisis centers see the results of human trafficking.* Federal funds may be available to form a human trafficking task force.

*Rape crisis and prevention training needs to be extended to Indian reservations and tribal lands.*

### **Amendments to Immunization Act: Registry of Critical Patient Data**

Dr. Lance Chilton, member of the New Mexico Pediatric Society, advocated for using the New Mexico Statewide Immunization Information System to collect health information for children that could be accessed during disasters and other emergencies.

### **Child Advocacy**

Child advocates Shelly A. Bucher and Esther Devall, both professors at New Mexico State University, returned to the topic of childhood trauma. They advised the committee that,

nationally, there are three million referrals for child trauma and the most prevalent cause is child neglect. Ms. Bucher and Dr. Devall hope to build a continuum of trauma-informed care and training systems, with the goal of coordinating existing programs and resources to avoid duplication and eliminate gaps.

Another important aspect of their work is the development of training materials to teach techniques for interviewing children who may be victims of child abuse. While "everyone" in New Mexico is required to report child abuse, more training to recognize and respond to child abuse is needed by teachers and other professionals. The largest group being trained currently is foster parents.

### **Alternative Pain Management**

The day closed with a panel of acupuncture practitioners, including Dr. Nityamo Lian, Dr. Selah Chamberlain and Michelle Frost, who works at the county detox facility. Panelists advocated the use of acupuncture for a number of reasons: it is a widely available and less expensive alternative to traditional medicine; there are no drug interactions from acupuncture; and acupuncture can provide relief to those attempting to recover from drug addiction. Panelists advocated for including acupuncture among the state's essential health benefits. Acupuncture is not currently covered under Medicare or Medicaid, but it is covered under the Mi Via waiver.

### **Public Comment**

Commenters reminded the committee that the disabled are sexually abused more frequently, that the disabled need to be accounted for in the event of a public emergency and that there is no regulation of boarding homes for the mentally ill.

## **Wednesday, September 12**

### **Centennial Care: Updated Waiver Application**

Julie Weinberg, the director of the Medical Assistance Division of the Human Services Department (HSD), gave an update on the Centennial Care waiver application and the corresponding request for proposals (RFP) to managed care organizations.

On questioning, the following concerns and topics were raised:

*Providing Medicaid recipients with explanations of benefits.* Ms. Weinberg stated that providing recipients with explanations of benefits would be expensive and that the HSD would rather spend the money on care. She nevertheless agreed to take this suggestion under advisement.

*Protection of behavioral health dollars.* According to Ms. Weinberg, the Medicaid managed care organizations will have to demonstrate that they spend the same level on behavioral health services and there should not be a drop in utilization of behavioral health services under Centennial Care. There will be reporting required with behavioral health services broken out.

Ms. Weinberg promised to provide the committee with citations to provisions in the RFP that purportedly protect behavioral health dollars.

*Home visiting and early intervention.* Ms. Weinberg stated that these services are not included in the waiver application because they are being offered now by managed care organizations and behavioral health organizations as "value added services". There is no plan to increase funding for these services until there is a determination as to effectiveness. A member requested Ms. Weinberg to provide information on how much the state spends on home visiting. Another member wanted to know what percentage of families that qualified for Medicaid received the home visiting benefit and was promised this information by Ms. Weinberg.

*Tribal consultation in connection with the waiver.* In response to complaints about lack of tribal consultation, the HSD has created a Native American subcommittee to the HSD Medicaid Advisory Committee. In addition, a Native American advisory board to all of the Medicaid managed care organizations is required under the RFP.

*Outreach to persons eligible for Medicaid.* One committee member commented that approximately 50,000 New Mexicans are currently eligible but not enrolled in Medicaid. Ms. Weinberg stated that the HSD believes that the eligible-but-not-enrolled population is between 20,000 and 30,000. According to Ms. Weinberg, the Medicaid managed care organizations are not required to conduct outreach under the RFP and are not paid for doing outreach. The HSD contracts with the New Mexico Primary Care Association to conduct outreach and make presumptive eligibility determinations.

#### **ASPEN: The HSD's Enrollment Information Technology**

A panel from the HSD, including Charissa Saavedra, deputy secretary, Ted Roth, director of the Income Support Division of HSD, and Sean Pearson, chief information officer, reported on the department's online enrollment system. The new system should provide Medicaid recipients with internet access. An online eligibility application can originate from anywhere, but a caseworker will still have to make the eligibility determination. Most of the \$105 million implementation budget was paid for with federal funds. According to the panel, this system is different from the system that will be used for the health insurance exchange and did not use exchange grant funds.

#### **Consumer Experience with the New Mexico Works/Temporary Assistance for Needy Families (TANF) Program; Status Update: New Mexico Works**

A panel of experts from New Mexico Legal Aid reported that those who are disabled and cannot work are nevertheless required to work under the state's TANF program. All adults and minors in households are required to complete extensive paperwork, even those who are severely disabled. There are no caseworkers available to help these persons, and failure to complete the paperwork will result in sanctions. Participants are required to keep track of work hours and obtain a receipt showing hours worked. This requirement may ask too much of the mentally

disabled, who are then dropped from the program. In response to a question, a disability advocate indicated that the state could have applied for a waiver under the TANF program but did not.

The next panel, from New Mexico Works, explained that all parents receiving TANF aid must participate in a job enrollment program run by SL Start.

### **Supporting Health Development During a Child's First Three Years**

Dr. Andrew Hsi discussed supporting health development during a child's first three years. He provided details about the FOCUS (formerly Los Pasos) and Milagros programs. FOCUS is funded by the Department of Health through the University of New Mexico to provide support and services for families of children from birth to three years of age who are at risk for or experiencing a developmental delay and includes home visiting services. Milagros is another University of New Mexico initiative, a perinatal substance abuse program that has served over 2,000 women since its inception. Dr. Hsi was invited to provide the committee with a request for an appropriation to expand his programs statewide.

### **Supporting Early Childhood Development**

Mimi Aledo-Sandoval, senior fiscal analyst with the Legislative Finance Committee, presented more startling statistics regarding New Mexico's children. New Mexico ranks forty-ninth for child well-being, with nearly 30 percent of young children living in homes with household incomes below the federal poverty level. One-third of children lived in families where no parent had a full-time job in 2009. New Mexico ranks forty-seventh among states for child homelessness. Approximately 71 percent of births were covered by Medicaid in 2010. The details of the CYFD 2014 budget request are found in Ms. Aledo-Sandoval's handout.

Dan Haggard, director of early childhood services for the CYFD, provided an overview of early childhood investment zones and reviewed early learning programs, including home visiting. Unfortunately, there is not enough funding to serve all children in need in the state. The severity of abuse and neglect has increased. While home visiting services are the most effective, there is a shortage of local resources in the communities where populations most at risk are located. Counties of greatest need have been identified as early childhood investment zones.

On questioning, the following concerns and topics were raised:

*The distinction between case management and true home visiting.* Home visiting has a curriculum, with assessments administered over time. Often rural areas lack support services for home visiting. Project ECHO is providing local practitioners with support.

*Medicaid may be the best funding source for home visiting.* According to Ms. Aledo-Sandoval, the HSD's Medical Assistance Division has not shown an interest in home visiting. Mr. Haggard reminded the committee that Medicaid only provides reimbursement for medically necessary care. Members suggested looking at efforts by other states, such as Kentucky, to roll home visitation into their Medicaid programs.

### **Attorney General's Informal Opinion on Creating a State Exchange**

Mark Reynolds, assistant attorney general, explained the informal opinion issued by the attorney general on the legal implications of the governor creating a health insurance exchange by executive order after having vetoed exchange legislation. In short, in the opinion of the attorney general, such action may be an unconstitutional violation of the separation of powers. A copy of the informal opinion is posted on the committee web site.

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

**October 10-12, 2012**  
**Room 322, State Capitol**  
**Santa Fe**

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, at 9:15 a.m. on Wednesday, October 10, 2012, in Room 322 of the State Capitol.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez (10/11)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Nora Espinoza

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye (10/10)  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia (10/11 and 10/12)  
Rep. James Roger Madalena  
Sen. Cisco McSorley (10/11 and 10/12)  
Rep. Bill B. O'Neill  
Sen. Nancy Rodriguez  
Sen. Sander Rue (10/11 and 10/12)  
Sen. Bernadette M. Sanchez  
Rep. Mimi Stewart (10/11 and 10/12)  
Rep. James E. Smith (10/12)

**F**

Sen. Rod Adair  
Rep. Eleanor Chavez  
Sen. Mary Kay Papen  
Sen. John C. Ryan

**T**

## **Guest Legislators**

Rep. Patricia A. Lundstrom (10/10 and 10/12)

Rep. Dennis J. Roch (10/12)

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

## **Staff**

Michael Hely, Legislative Council Service (LCS)

Shawn Mathis, LCS

Rebecca Griego, LCS

## **Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts are in the meeting file and posted online.

## **Wednesday, October 10**

### **Medicaid Innovations: Community Care of North Carolina (CCNC)**

After welcome and introductions, Dr. L. Allen Dobson, Jr., president and chief executive officer of CCNC, made a presentation regarding health care delivery innovations made by CCNC, the nonprofit contractor that manages North Carolina's Medicaid program. (See handout.)

Dr. Dobson explained that he started as a rural primary care physician. He took part in over a decade's worth of work by the state and provider community to improve care and bend the rising health care cost curve in the state. Findings apply to fee-for-service (FFS) care delivery, as well as to capitated programs.

Medicaid tried various ways to achieve health care cost savings. Cutting provider reimbursement offered quick savings but reduced access through provider attrition. Lowering eligibility shifted the burden of care to the local community, as patients sought care through emergency rooms and visits to providers for which the providers could not collect.

North Carolina's Medicaid program has an \$11 billion annual budget and serves 1.6 million patients a year. CCNC realizes that primary care is "foundational", with care coordination crucial to cost-effective care. North Carolina's Medicaid program is currently among the 10 most highly rated in the country, having achieved a negative cost curve.

Timely access to claims data has been crucial. Data analysis reveals that a small group of aged, blind and disabled patients represents two-thirds of total patient care costs. As a result, CCNC focused on building systems around the highest-need patients. Now there is a statewide

network of medical homes, and nearly all of North Carolina's primary care providers participate in Medicaid.

North Carolina's Medicaid program manages the money and retains the savings. Solutions developed to manage high-need patients come from providers. This is a management, instead of regulatory, structure in which providers have ownership of improvement initiatives. Care is delivered through all willing provider community networks, which are compensated through an enhanced per-member, per-month payment. FFS is still in use. Communities drew their own regional network maps.

North Carolina also has a pharmacy home model to analyze and track patients on multiple medications. Providers "own" this database and upload data to it. The database has allowed providers to perform predictive modeling to identify patients needing attention and then advise the community on interventions.

The federal Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services provides grant funding for North Carolina's community care structure.

*Lessons learned:*

- Data have to be available for each patient at the time and point of service.
- Community resources are necessary, in addition to FFS, to manage complex patients across silos. These resources are best located as close to the "ground", or community, as possible.
- Creating local collaboratives has been helpful. There needs to be a physician leader in a community. These physician leaders need to be identified and engaged. Dr. Dobson noted that it is very hard to put this in a contract. Contracts are inflexible, and flexibility is needed for local variations.
- Improvement is incremental by small steps over time.
- Physicians are the state's best fraud detectives. They report unusual claims activity.
- Risk-taking is not essential but shared accountability is. Doctors understand that poor outcomes negatively affect their fees.
- Medicaid planning needs to be done on four-year or six-year horizons. A decision may take six months to implement, and results are not apparent within one election cycle. Results come in the next biennium.
- Changing the health care delivery system on a budget cycle is problematic.

On questioning, Dr. Dobson and committee members addressed the following concerns and topics.

*Managing Medicaid managed-care organizations (MCOs).* A member noted that New Mexico has statutory provisions for medical homes, but there are potentially five or more MCOs that would manage them. The member inquired whether such a system is too complex. Dr.

Dobson noted that it is "not inconceivable" to have well-run managed care programs, but requirements should be standardized, and the delivery system has to be uniform across all MCOs. In addition, MCOs must be held accountable for contract deliverables. It was noted that no one from the Human Services Department (HSD) was in attendance.

**D** *The impact of reduced hospital admissions on hospital finances.* A member noted that achieving reduced hospital admissions could affect hospital finances. Dr. Dobson explained that hospitals are part of the community provider network tasked with coordinating care; most hospitals do not complain about reduced Medicaid admissions because they do not depend on Medicaid as an income stream. Further, North Carolina has reduced only the growth rate of Medicaid, not fees. No hospitals have gone out of business.

*Managing care for the disabled.* A member noted that 80% of North Carolina's Medicaid expenditures are for disabled enrollees. Dr. Dobson advised that North Carolina is enrolling nursing homes in a medical home model. In his view, addressing the uninsured aging disabled population can yield savings by delaying their entry into Medicaid.

*Managing transitions of care.* North Carolina's Medicaid program has saved \$50 million through better management of care transitions. CCNC receives live communications twice a day regarding all discharged patients. A care manager is assigned to every patient who leaves the hospital. CCNC stratifies risk to determine which patients need more intensive transitional care. Some patients need home visits right away, others do not. The care managers do not work for home health care agencies.

*The importance of claims data.* North Carolina's CCNC claims database is a provider system that is used and kept current by providers. Enrolled providers have access to all of the data that are collected, including pharmacy data and feeds from hospitals. CCNC also asks providers to record delivery of care coordination services for which they cannot charge under a zero dollar billing code in order to track these services.

**F** *Building a system for those who need the most care saves the most money.* Complex Medicaid patients and the frail elderly need the most care. Dr. Dobson advises building a system around these patients to realize the greatest savings. CCNC stratifies patients into 26 categories to identify those requiring additional care management. At least half of its complex patients co-present with behavioral health issues, and behavioral health is carved into the Medicaid program.

**T** *Holding physicians accountable for noncompliant patients.* A member expressed concern about penalizing providers when patients are noncompliant. Dr. Dobson stated that current Medicaid regulations place limits on patient inducements. Noncompliant patients may be divided into three categories:

- those whose care is so complex that they "fall through the cracks";
- those with situational barriers for whom motivational interviewing techniques or having a good list of local community resources may help; and

- those who are stubborn (which Dr. Dobson stated is a smaller group than one might think).

CCNC reporting does not penalize doctors for noncompliant patients; the reports simply identify patients needing more focus.

### **Public Health Vision for New Mexico**

Dr. Robert G. Frank, president, University of New Mexico (UNM), and Dr. Paul Roth, chancellor for health sciences and dean of the UNM School of Medicine, made a presentation about creating an accredited school of public health in New Mexico. While Dr. Frank proposed UNM as the hub, he envisions collaboration with New Mexico State University (NMSU) and other community colleges throughout the state. UNM has 57 faculty members with public health degrees. He estimates that it would take from four to seven years to achieve accreditation. (See handout.)

Dr. Frank, Dr. Roth and committee members addressed the following concerns and topics:

*The need for statewide development of health services and programs.* A member stated that for many New Mexicans, regional health centers in Texas are closer than Albuquerque. Dr. Frank noted that no single resource could serve the entire state. However, public health differs from acute care services in that it focuses on populations rather than on individuals. Dr. Roth added that faculty for the school of public health need not all be located in Albuquerque, but it would be important for the faculty to have an understanding of rural health needs and concerns. Another member observed that the UNM School of Medicine does not admit very many candidates from rural areas of New Mexico. There was also a request that UNM focus more on training Native Americans in the health fields.

*The distinction between current public health degree offerings and those that would be offered by a school of public health.* Dr. Frank explained that UNM currently offers a master of public health degree, but not a bachelor or doctoral degree. Though the Robert Wood Johnson Center for Public Policy does some work in the area of public health, it is a research center and does not offer degrees. When asked about the advantage of establishing a school of public health, Dr. Frank explained that universities with schools of public health have more expertise to apply to local public health challenges.

### **UNM Health Sciences Center (HSC) Update and Statewide Role and Mission in New Mexico**

Dr. Roth advocated for a new UNM hospital with 96 beds to address a current shortage of inpatient beds, which is causing long waits for admitted patients and diversion of patients to other facilities. Unlike many states, New Mexico has a shortage of inpatient beds overall. The new hospital will specialize in elective surgery. Dr. Roth next reviewed the UNM HSC's funding requests for the 2013 legislative session (see handout). He noted that the UNM School of Medicine recently received a national award for public service.

Dr. Roth and committee members addressed the following concerns and topics.

*The need for continuing support of Project Extension for Community Healthcare Outcomes (ECHO).* Several members expressed support for Project ECHO as one strategy to address the health care work force shortage. A member expressed concern that the Department of Health (DOH) is not more supportive of funding for this program. Dr. Roth stated that he thinks that Project ECHO has only scratched the surface in terms of addressing the shortage of specialists in rural areas. Another member commented that she is sure that Project ECHO has saved lives in her community. Noting the value of Project ECHO for rural New Mexicans, Dr. Roth was asked why Project ECHO lost funding in recent years. He explained that "everyone" had their budgets cut. Project ECHO had a contract with the DOH that has since ended. He said that Project ECHO suffered as a result and has been forced to seek funding outside of the state. It has "only scratched the surface" of its potential to help in rural areas in delivering specialists' expertise. The U.S. Department of Veterans Affairs has adopted the Project ECHO model, as have other states. A member noted that the LHHS has already endorsed Project ECHO funding and that the DOH has told the Legislative Finance Committee that Project ECHO does not need funds. The member stated that the LHHS should educate the DOH on this point. One member commented that a hospital group doing business in the state has its own equivalent of Project ECHO at no cost to the taxpayers. It provides neurological services to 50 hospitals. The member stressed that Project ECHO is not the only "game in town" and that a government approach is not the only way.

*The need to raise salaries to retain medical school faculty.* Concern was expressed about the low pay for UNM faculty — with UNM faculty earning salaries in the lowest quartile among faculty nationwide. Dr. Roth noted the difficulty in recruiting, when new faculty must be brought in at the fiftieth percentile while older hires earn less. This is part of UNM's current budget request, so that faculty salaries may be modestly increased.

*Using NMSU's agricultural extension framework for health extension rural offices (HERO).* There was a discussion about UNM's search for someone to run the Hobbs HERO program and the difficulty for Medicaid patients in Hobbs to get to Albuquerque. In response to an inquiry, Dr. Roth stated that he does not know whether UNM would use HERO to apply for additional grant funding.

*Other issues.* A member expressed support for an appropriation to the Office of the Medical Investigator (OMI), housed at UNM, for the return of bodies from the OMI to families. Currently, families must bear that cost.

Dr. Roth noted that the combined degree BA/MD program is fully funded.

In response to a question about delays in building the new UNM hospital, Dr. Roth explained that the State Board of Finance tabled this project over concern in the community about the project.

A member expressed disappointment that funding for a waiver of primary care medical education tuition, as provided in statute but never funded, is not included in the UNM HSC's requests for funding. Dr. Roth told the committee that he would look into the matter.

A member asked whether the UNM HSC supports a Medicaid expansion to cover "childless adults" with incomes below 238% of the federal poverty level (FPL) pursuant to the federal Patient Protection and Affordable Care Act (PPACA). Dr. Roth stated that UNM supports the Medicaid expansion.

### **New Mexico Health Connections**

Dr. Nandini Kuehn, president of the board of directors for New Mexico Health Connections (NMHC), introduced the plan that the NMHC intends to offer on the state health insurance exchange or exchanges. It will be a nonprofit, consumer-operated and -oriented or "co-op" plan pursuant to PPACA provisions providing for the establishment of these plans and mandating their inclusion on state exchanges. The NMHC plan will reinvest any surplus generated into the plan, Dr. Kuehn explained. (See handout.)

Several members of the audience were introduced as members of the NMHC board, including Charlie Alfero; former Lieutenant Governor Diane Denish; Dr. Barbara McAneny; and Ken Carson. Dr. Kuehn explained that this board will step aside once NMHC is ready to sell insurance.

NMHC Chief Executive Officer Dr. Martin Hickey introduced himself to the committee and stated that he recommends the North Carolina approach to health care delivery that Dr. Dobson described to the committee earlier in the day. Dr. Hickey endorsed the idea of cutting health care costs by actively managing patients at high risk before risks materialize.

Dr. Hickey stated that the high cost of health care is driving people out of health care. Employers are dropping or limiting coverage. People are beginning to see deductibles of \$6,000 to \$7,000. This means that hospitals do not get paid, so the hospitals raise rates to cover uncompensated care. This, in turn, raises insurance premiums. He described this process as a "death spiral". The payment scheme is broken, he said; rational market behavior maximizes utilization under the FFS model. Studies have shown that medical practices with the latest medical diagnostic equipment order more tests than practices without such technology.

Dr. Hickey explained that co-ops such as the NMHC were formed under the PPACA, with the federal government making \$3.4 billion in grant funding available to all 50 states. Currently, there are 26 health insurance co-ops nationwide. In addition, there are many nonprofit co-op plans that have been operating for many years.

The NMHC's health insurance offerings will cover individuals and small businesses with fewer than 100 employees. The NMHC may eventually provide insurance to larger organizations as well. The co-op will focus on plans for individuals with incomes between 138% and 400% of

the FPL. The NMHC will be licensed as any other insurance company by the state's Insurance Division of the Public Regulation Commission. It will seek certification as a qualified health plan to be offered on the state health insurance exchange or exchanges. The superintendent of insurance has requested the co-op to offer health insurance statewide.

**D** The NMHC's policy pricing will be transparent. As a nonprofit plan, it will not have to add a 9% profit into premium calculations. This should help to compete with other insurers. Profits will be put back into the organization either to improve benefits or to reduce the cost of the insurance. The operational board will be composed of members. There will not be any members representing health care institutions, thus eliminating potential conflicts of interest.

The NMHC is expected to reduce health care costs by 30% through elimination of unnecessary care and the use of system innovations such as the patient-centered medical home, a primary care physician "quarterbacking" a team that works with high-risk patients. The NMHC will place some of these teams into federally qualified health centers (FQHCs). These teams will be able to do high-risk complex care intervention like Project ECHO. Informatics now are so superior that they can analyze claims history and pharmaceutical history and project risk for the coming year.

The biggest savings are in improvements in transition of care that can reduce readmission rates by half. This reduction is significant over a large population. Physicians will review data to "drill down" on any disease, any individual or any provider to take the information and share it with the physicians to look at their outcomes in group reviews. If physicians analyze data and their time doing this is counted under the medical loss ratio, there will be reduced costs, better quality and sharing of surplus under quality parameters. The NMHC intends to share savings with primary care and behavioral health providers.

The NMHC will offer plans at five levels of coverage, with actuarial values tied to the level of enrollee copayment.

**F** Dr. Hickey noted a "terrible shortage" of 400 to 600 primary care physicians in the state, which he explained is attributable to low compensation when compared to other areas of medical specialization. Returning savings to primary care physicians serves as an inducement to primary care physicians.

Dr. Hickey stated that small business is strongly supportive of the co-op given the large annual increases in premiums.

**T** In the insurance business, the way one makes money is to insure healthier patients. The federal government has built in protection against adverse selection for all co-ops. Risk corridors and reinsurance will help co-ops that end up with sicker patients to succeed financially.

On questioning, the following topics were discussed.

*Medicaid expansion.* In response to a question on enrollment in the NMHC and in Medicaid under the expanded federal option, Dr. Hickey explained that individuals may enroll in the NMHC as of January 1, 2014. Shortly after that, there will be a process for members to be nominated to sit on the board. This board has to be in place by the end of 2015.

**D** As for Medicaid enrollment, 180,000 New Mexicans are expected to qualify for Medicaid under the expansion, and 200,000 would be eligible to purchase on the exchange. Individuals with incomes under 138% of the FPL will qualify for Medicaid. Subsidies for purchase of plans on the exchange will be available to those with incomes from 138% of the FPL to 400% of the FPL. The NMHC anticipates that there may be "churn", or movement back and forth between Medicaid and private plans, due to employment or family status.

*Premiums and sustainability.* A member asked how NMHC premiums would be priced. Dr. Hickey answered that an actuarial firm is pricing its plans, but pricing will also depend upon regulation. Estimates are expected in the spring of 2013. The NMHC has run proprietary projections for its business model and is confident that it is sustainable. The NMHC plans to offer Medicare supplemental coverage beginning in 2017, pursuant to federal regulations. The NMHC has just applied to join the New Mexico Health Insurance Alliance. Another member voiced "serious concerns" about the NMHC.

*Medically unnecessary care and care coordination.* Responding to an inquiry about cutting costs while increasing provider compensation, Dr. Hickey stated that the goal is to "do more at lower cost", identifying higher-risk patients earlier to avoid or delay costlier outcomes later. In response to a statement by a member that defensive medicine drives unnecessary care, Dr. Hickey informed the committee that defensive medicine is only responsible for 2% to 5% of unnecessary care. From his experience with the BlueCross BlueShield Association, physicians with diagnostic equipment in their offices perform more tests. The NMHC will be contracting with FQHCs, primary care providers and hospitals.

*NMHC's management and board of directors.* All executive compensation has been vetted by the federal Centers for Medicare and Medicaid Services and will be public. The NMHC board is a volunteer board whose members are not compensated. A committee member commented on the impressive slate of NMHC's board members.

A member asked whether legislative approval is required for the NMHC to operate. Dr. Hickey stated that it would not be needed and that the presentation was only informational.

*All payer claims database and health information exchange.* Dr. Hickey informed the committee of a trend in states establishing all-payer claims databases. He was involved in the formation of New Mexico's health information exchange. In his opinion, the exchange is now robust and has a capable information technology vendor. The cost of information storage is more affordable than ever. Whether through an all-payer claims database or the exchange, aggregated patient information can be an invaluable tool to compare care among physician peers.

## **Aging and Long-term Services Department (ALTSD) Update**

*Alzheimer's disease.* Secretary of Aging and Long-Term Services Retta Ward first addressed the status of the ALTSD's work on House Memorial 20 (2012), which requested the ALTSD to convene an Alzheimer's disease task force. The task force has been convened and expects to meet its 2013 reporting date. The task force is putting together a state plan to include recommendations for policy, legislation and funding. The task force is large and diverse. It includes the following working groups: public awareness; early detection and diagnosis; quality of care; needs of caregivers; research into brain health; and health care system capacity. The task force will look at available resources, methods of addressing the diverse population affected and the effects of poverty on individuals with Alzheimer's disease. At the same time, the National Alzheimer's Project is working on a national plan for Alzheimer's disease and related dementias.

Secretary Ward noted that 18% of all deaths in New Mexico in 2008 were attributable to Alzheimer's disease. At age 65, the odds are one in eight that a person will develop Alzheimer's; at age 80, the odds are 50/50. Recent research suggests that diabetes can drastically increase the incidence of Alzheimer's.

*Elder abuse.* Secretary Ward addressed the ALTSD's charge to investigate incidents of elder abuse and neglect. She noted that the Aging and Disability Resource Center's toll-free hotline, at 1-800-432-2080, receives reports of elder abuse and neglect and refers them to the ALTSD's Adult Protective Services Division (APSD). She stated that staff shortages have resulted in fewer investigations. Twenty-three percent of cases investigated were substantiated. A smaller percentage of cases requiring response in 24 hours were substantiated.

Many calls to the APSD involve self-neglect, for which the APSD may provide home care services. A typical report involves a woman in her late 70s or 80s, living alone with no family and unable to drive. Such elders are often so ill or frail that they cannot take out the trash, run errands, go shopping or get to medical services. They cannot afford paid help, as many have incomes of less than \$800 a month. Twenty percent of home care clients have even more severe limitations. These individuals are at a high risk of premature institutionalization. Secretary Ward noted that it is less expensive to keep these individuals in their homes. For this reason, the ALTSD is requesting more money for home care services in its budget.

*Hunger.* Secretary Ward informed the committee that 15% of the elderly go hungry, with New Mexico ranking second in the country for the number of adults facing food insecurity. Since the recession, the number of seniors experiencing the threat of hunger has increased by 34%. The ALTSD administers federal pass-through dollars that go to area agencies for senior meal programs.

*Continuing Care Act rulemaking.* Secretary Ward noted that there are nine continuing care communities in the state. In response to recent changes to the Continuing Care Act governing contractual relationships between continuing care community residents and operators,

the ALTSD is conducting stakeholder meetings. The department expects to issue rules in the summer of 2013. Department staff are also drafting and updating Continuing Care Act consumer guides.

*Prescription drug abuse.* Rates of prescription drug overdose are higher for seniors in rural and poor areas. According to the secretary, those over 65 mostly misuse legal drugs, including alcohol and prescription drugs. In addition, Gino Rinaldi, deputy secretary of aging and long-term services, told the committee that older patients tend to keep their unused medicines in their homes, so they are good sources of drugs for diversion.

On questioning, the following topics were discussed.

*Criminal prosecution for elder abuse.* One member urged removing crimes against elders from the Hate Crimes Act because establishing the elements of a hate crime make it more difficult to successfully prosecute assaults against the elderly.

*Investigating elder abuse.* A member questioned why only 50% of 10,000 reports made were investigated. Secretary Ward explained that the Aging and Disability Resource Center screens these calls using established criteria to determine whether any investigation needs to take place. After intake, a field supervisor conducts a search for previous reports. A key factor is whether there is an allegation of neglect, abuse or exploitation. When it is clear that the elder has decisional capacity, the center does not investigate. Sometimes the reported information is not sufficient to locate the alleged victim. These factors are consistent with statistics reported nationwide. The member asked whether, for the 23% of substantiated cases, charges had been filed. Secretary Ward answered that if the case involves a crime, it is referred to law enforcement and to the Office of the Attorney General. Fifty percent of cases last year involved self-neglect and, thus, there was no one to prosecute. **\*The member requested that the ALTSD supply the number of those who are convicted or who face penalties.** Note: In response to this request, on November 7, Secretary Ward sent the following answer:

**Percent of Substantiated Abuse Cases Prosecuted:** Adult Protective Services does not have this information. The Adult Protective Services Act is the civil law upon which Adult Protective Services is authorized to act. APS conducts investigations and substantiations based on a preponderance of the evidence. APS refers cases to law enforcement when there is an immediate safety issue or when APS case workers encounter evidence of a crime. In some cases, law enforcement is already involved when APS is referred in to conduct an investigation. Once a case is referred to law enforcement, APS does not receive additional information as to whether the case was successfully prosecuted. In cases in which there is a criminal conviction, it may take place several years after APS was involved. Prosecution may be based on 1) domestic violence statutes or 2) Resident Abuse and Neglect Act (30-47-1 NMSA 1978). APS cooperates fully with law enforcement, providing information to assist with investigations and prosecutions.

[Secretary Retta Ward, electronic mail of November 7, 2012.]

## **Public Comment**

Ruth Hoffman of Lutheran Advocacy Ministry noted that New Mexico has a state general fund supplemental nutritional assistance program (SNAP, formerly known as "food stamps") supplement for seniors. It is a minimum of \$25.00 a month. The federal SNAP allotment is very small. The HSD is asking for an increase in funding to keep that amount for the program. Ms. Hoffman supports an increase in the SNAP supplement to \$50.00 a month. This would cost \$1 million for 5,000 seniors. She noted that Governor Susana Martinez has been very supportive of this program.

Donna Higdon told the committee that she is concerned about the lack of prosecutions for elder abuse. She has made public records requests to the city police, county sheriff and state police requesting a breakdown of case statistics. The information she received showed that, for two years in which 51,000 cases were recorded, not one case of elder abuse was prosecuted. Ms. Higdon advocates giving out pamphlets that instruct those reporting elder abuse to contact the police, not the APSD. According to Ms. Higdon, response time is too slow for the APSD. **\*A member suggested that elder abuse laws may need to be re-evaluated and that perhaps there should be an interim task force to study the issue, looking to laws of other states such as California.** A committee member noted problems in prosecuting the exploitation of elderly people by fraudulent telephone solicitations. Nearly all of these calls, the member stated, are from outside the U.S.

A motion was made, then withdrawn, on the matter of a committee letter to the State Board of Finance to encourage support for UNM's new hospital expansion.

## **Thursday, October 11**

### **Hotspotting**

Dr. Jeffery Brenner, director of the Institute for Urban Health at Cooper University Hospital and executive director of the Camden Coalition of Healthcare Providers, appeared before the committee via webcast. Dr. Brenner is known nationally as a pioneer of a different model of health care delivery, focused on "hotspots". Dr. Brenner framed the problem for the committee:

- the bulk of federal debt going forward is for health care;
- 85 million "baby boomers" are heading toward the most expensive health care system in the world;
- the U.S. does not have the best health care system in the world — just the most expensive;
- the health care industry is overbuilt with hospitals and specialty care;
- providers make money if they "cut, scan, zap or hospitalize" a patient;
- there is no financial incentive for a physician to spend time talking to a patient;
- hospital stays cost an average of \$10,000;
- emergency room visits cost an average of \$500;
- hospital stays are 40% of total health care spending; and

- health data are locked up in the hands of the state and private health insurers that do not want to share it.

Dr. Brenner recounted steps taken to reduce Medicaid spending in Camden, New Jersey. There, Medicaid was spending \$100 million annually on emergency room visits alone. Dr. Brenner asked the committee to imagine how much primary care one could buy for \$100 million.

The first step in Dr. Brenner's strategy to reduce Medicaid spending was to analyze available Medicaid health data to identify patients that were the highest users of services. Next, the home addresses of these patients were mapped against census blocks. This exercise revealed that most of the expensive Medicaid patients were clustered in two buildings populated by the elderly and disabled. Care coordination was then built around rank-ordered high-cost Medicaid beneficiaries, using nonprofit and church community resources. The goal of the strategy's clinical model is to "glue" a high-use patient to a primary care provider. Critical to care coordination are teams of health care workers, process workflow and real-time data feedback loops. According to Dr. Brenner, hotspot patients are identified by daily data feeds from hospitals and emergency rooms — not necessarily from referrals. Of note, the data system he uses for real-time tracking of patients is off-the-shelf, affordable software that can be run by a student intern. He told the committee that the barrier to this real-time tracking is not the technology, it is the unwillingness of insurance companies and state governments to share the data. (See handout.)

The following concerns and topics were discussed during questioning.

*The impact of behavioral health and addiction on rates of utilization.* Dr. Brenner dispelled the notion that mental health problems and addiction are the primary drivers of high hospital use. According to Dr. Brenner, poor patients have many life challenges. They live on \$660 per month, and one of their coping skills is to go to the hospital.

*Community and local resources are key to reducing unnecessary utilization.* Dr. Brenner believes that the community has to reconfigure the health care delivery system around high-cost Medicaid beneficiaries. He does not believe that there is a "federal fix" to reduce Medicaid spending; this is a local issue capable of a local solution.

*Hospitals as legacy institutions.* A member asked about the impact of reducing hospital admissions and emergency room use upon hospital finances. According to Dr. Brenner, hospital administrators know that the current hospital business model "is coming to an end". This is evidenced by consolidation in the hospital industry, through merger or closure. He compared the hospital industry to Blockbuster or Kodak. The new hospital business model will have to focus on delivering better, rather than more, care. As a result, hospital administrators are interested in reducing the amount of uncompensated or undercompensated care that hospitals provide to high-cost Medicaid beneficiaries.

*The importance of a physician champion for new approaches to reduce health care costs.* According to Dr. Brenner, a clinician and great project manager are needed to field a great team. He stated that clinicians need to "get out of the way". Dr. Brenner recognized Dr. Sanjeev Arora, director of Project ECHO at the UNM HSC, as a world-class innovator in health care. In fact, Dr. Brenner has sent members of his staff to train with Project ECHO.

**D** *Steps that can be taken right now.* Dr. Brenner stated that incremental improvements in care coordination and cost reduction can take place right now. According to Dr. Brenner, New Mexico's Medicaid program has the ability to identify the five most expensive Medicaid beneficiaries in each community. He suggests providing the cost data for those individuals to the community's business leaders, using a "governor's challenge" to ask local business leaders to develop a plan to address the health care needs of these high users. In response to a member's interest in an approach used by Maine, Dr. Brenner advised that Maine uses a waiver to set up a community outreach team. This is an immediate small project that can be done at very low cost. **\*A committee member wondered whether the committee could challenge the state's Medicaid MCOs to identify the hotspotters to reduce costs. \*A member wondered whether current health information collaboratives could identify hotspots. \*Another member requested information on Maine's community outreach approach.**

*Remote care coordination and case management.* In his opinion, telephonic case management is an "utterly inadequate tool". There is no evidence-based data showing that telephonic case management works, absent an existing relationship. It is easier for a Medicaid MCO to hire 100 nurses to sit in a phone bank than to implement face-to-face care coordination because this is not its core business, and there is no way to ramp up for this. So in the state's contract, the MCO must be required to provide this service by purchasing locally.

*Innovations in reimbursement.* Dr. Brenner believes that it is difficult to manage a system that blends FFS and capitated rates. He advocates using one or the other, but not both. North Carolina's Medicaid program is FFS. Arizona's Medicaid is managed care. Dr. Brenner believes that to have a true integrated health care delivery system, all costs must be "in the same bucket".

*The importance of data sharing.* Pat Montoya, director of Aligning Forces for Quality with HealthInsight, emphasized the critical need for data that remain siloed. She urged policymakers to signal that data sharing is imperative and noted that UNM has the current capability to analyze such data. She suggested that a memorial discouraging the siloing of claims data might be in order. Jeff Dye, president and chief executive officer of the New Mexico Hospital Association, agreed that there needs to be collaboration, with the state taking a leadership role. According to Mr. Dye, hospitals are submitting discharge data to the New Mexico Health Policy Commission, but this is currently unfunded. Mr. Dye stated that an all payer claims database is needed. Maggie Gunter, president of LCF Research, the entity that runs the state's health information exchange, advised the committee that several states have passed all payer claims database legislation. According to Ms. Gunter, this is achieved through a mandate that health plans share data, with funding appropriated for the establishment and administration of the

database. Ms. Montoya added that Colorado's all payer claims database has been established with grant funding. A representative from Project ECHO advised the committee that a new grant project is using data from four MCOs that have been sent to Tufts and New York University for analysis, using certain Medicaid filtering, for predictive modeling of projected costs. **\*A member asked whether legislation is needed to require the sharing of health data. \*A member suggested legislation requiring the establishment of an all payer claims database.** Another member commented that health policy should be data-driven.

A member commented that "it is incredible" that no one from the state's Medicaid office was in attendance for Dr. Brenner's presentation.

### **Rural Care Coordination Innovations**

Charlie Alfero, director of the Center for Health Innovation (CHI) of Hidalgo Medical Services, continued the morning's focus on local solutions to health care challenges. The CHI's approach is to use rural areas as a hub for training physicians. He emphasized that rural New Mexico wants to import, not export, health service providers. The strategy is to use local resources to take care of the local population. He indicated that the CHI already has a contract with UNM and Molina Healthcare to focus on the most expensive Medicaid beneficiaries. Already, the CHI has reduced the number of prescriptions, emergency room services and inpatient stays for this population. He advised the committee that Molina has hired UNM to build a curriculum for care coordination in nine states. (See handout.)

During questioning, the follow topics were discussed.

*Caps on primary care training slots.* According to Mr. Alfero, Las Cruces has the same number of primary care training slots as in 1997. The CHI wants to organize a consortium for family practice training. In response to a question from a member, Mr. Alfero stated that the cap on training positions was originally imposed to reduce health care costs.

*Local data are available.* Mr. Alfero believes that there is no need to wait upon the development of an all payer claims database; entities that possess health claims data could be required to share data now.

### **Tribal Consortium**

Ileen Sylvester, vice president of executive and tribal services, Nuka Institute coordinator, Southcentral Foundation, made a presentation to the committee via webcast from Alaska. The Southcentral Foundation is composed of 55 tribes with seven different tribal leadership groups. Its board is composed entirely of Alaska natives who are also shareholders. In 1998, the foundation assumed responsibility for the entire primary care system through a 638 compact with the Indian Health Service. In 1999, the foundation assumed ownership of the Alaska Native Medical Center. The Nuka system of care was adopted in 2000 as part of a redesign of the system to incorporate customer choices and values. It is built upon shared responsibility, in which the customer is also an owner. In addition to operating various hospitals and other health care

facilities, the foundation makes substantial use of health aides for village health care. Ms. Sylvester provided the following details about this highly successful health system:

- Last year's budget was \$200 million, with 1,600 employees and 64,000 customer-owners.
- The Nuka health system not only provides health care to Alaska natives, it also serves as an employer of Alaska natives. Over 50% of its employees are Alaska natives or Native American. Employee development is encouraged and supported. Every employee has a performance development plan with a clear understanding of how each employee supports the organization's vision.
- Services offered must be financially sustainable and viable. Employees from within the community are trained to take over.
- There is an internship program for young people from 14 years old to 18 years old. Each summer, 55 interns enter the program to develop tribal leaders of tomorrow. Those who go through the internship can step right into employment.
- Regional health centers are convenient for customer-owners with minimal stops to get all their needs addressed. The Anchorage campus serves as a gathering place for native peoples.
- Customer focus includes an annual gathering to get feedback on services. In addition, Nuka is piloting a real-time customer survey using iPads when the patient comes for an appointment. These surveys go to department managers and vice presidents as part of continuous improvement efforts.
- In 2011, the system won the Malcolm Baldrige National Quality Award for its unique relationship-based health delivery system, for obtaining the highest level of patient-centered medical home and for reducing staff turnover.

During questioning, the following topic was discussed.

*Relations with state and federal governments.* The Alaska Tribal Health Compact (1994) authorizes tribes and native health organizations to operate health and health-related programs. It is the umbrella agreement for the relationship between tribal governments and the United States. Alaska is the only state in which over 99% of health programs are managed by tribes and Alaska native organizations. According to Ms. Sylvester, under this compact, all tribes collaborate. They do not all agree, but as a whole, as a caucus, they negotiate with the federal government in one voice. Ms. Sylvester explained that 225 federally recognized tribes are parties to the compact. There is also an Alaska Native Health Board, which serves as the statewide voice on Alaska native health issues. It emphasizes the importance of self-determination in health care services. At its annual meeting, priorities are identified for consideration by state and federal legislators. Ms. Sylvester emphasized that, as a statewide health system, when an issue is identified, the tribes speak with one voice and carry the same message.

## Statewide Expansion of Cancer Clinical Trials

Terri Stewart, executive director of the New Mexico Cancer Care Alliance (NMCCA), and NMCCA board co-chairs Dr. Cheryl Willman and Cal Ridgeway appeared before the committee to advocate for funding to enable rural physicians and patients to participate in cancer clinical trials. The NMCCA is a nonprofit organization outside of the UNM HSC that is a statewide alliance of health care institutions and hospitals that makes cancer clinical trials available to patients throughout New Mexico. This model is being mandated elsewhere. There are rural cancer physicians who would like to join the NMCCA but lack the infrastructure or staff. The alliance is requesting \$200,000 to hire four employees to help rural physicians to participate in clinical trials through the alliance. This will permit patients in clinical trials to stay in their own communities. Dr. Willman highlighted that telemedicine now makes it possible to have cancer patients managed by their local physicians.

During questioning, the following issues were raised.

*The shortage of chemotherapy drugs.* In response to a question, Dr. Willman confirmed that there is a shortage of chemotherapy drugs in the United States as a consequence of the federal Medicare Modernization Act. She explained that pharmaceutical companies stop making a drug when the generic becomes available, because the generic is much less expensive and less profitable. This shortage has affected the opportunity for a patient to participate in clinical trials. Wealthy health care institutions are better able to compete for scarce drugs. **\*A member requested that a letter be written to New Mexico's congressional delegation to support changes in the Medicare Modernization Act to alleviate the shortage of cancer treatment drugs.**

*Funding for the NMCCA.* Funding for the NMCCA must come through the DOH through a request for proposals. An appropriation to the DOH for a statewide alliance would be required.

*New Mexico requires health insurers to offer coverage for cancer clinical trials.*

## Community Services Block Grant Update

Ted Roth, director of the Income Support Division of the HSD, appeared before the committee to report on the status of the block grant from the U.S. Department of Health and Human Services to the state. This grant is a flexible federal funding source to local communities through a network of community action agencies to reduce poverty. (See handout.)

During questioning, the following topics were discussed.

*Whether the department's web site had a proper link for services available through the block grant.*

*The fate of individual development accounts.*

*Whether low participation in programs is an indicator of low outreach.* Mr. Roth added that qualified low-income individuals may not be able to come up with their share of matching funds for programs that require this.

### **Other Matters**

A member requested that the minutes reflect that the Las Vegas Rape Crisis Center provided the committee with the results of a financial audit.

Members discussed the governor's plans for a health insurance exchange and Medicaid expansion.

In response to a member's question, Mr. Hely reported that provisions of the PPACA will bring Medicaid reimbursement rates for primary care into alignment with Medicare reimbursement rates.

### **Friday, October 12**

#### **Dental Therapists and Access to Dental Care in Rural and Tribal Areas**

New Mexico ranks forty-ninth among states in dental health, with 36% of third graders suffering from untreated dental decay, according to attorney Pamela Blackwell, project director for oral health access at Health Action New Mexico. Along with Ms. Blackwell, a panel of experts made the case for using dental therapists in areas where there is a shortage of dentists. According to the panelists, dental therapists can fill this gap with home-grown, culturally competent and high-quality dental care.

Dr. Todd Hartsfield, D.D.S., assistant professor of clinical dentistry at the Arizona School of Dentistry and Oral Health, has a long history of teaching dentists and others. He explained that he has trained and supervised dental therapists for 20 years, starting up a dental therapist program in Saskatchewan. In rural or remote village areas, dental therapists see more patients than fly-in dentists because they live in, and are from, the communities they serve. Their salaries contribute to the local economy. Dental therapists remain under the supervision of a dentist and are subject to frequent spot-checks; once licensed, a dentist's work is never inspected. Dental therapists prescreen patients and perform dental preparation so that when the dentist flies in, the dentist's time is used efficiently. According to Dr. Hartsfield, due to their limited scope of practice, dental therapists are more experienced at performing the procedures they are licensed to perform than most dentists. Further, no study has shown that care administered by dental therapists is inferior to that of dentists. Finally, there has not been a single complaint lodged against a dental therapist in Saskatchewan since the use of dental therapists began.

Daniel Kennedy, an Alaska native and dental therapist from Klawock, Alaska, told the committee how he was chosen by his village to receive training as a dental therapist. His education included course work in pathology, biology and anatomy through the University of Washington. His second year was spent in Bethel, Alaska, which is a hub for 58 Alaska native

villages. There, he received clinical training Monday through Friday from 8:00 a.m. to 6:00 p.m. Next, he was in a preceptorship under a dentist for 400 hours (six months) of direct supervision. His total education and training took 3,000 hours over three years and nine months to complete. Now practicing in his hometown of Klawock, he told the committee that he is related to most of his patients. He treats patients at Head Start and the senior center, and he even makes house calls. Mr. Kennedy stated that there are currently 33 dental therapists practicing in the interior of Alaska.

Dr. Ronald Romero, the former dental director for the DOH, is now retired and works with school-based programs. He has traveled to Alaska to assess its dental therapist program and to evaluate the training and curriculum. He stated that he was "very impressed" and observed "safe and technically appropriate care". He advocates using dental therapists in tribal dental health clinics, DOH programs, school-based programs, FQHCs and frontier and rural communities.

Michael Bird, M.S.W., M.P.H., public health consultant to the Pueblo of Kewa/Santo Domingo, told the committee how the American Dental Association (ADA) had attempted to block the use of dental therapists in Alaska but lost on the issue of tribal sovereignty. Mr. Bird advised the committee that following this loss in the courts, the ADA successfully lobbied for a provision in the PPACA that precludes tribes and the Indian Health Service from using dental therapists. He complained that this provision erodes self-determination and tribal sovereignty. According to Mr. Bird, this provision means that tribes must obtain authorization from the state in order to use dental therapists.

Don Weidemann, administrator for the Union County General Hospital in Clayton, New Mexico, explained how the shortage of dentists has affected his community. Currently, the closest dentists are in Dalhart or Amarillo, Texas. This means that his employees must take an entire day off to go to the dentist. Even with the promise of aid in recruiting a dentist from the president of the dental association, and two years after purchasing dental equipment, the community has been unable to attract a dentist. He supports legislation licensing dental therapists to ease the shortage of dental care in small rural communities.

Upon questioning, the follow topics and concerns were raised.

*Dental hygienists are not filling the gap in dental care.* The shortage of dentists affects the ability of dental hygienists to obtain employment and provide dental care. A representative of the New Mexico Dental Hygienist Association told the committee that schools are graduating twice the number of dental hygienists than there are available positions.

*The need to "glue" dental therapists to a community.* This involves recruiting dental therapists from the community in which they are expected to practice. A member suggested legislation requiring return to the community if training or education is state-funded.

*Using existing higher education resources to provide dental therapist education and training programs.* Members mentioned San Juan College, Eastern New Mexico University and Dona Ana Branch Community College as possible sites for such programs. Dr. Romero stated that UNM could train dental therapists. Dr. Charles Taver, a professor in the department of medicine at UNM, advised that UNM has an advanced dental education residency program and could train dental therapists if directed to do so by the legislature. Funds may be available under the PPACA for dental demonstration pilots.

*Legislation to allow Native American tribes and pueblos to use dental therapists.* Two members expressed willingness to carry such legislation.

*Other states considering licensing dental therapists.* Minnesota and Kansas are closest to enacting dental therapist legislation. Twenty states are now considering licensing dental therapists. A member recalled the battle to enact legislation to license physician assistants. He stated that he could not imagine where health care would be today without physician assistants. He observed that, given the time lag to get dental therapists educated and trained, if legislation had been enacted two years ago, the state would be ahead of the game.

*Audience members supporting the licensing of dental therapists.* Audience members supporting dental therapists included: Lydia Pedley, president, Health Action New Mexico; Jerry Lujan, Seniors United; Dr. Howard Rhodes, dental director, Fort Sumner; and Dr. Jerry Harrison, director of New Mexico Health Resources, Inc.

### **Report from the Task Force on Work-Life Balance**

Giovanna Rossi Pressley, president, Collective Action Strategies, and Lee Reynis, Ph.D., and director of the Bureau of Business and Economic Research at UNM, updated the committee on findings based on survey responses from New Mexico employers. Of note, the panel reported that 60% of children under six years old have parents who work outside the home during the day. They advised the committee that this phenomenon has caught the attention of the early childhood development community. The speakers requested the committee to fund further work of the task force to recognize family-friendly employers and to support a memorial encouraging more businesses to work with the task force in the future.

### **Physician Aid in Dying**

A panel made up of patients, physicians, end-of-life advocates and an attorney for the American Civil Liberties Union of New Mexico advocated for greater patient choice in end-of-life care.

Dr. Katherine Morris, a surgical oncologist who now works at the UNM HSC, appeared in her capacity as a private citizen to explain how she came to be the center of Oregon's physician aid-in-dying legislation. She stated that, for those patients who want to die with dignity, the absence of an affirmative law puts physicians at risk of legal action. Dr. Morris is currently a plaintiff in a suit for declaratory and injunctive relief seeking a determination that New Mexico's

assisted suicide statute does not criminalize the conduct of a physician providing aid in dying to a mentally competent, terminally ill patient who has requested such aid.

Barbara Lee, president of Compassion and Choices, explained that aid in dying is not suicide and that those patients choosing it are not suicidal. Such patients are terminally ill and wish to die at home at a time of their own choosing. Further, a large percentage of those opting to receive medication do not terminate their own lives. Oregon, Washington and Montana permit mentally competent, terminally ill adult patients who are capable of self-administering lethal medications to obtain them legally from a physician, subject to stringent legal requirements.

Aja Riggs, a patient suffering from an aggressive uterine cancer, told the committee that she has gone through many courses of cancer treatment and has not tolerated it well. If she is going to die from this disease, she does not want to be in pain, or unconscious and surrounded by her distressed family. She would like the option and comfort of physician aid in dying to allow her to die a peaceful death. She has intervened in the lawsuit filed by Dr. Morris.

Upon questioning, the following topics and concerns were raised.

*This is suicide, and suicide is wrong.* A member of the committee scolded the presenters and audience members for "not calling a spade a spade". Another member questioned whether the state has the right to force people to live just because advances in medicine can extend the dying process.

*Ways in which states have adopted physician aid-in-dying laws.* Oregon and Washington have passed such laws through referendum. Montana's law is based upon a court ruling holding that physician aid-in-dying is not against public policy. A member asked whether any legislators in other states had lost their seats because they supported physician aid-in-dying laws. Ms. Lee replied that, to the contrary, several legislators had lost their seats for holding up this legislation. Ms. Lee stated that the political arm of the Catholic Church was the only organized opponent to physician aid-in-dying legislation. A member commented that "we should stay away from religion when we write our laws".

*The distinction between physician aid-in-dying and advanced directives.* Physician aid-in-dying statutes have stringent requirements to ensure that the patient is mentally competent to make end-of-life decisions and is not acting impulsively. Advanced directives come into play when a patient is no longer competent or capable of making decisions regarding medical care. According to Ms. Lee, one has nothing to do with the other.

### **Nurse Advice New Mexico (NANM) and Health Care Delivery Innovations**

Presenters from NANM explained that it is a public-private partnership that provides statewide telephonic health advice. The organization operates under contract with the DOH to provide advice to consumers during outbreaks of disease and to assist the state in public health surveillance and reportable conditions. It also provides an after-hours health advice line for

physician groups. NANM anticipates being a vendor for Medicaid MCOs that are required to hire local businesses for health hotlines. Calls are taken for both insured and uninsured patients. NANM is not compensated for approximately 12% of the calls it takes.

### **Greater Albuquerque Medical Association Pre-Hospital Navigation Program**

This pilot program seeks to reduce the unnecessary use of the emergency room by patients who could appropriately be treated at primary care or urgent care centers. It is managed through 911 emergency dispatchers utilizing a computer to determine whether the patient is "low-acuity". While presenters hope that this medical assessment pilot will eventually have a sustainable funding stream, they are not seeking funds from the legislature at this time.

### **Essential Health Benefits**

Superintendent of Insurance John Franchini concluded the meeting with an update on the selection of the state's essential health benefit benchmark plan. He advised the committee that the Lovelace Classic PPO had been chosen as the benchmark plan and that the next step would be to ensure that the plans on the proposed state health insurance exchange would have parity. He believes that nine to 10 health insurance companies will participate in the exchange and that this will increase competition.

Superintendent Franchini also advised the committee that the New Mexico Medical Insurance Pool (NMMIP) is running at a deficit of \$150 million. According to the superintendent, there are 9,000 insureds in this pool. He believes that the PPACA will result in the availability of health insurance coverage to these persons through the state health insurance exchange. Currently, health insurance companies receive a premium tax offset for contributions to the NMMIP. Once the pool is obsolete, the state will receive full premium taxes from health insurers.

Questioning from members focused on whether state-mandated benefits would be included in policies offered on the proposed health insurance exchange.

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

**November 26-27, 2012  
Room 322, State Capitol  
Santa Fe**

**D** The sixth meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, at 9:20 a.m. on Monday, November 26, 2012.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair (11/27)  
Rep. Nora Espinoza  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Antonio Lujan

**Advisory Members**

Sen. Rod Adair (11/26)  
Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez (11/26)  
Rep. Miguel P. Garcia  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Sander Rue  
Sen. Bernadette M. Sanchez  
Rep. Mimi Stewart

Rep. Ray Begaye  
Sen. Stephen H. Fischmann  
Rep. James Roger Madalena  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. John C. Ryan  
Rep. James E. Smith

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

**Staff**

Michael Hely, Legislative Council Service (LCS)  
Shawn Mathis, LCS  
Rebecca Griego, LCS

**Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts and other written testimony are in the meeting file.

## **Monday, November 26**

### **Welcome and Introductions**

Senator Feldman called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

### **Reinsurance and Risk Adjustment**

Deborah Armstrong, executive director of the New Mexico Insurance Pool, explained several concepts applicable to key insurance reforms under way under the Patient Protection and Affordable Care Act (PPACA). They are reinsurance, risk adjustment and risk corridor, which are explained in her handout, posted on the legislature's web site. These approaches are necessary to provide the health insurance industry with a "soft landing" following the PPACA mandate of guaranteed issue of coverage (meaning that everyone must be insured regardless of pre-existing conditions or health status) and through the transition to nearly universal health care coverage through health insurance exchanges.

With regard to reinsurance, Ms. Armstrong's recommendation is that New Mexico operate its own reinsurance program to allow for flexibility in setting the contribution rate, parameters and payment methodology. As for risk adjustment, she advised that there is no advantage to New Mexico conducting risk adjustment modeling because the federal government will be doing it and the calculations are essentially the same.

Upon questioning from the committee, the following topic was among those discussed:

*The fate of the New Mexico high-risk pool.* John Franchini, superintendent of insurance, told the committee that once the health insurance exchange is in operation, those in the state's high-risk pool would be able to obtain insurance through the exchange. He explained that when the high-risk pool becomes obsolete, so will the corresponding premium tax credits that have been given to the state's health insurers. Without these tax credits, the amount of insurance premium tax that the state collects will increase by \$70 million annually.

### **Aligning Forces for Quality**

Pat Montoya, project director for the Albuquerque Coalition for Healthcare Quality (ACHQ), gave a presentation on the Robert Wood Johnson Foundation's aligning forces for quality (AFQ) innovation initiative, which focuses on improving the quality of care, improving health care efficiencies and addressing health care costs. According to Ms. Montoya, there are 16 AFQ communities across the country. She explained that the ACHQ is seen as a neutral convenor to bring competitors together to share best practices. Ms. Montoya's handout is posted on the legislature's web site.

Upon questioning, committee members discussed the following:

*Payment reforms to bend the health care cost curve.* Two committee members were critical of new payment reforms such as bundled payments (payment for episodes of care) and not paying for hospital readmissions within 30 days of discharge. One member does not believe that bundled payments result in fair compensation to physicians. Another commented that as long as physicians are under pressure to discharge patients from the hospital, they should not be penalized for readmissions. **\*A committee member requested a presentation on bundled payments next interim.**

### **Improving Quality Across Transitions of Care**

Sheila Coneen, project director for care transitions, HealthInsight New Mexico, introduced her organization as a Centers for Medicare and Medicaid Services contractor from 2011 through 2014. Her current project is focused on preventing avoidable readmissions by improving transitions of care. She recited disturbing statistics. One in five Medicare beneficiaries (2.6 million seniors) is rehospitalized within 30 days of discharge, at an annual cost to Medicare of over \$20 billion. This amount represents nearly 20% of Medicare's annual budget. Beginning in October 2012, hospital payments are being reduced based on the percentage of preventable Medicare readmissions for certain conditions. Ms. Coneen's handout is posted on the legislature's web site.

Upon questioning, committee members discussed the following:

*New Mexico's ranking for hospital readmissions is in the top 10%.* Committee members were surprised to learn that New Mexico has a relatively low rate of preventable hospital readmissions. Ms. Coneen explained that areas with high rates of readmissions tend to be urban and have a lot of hospitals. Since there are few hospitals in New Mexico and greater distances between hospitals, services are not as readily available. Responding to a question, she described the typical readmitted patient as an older person with a chronic illness who is taking multiple prescriptions with limited family support.

### **All Payer Claims Database**

Ross Winkleman, a health care consultant and actuary with Wakely Consulting Group, explained that an all payer claims database (APCD) houses claims data collected from all health insurance companies operating in a state. Typically, data collected would include identifying and demographic information for each insured person, laboratory test results, diagnosis codes, procedure codes, dates of service, costs, cost sharing and other information about each claim submitted for payment to the insurer. Mr. Winkleman explained that information contained in an APCD provides the raw data that are essential to measure quality and effectiveness of care, benchmark cost and quality improvement initiatives, to support payment reform and to perform risk adjustment. Mr. Winkleman reminded the committee that "you can't improve what you can't measure".

Mr. Winkleman told the committee that there are two ways to create an APCD: voluntarily or through legislation. Currently, New Mexico does not have an APCD and no planning for an APCD is under way. The estimated cost to maintain an APCD is between \$750,000 to \$1.5 million per year. (See handout.)

During questioning, committee members discussed the following:

*Legislation to create an APCD.* **\*Several members support legislation to create an APCD.**

*D Including behavioral health claims in the APCD.* Several members believe it is important to capture behavioral health claims data in the APCD as a way to monitor the performance of Medicaid managed care organizations in providing behavioral health services.

*Privacy concerns.* Members were concerned about protecting the privacy of patients. Mr. Winkleman assured them that the data in an APCD are encrypted and maintained to comply with state and federal privacy laws by entities that do this as a routine aspect of their business.

*Where would an APCD be housed?* Maggie Gunther, LCF Research, explained that the New Mexico Health Information Collaborative would be the logical organization to be in charge of the the APCD, particularly in light of the synergy between the APCD and the existing health information exchange, which already contains patient records for over one million New Mexicans.

### **Prescription Drug Abuse and Dependence: Report on Medical Professional Associations' Collaborative Solutions**

Ralph McClish, executive director of the New Mexico Osteopathic Medical Association, announced that his organization will be promulgating regulations that mirror those of the New Mexico Medical Board that are directed at physicians who prescribe pain medications that can be abused. Mr. McClish told the committee that his association supports legislation such as Utah House Bill 137 on pain medication management and education, which identifies physicians who appear to be over-prescribing pain medication and requires them to appear before a non-punitive peer review panel. The association also favors requiring a patient who is supposed to be on pain medication to undergo urinalysis to confirm that the patient is taking, and not diverting, pain medication.

Mr. McClish candidly admitted that last year he was opposed to measures requiring physicians to participate in continuing medical education on pain management because he was "ignorant" of the magnitude of the problem with prescription drug abuse. He stated that this legislative session, his association will not be opposing any legislation to address the prescription drug overdose and abuse problem.

## **Report from Senate Memorial 45 Harm Reduction Task Force**

A panel, including Dr. Bill Weise and Dr. Harris Silver, reported on the current status of "harm reduction" measures in New Mexico. These measures include needle exchange programs and the use of Narcan to prevent opiate overdose. Panelists also discussed the use of suboxone and methadone to counter heroin addiction. Recommendations included:

- ensuring that residential treatment is a benefit under health insurance policies offered in the state, including those offered on the state's proposed health insurance exchange;
- making sure that substance abuse treatment is covered under the state's Medicaid plan;
- requiring that suboxone treatment be available in the state's prisons;
- lowering the age to participate in needle exchange programs;
- appropriating funds to the Department of Health for Narcan harm reduction; and
- creating an agency devoted to drug addiction and substance use disorders to develop a long-term strategy that integrates public and private resources.

[See the Final Report, Senate Memorial 18, New Mexico Drug Policy Task Force (fall 2011) and two interim reports of the Senate Memorial 45 Study Group on harm reduction related to opioid use and dependency (2012) and "Findings and Recommendations of the Senate Memorial 18 NM Drug Policy Task Force", all posted on the legislature's web site.]

## **Improving Outcomes for Pregnant Women and Infants Through Medicaid**

Pamela Galbraith, program evaluator for the Legislative Finance Committee (LFC), presented her evaluation of Medicaid outcomes for pregnant women and very young children. Her data, conclusions and recommendations are set forth in a comprehensive report that is posted on the legislature's web site.

During questioning, committee members discussed the following:

*Medicaid does not pay for home visiting programs.* While Medicaid pays for 71% of all births, it does not currently pay for home visiting programs that are vital to improve the long-term prospects of New Mexico's most vulnerable families. The LFC is recommending legislation to ensure that the state's Medicaid plan includes evidence-based home visitation.

## **Public Comment**

Dr. Dale Alverson requested Senator Ortiz y Pino to carry legislation requiring reimbursement for telehealth services by third-party payers.

Roman Maes informed the committee that Representative Espinoza and Senator Cisneros would be co-sponsoring a bill to expand the practice of anesthesiologists beyond the University of New Mexico Health Sciences Center system.

## **Proposed Legislation for the 2013 Regular Session**

The committee discussed, voted on and endorsed appropriations bills. The list of endorsed legislation is posted on the legislature's web site.

### **Tuesday, November 27**

#### **Update on Medicaid and the PPACA**

Greg Geisler, senior analyst, LFC, gave a presentation that included projections on the cost or benefit to the state should it participate in the Medicaid expansion under the PPACA. Accounting for both revenues and expenditures from 2014 through 2020, total savings to the state are projected at \$443.6 million. Mr. Geisler's full report is posted on the legislature's web site.

#### **Medicaid Expansion**

Dr. Lee Reynis, director of the University of New Mexico's Bureau of Business and Economic Research (BBER), presented her projections of the impact of the proposed Medicaid expansion on the state's economy. For fiscal years 2014 through 2020, she estimates that the state will gain between \$477.7 and \$523.4 million. In her opinion, participation in the Medicaid expansion is "a good deal" for New Mexico. A copy of her presentation is posted on the legislature's web site.

Upon questioning, committee members discussed the following:

*The cost of administering the Medicaid expansion.* Dr. Reynis conceded that her projections do not take into account any administrative costs associated with the proposed Medicaid expansion. Mr. Geisler estimated that the state would need an additional \$2 million for administrative expenses related to the expansion. Brent Earnest, deputy secretary, Human Services Department (HSD), told the committee that the HSD would need \$2.8 million to pay for enrollment of the newly eligible under an expansion of Medicaid. A member pointed out that if the state coverage insurance program is obviated by the expansion, it would free up \$19 million that could be applied to administrative expenses associated with the expansion.

*Skepticism about the claimed benefit to New Mexico of the Medicaid expansion.* A member requested the BBER to study "the other side of the equation", including: the impact on gross receipts tax, the potential for full-time employees to be moved to part-time by employers that cannot afford employer-sponsored health insurance benefits, penalties assessed on small employers that will affect the amount of corporate income tax collected by the state and any other taxes that are included in "Obamacare".

#### **Basic Health Plan Report**

Kelsey McLowan-Heilman, staff attorney for the New Mexico Center on Law and Poverty, explained the PPACA's basic health program (BHP). This is a health insurance option given to states for low-income individuals who are not eligible for Medicaid and who have incomes up to 200% of the federal poverty level. Ms. McLowan-Heilman revealed that federal subsidies to

purchase health insurance through health insurance exchanges will not help approximately 63,500 New Mexicans who are still too poor to afford the premiums or cost sharing associated with health insurance plans offered through a health insurance exchange.

If New Mexico implements a BHP as provided by the PPACA, the state receives 95% of the value of tax credits and subsidies that would have gone to these lower-income individuals to purchase coverage on an exchange. The state would place these funds in a trust, and insurance companies would competitively bid to offer standard health plans through the BHP. BHP enrollees would choose among plans, and the state would pay insurers for the coverage provided. Any excess funds in the trust would be used to reduce costs or improve benefits for BHP enrollees. Nevertheless, BHP enrollees would still pay a portion of premiums and out-of-pocket costs. Ms. McLowan-Heilman recommends that New Mexico obtain a state-specific actuarial analysis to provide an accurate estimate of the costs of both health insurance exchange and BHP plans. Her detailed report and related handouts are posted on the legislature's web site.

Upon questioning, committee members discussed the following:

*The impact of the BHP on other health reform strategies.* One member commented that the BHP had been rejected by California because it would reduce the population using the state's health insurance exchange. Ms. McLowan-Heilman added that unions are concerned that the BHP would weaken the PPACA provision penalizing employers whose employees seek coverage on the health insurance exchange because employer-sponsored coverage is unaffordable. There is no comparable penalty provision if an employee seeks coverage through the BHP.

*Getting an actuarial analysis for policies offered through a New Mexico BHP.* Responding to a question, Ms. McLowan-Heilman indicated that a New Mexico-specific actuarial analysis would cost between \$50,000 and \$60,000. **\*A member requested the superintendent of insurance to perform an actuarial analysis for the New Mexico BHP.**

### **Medicaid Update; Health Insurance Exchange Advisory Group**

Julie Weinberg, director, Medical Assistance Division, HSD, gave an update on the state's waiver application. Her handout is posted on the legislature's web site. When asked whether the governor had decided to expand Medicaid, she responded that no decision has been made yet.

Milton Sanchez, director of the New Mexico Office of Health Care Reform, and Sidonie Squier, secretary, HSD, provided an update on health insurance exchange planning. They advised the committee that the estimated cost to implement a health insurance exchange ranges from \$35 million to \$77 million. A copy of their handout is posted on the legislature's web site.

During questioning, committee members discussed the following:

- the health insurance exchange will be housed in the New Mexico Health Insurance Alliance;

- since the essential health benefits offered on the exchange will have to contain the same coverage mandated by state law, the premiums may be higher than those of other states;
- telehealth is not included in the current benchmark plan and this will need to be addressed because all of the federally qualified health centers utilize telehealth;
- the number of transactions that will take place over the exchange is unknown at present; and
- several members are concerned that residential treatment be included in plans offered on the exchange.

**D** The committee considered and endorsed a proposed New Mexico Health Insurance Alliance bill, despite protests from two members that the process to review the bill was too rushed. A copy of the bill is posted on the legislature's web site.

### **Public Comment**

Pam Roy, New Mexico Food and Agriculture Policy Council, advised the members of legislation sponsored by Senator Pete Campos requesting \$1.44 million to fund the purchase of New Mexico-grown produce for school meals. A copy of her briefing sheet is posted on the legislature's web site.

Joe Romero, New Mexico Waiver Provider's Association, alerted committee members to the use of the supports intensity scale (SIS) to make cuts to those receiving benefits under the state's developmental disability waiver. According to the association, the SIS is being used to dismantle family living (at home with relatives) in favor of supported living in group homes under private ownership. The association advised that in 2013, as many as 1,000 New Mexico families will lose their family living benefits. Mr. Romero's handouts are posted on the legislature's web site. Several other members of the public commented, echoing Mr. Romero's concern about the use of the SIS to eliminate assistance to families of the developmentally disabled in favor of institutionalization or care provided by private companies.

Susan Loubet requested that the Workforce Solutions Department study completed pursuant to House Memorial 30 on the percentage of women participating in job training and employment services be circulated to committee members and the public.

Nick Estes, New Mexico Voices for Children, reminded the committee that expanding Medicaid would save providers hundreds of millions of dollars in what would otherwise be uncompensated care.

Dick Mason, appearing for the Action Committee of the League of Women Voters, expressed his view that the board of the New Mexico Health Insurance Alliance not include representatives of insurance carriers and providers.

**Proposed Legislation for the 2013 Regular Session**

The committee discussed, voted on and endorsed legislation for the 2013 regular session. A list of endorsed legislation is posted on the legislature's web site.

The minutes of the September committee meeting were approved as submitted.

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BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE MINUTES

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**MINUTES  
of the  
FIRST MEETING  
of the  
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE**

**August 16, 2012  
Rehoboth McKinley Christian Health Care Services  
Gallup**

The first meeting of the Behavioral Health Services Subcommittee was called to order by Senator Mary Kay Papen, vice chair, on August 16, 2012 at 9:20 a.m. at the Rehoboth McKinley Christian Health Care Services (RMCHCS) hospital facility in Gallup.

**Present**

Sen. Mary Kay Papen, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Nancy Rodriguez

**Absent**

Rep. Ray Begaye, Chair

**Advisory Members**

Rep. Bill B. O'Neill  
Sen. Gerald Ortiz y Pino

Sen. Sue Wilson Beffort  
Rep. Mimi Stewart

**Staff**

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Theresa Rogers, Intern, LCS

**Guest Legislators**

Sen. Dede Feldman  
Sen. George K. Munoz

Additional guests are included on the guest list in the subcommittee file.

**Funding for Native American Treatment for Substance Dependence, Misuse and Abuse**

John Jay Azua, programs manager and interim executive director for the Na'Nizhoozhi Center, Inc. (NCI), gave a presentation on the center's work in treating and reducing the incidence of substance abuse in northwest New Mexico. The NCI, which is operated and staffed jointly by the City of Gallup, McKinley County, the Navajo Nation and the Pueblo of Zuni, is the state's largest inpatient alcohol abuse detoxification and treatment facility, currently serving approximately 24,000 clients annually. A primary focus for the center is its protective custody admission process in which inebriants are sent by law enforcement officers to the NCI, rather than to jail, and held in protective custody for up to 72 hours for detoxification and intervention pursuant to the Detoxification Reform Act. Mr. Azua cites the success of this 72-hour hold and the center's subsequent referrals to substance abuse treatment as one reason McKinley County is no longer ranked number one for incidents of exposure deaths and driving while intoxicated (DWI). He noted that federal funding is not available for detoxification, and for this reason the

center uses the detoxification funding it raises from other sources to leverage federal funding for treatment services.

Since it opened 20 years ago, the NCI has received its operational funds through a combination of grants, Navajo Nation funding, local funding and federal funding, with the latter primarily via direct contracts with the Indian Health Service (IHS) that were made possible under the federal Indian Health Care Improvement Act. Under federal health care reform efforts, however, the IHS no longer contracts directly for services; as of 2011, funds are sent directly to tribes — in the NCI's case, the Navajo Nation — pursuant to the federal Indian Self-Determination and Education Assistance Act. Mr. Azua stated that this change in the funding structure puts the NCI at great risk of having to close its doors, despite 20 years of success. The Navajo Nation contracted with the NCI in 2011 at only 57 percent of the center's full-funding needs, and the Nation has indicated it will again deny full funding in its 2012 contract, if the contract is awarded at all.

Mr. Azua was briefly joined by Dominique Dosedo, program manager for the Juvenile Substance Abuse Crisis Center (JSACC), which is the only residential substance abuse treatment facility for juveniles in the United States. The JSACC serves an average of 30 juvenile clients per month and, like the NCI, provides 72-hour protective custody for detoxification. Also like the NCI, the JSACC has experienced a recent drop in funding that threatens the level of services it will be able to provide.

On questioning from subcommittee members, the presenters addressed the following concerns and topics.

*Seventy-two-hour protective custody hold.* Non-DWI inebriants are booked but not charged with a crime prior to being placed in protective custody at the NCI. DWI inebriants are booked and placed in jail.

*NCI budget and payments.* The NCI's annual budget in 2005 was \$2 million and has now been cut to \$1.4 million without a decrease in the need for services. With its Navajo Nation contract now in question, the NCI is going directly to chapters to push for continuation of the contract. The NCI is paid by OptumHealth, the federal Substance Abuse and Mental Health Services Administration and community grants for services provided to clients under court order.

*NCI clientele and services.* While the NCI will take clients of any background, 98 percent are Native Americans. The NCI can do substance abuse assessments but is prohibited from imposing mental health diagnoses. Treatment following detoxification is voluntary unless the client is under court order. Much of the treatment offered through the NCI is based in traditional Native healing practices.

*Liquor excise tax.* McKinley County, which is the only county authorized by statute to impose a liquor excise tax, receives approximately \$1.5 million annually from the tax and shares those funds with Gallup. The NCI receives a small portion of the tax for its First Step Program, but the bulk of the tax revenue goes to other programs in the area. Liquor excise tax revenue is disbursed by recommendation of a local liquor excise tax committee, as required by law.

*Suggestions.* Increase the liquor excise tax. Identify other funds to be appropriated or earmarked for substance abuse detoxification and treatment. Designate the NCI as an institution rather than a program under federal law. Designate in federal statute which institutions will receive funding.

- ★ Senator Ortiz y Pino suggested that the subcommittee recommend to the Legislative Health and Human Services Committee (LHHS) legislation to allow more counties to impose the liquor excise tax.
- ★ Senator Munoz recommended that the subcommittee request that the LHHS send a letter to the New Mexico congressional delegation to identify facilities such as the NCI in the federal budget bill.

### **Rural Hospital's Perspective on Behavioral Health Services**

Gretchen Woods, nurse manager for RMCHCS behavioral health services, gave an overview of behavioral health services provided by the hospital as well as some challenges it faces in getting timely reimbursement. With both inpatient and outpatient services available, the hospital is the most comprehensive behavioral health facility in the area, even after funding shortfalls forced the recent closure of its secure psychiatric unit. The client population is split fairly evenly among three groups — Native Americans, Hispanics and others — with 40 percent of them Medicaid-eligible. Reimbursement for services does not cover all that are provided, e.g., medical detoxification, the costs of which are absorbed by the hospital. Past funding from the Navajo Nation has dried up in recent years, and some private insurance reimbursement is not available because New Mexico does not have the acute care facility-licensing structure required by certain insurers. Nearly all reimbursements to the hospital now come from OptumHealth; however, that company is \$750,000 in arrears for behavioral health services invoices dating back to 2009. Some of the delay in reimbursement centers on the facility's child psychiatrist: OptumHealth has intermittently rejected invoices for this doctor's services based on the question of whether he is or is not properly credentialed.

On questioning from subcommittee members, Ms. Woods addressed the following concerns and topics.

*Mental health diagnoses and treatment.* The most prevalent mental health issues in the area are posttraumatic stress disorder (PTSD) and trauma. Mental health should be treated in the long term, similar to diabetes. A major obstacle to treatment compliance is denial, which leads patients to stop taking medication prematurely. The RMCHCS residential treatment facility receives patients from all over the state.

*Funding and coverage gaps.* RMCHCS does not receive any funding from the liquor excise tax even though it does treat DWI patients. Indigent care covers some, but not all, of the uninsured who receive services through RMCHCS and women get Medicaid coverage if they have children, but Hispanic males tend to fall into a coverage gap.

*Case management.* Case management services were reimbursed by the state in the past but no longer qualify for reimbursement. Visiting community health nurses in the area provide case management, even though they are neither trained in nor reimbursed for the service.

*Suggestion.* Replicate in New Mexico a Seattle community outreach program that puts master's level counselors in the field to work with the mentally ill and reduces law enforcement involvement with this population. A modified version of the program is in place in Gallup through Western New Mexico Counseling, though only with patients who have already gotten initial behavioral health services through RMCHCS.

- ★ Senator Ortiz y Pino requested that subcommittee staff research the issue of acute care facility licensure through the Insurance Division of the Public Regulation Commission and the Department of Health.
- ★ Senator Papen directed Troy Fernandez, senior director of the Behavioral Health Services Division of OptumHealth, to investigate the delays in reimbursements to RMCHCS and the issues concerning the child psychiatrist's credentialing and to report back to RMCHCS.

### **Centennial Care and the Impact of State Behavioral Health Reform on Native Americans**

Cathleen E. Willging, Ph.D., senior scientist and mental health services researcher at the Behavioral Health Research Center of the Southwest (BHRCS), spoke to the subcommittee about concerns regarding behavioral health services under the state's proposed Centennial Care waiver. Unlike the state's current Medicaid system, which "carved out" behavioral health services funding beginning in 2005, the Centennial Care waiver would "carve in" such services, thus blending the funding with all other Medicaid services. Dr. Willging raised concerns about the waiver on several points and made some suggestions as to how the state should proceed.

1. The carve-in model was eliminated in 2005 because of known problems that led to behavioral health programs closing down, providers turning away Medicaid clients and, according to a Legislative Finance Committee (LFC) audit, only 55 percent of Medicaid funding for behavioral health being spent on direct client services.

2. Although the carve-out system has had some difficulties under both single-entity contractors to date — ValueOptions and OptumHealth — it can function well if adequate state oversight and monitoring are in place.

3. The state should prevent problems that arose in past Medicaid transitions by appointing an external monitor to assess the readiness review process and implementation period and by requiring a hold-harmless period to protect providers dealing with changes in codes, processes and rates.

4. Performance data collected across the Medicaid managed care organizations (MCOs) should be made available to the public, as they were prior to 2005. These data are now reported to the Interagency Behavioral Health Purchasing Collaborative (IBHPC) and are not available to the public in a user-friendly format.

5. The waiver should include more billing and service flexibility to allow better access to comprehensive community-based care rather than limit these services to behavioral health homes. In addition, while the waiver calls for nurse care managers in behavioral health homes, a recent BHRCS work force study suggests there are very few psychiatric nurses in the state available to perform care management and coordination.

6. The waiver application includes reduction of administrative burdens only in principle. In fact, by replacing the current single-entity structure for behavioral health services with a multiple-MCO structure and adding regional core service agencies (CSAs) for review at the local level, the administrative burden for providers is increased.

7. Funding for Native Americans' behavioral health care under the waiver should be closely monitored so that MCOs either do not receive per capita payments for care that is actually delivered through the IHS system or are required to use these payments for programs that benefit Native Americans. Services and outreach to Native Americans should be culturally sensitive and linguistically appropriate.

8. A solid evaluation plan for the waiver should be in place from the beginning.

On invitation of the vice chair, Diana McWilliams, acting chief executive officer (CEO) of the IBHPC and acting director of the Behavioral Health Services Division of the Human Services Department (HSD), spoke from the audience about the waiver. The IBHPC is one of the contract signatories and will be involved in the final provider selections. An evaluation committee will score the proposals and submit final recommendations by the end of 2012, with the contracts awarded early in 2013. The administrative burden for providers will be capped at a certain percentage and MCOs will be prohibited from recouping administrative expenses by cutting services. Triggers will be in place under the waiver, and there have been discussions on possibly adding an independent monitor to evaluate the new system.

On questioning from subcommittee members, Dr. Willging addressed the following concerns and topics.

*Transition and administration.* Providers face problems with any major transition in the Medicaid structure or increase in administrative burden. The hold-harmless period during the 2005 transition helped providers adapt gradually to structural changes.

Subcommittee members expressed concerns over the increased administrative burden for providers under the waiver, the fact that the executive is proceeding with the waiver application without legislative input and that a carve-in structure adds potential for a lack of transparency. One member voiced support for a carve-in structure on the point that it gives clients choices that they do not have under the single-entity management of a carve-out structure.

- ★ Ms. McWilliams will provide information on access and payment for Native American behavioral health services under the waiver.
- ★ Senator Feldman requested that: (1) the Behavioral Health Services Division review Dr. Willging's report regarding increased administrative complexity under the waiver and submit recommendations to remedy the situation; and (2) the MCO contracts include specific provisions for credentialing of Native American providers, navigators and home health workers, with an emphasis on case management.

### **Medicaid Behavioral Health Services Through 2013 and Under Centennial Care**

Ms. McWilliams gave the subcommittee an overview of and status report on the Centennial Care waiver application. The application was submitted to the Centers for Medicare and Medicaid Services (CMS) on April 25, 2012; the CMS responded with a request for additional stakeholder input, and the HSD will submit application updates after holding more public meetings and tribal consultations. The waiver's core principles are comprehensive service delivery (within a three-level care coordination structure); personal responsibility; payment reform; and administrative simplicity. Protections in the waiver for behavioral health services include required reporting to the IBHPC; joint decision-making authority between the director of

the HSD's Medical Assistance Division and the CEO of the IBHPC; "fenced funding" for behavioral health services via a separate subcapitation rate; CSAs, with allowances for subcontracts to those agencies; behavioral health homes, to be ready by January 1, 2014; required behavioral health expertise for psychiatrists and leadership staff in MCOs; required coordination between the juvenile justice system and the Children, Youth and Families Department; and a requirement that MCO subcontracts for behavioral health services stay within the contract's overall cap on administrative costs.

On questioning from subcommittee members, Ms. McWilliams addressed the following concerns and topics.

*Carve-in structure.* While a carve-in favors large, out-of-state MCO corporations that already offer behavioral health services, the contract is not written to favor such entities but, rather, whoever will bring the best outcomes. All contracting MCOs are required to offer behavioral health services and assume the risk that comes with per-member-per-month payments; they are also required to report on their expenditure of these payments. While the waiver's carve-in meets the CMS requirement and the HSD's goal of budget neutrality, it was not designed for savings on behavioral health services, and the HSD has not projected any at this time.

*Developmentally disabled (DD) and multiple impairments.* DD waiver participants are exempted from the Centennial Care waiver. MCOs are required to address all impairments, including language barriers, in their three-level care coordination and to reach out to consumers rather than waiting for consumers to find the MCOs.

*Need for behavioral health services.* Eighty-five thousand people get behavioral health services each year through the state Medicaid program. For those leaving prison and leaving behind the behavioral health services they received under the Corrections Department budget, Medicaid expansion in the federal Patient Protection and Affordable Care Act will determine how many qualify for a continuation of those services under Medicaid. Projections for new enrollments have not been made because they depend on the Medicaid expansion but could be as high as 20 percent. In the past, the behavioral health services purchasing plan based services on funding, rather than on need.

*CSAs and providers.* If medically necessary, CSAs will be allowed to evaluate recommendations from competing providers. CSAs should include in their proposals that they will be contracting out to their existing provider network rather than narrowing the network by providing services in-house.

*Electronic records.* At this time, providers are not required to convert to an electronic records system; MCOs, however, are required to convert provider records to an electronic format.

*Time line for contract awards.* The request for proposals goes out with the contract by the end of August. Data will go to bidders on September 17. Bidders have 30 days to prepare bids, then reviewers have 30 days to review bids. Contracts will be awarded in early 2013.

Greg Geisler, senior fiscal analyst for the LFC, joined Ms. McWilliams to present excerpts from compilations of behavioral health actual and projected spending for fiscal years (FYs) 2008

through 2013 across all state agencies and from all sources, including federal block grants and funding for non-Medicaid programs. Spending is projected to be approximately \$392 million by FY 2013, down from nearly \$430 million in FY 2008. On questioning from the subcommittee, the presenters clarified that the IBHPC includes prisons but not counties; IBHPC money for the Corrections Department is for outpatient treatment only; and, while funding for non-Medicaid programs is not included in the Centennial Care waiver, the contract includes reference to these programs because MCOs have to interact with them.

★ Ms. McWilliams will provide information to the subcommittee and staff:

(1) to clarify her handout's chart showing the state general fund Medicaid cost increases projected through 2020;

(2) on the trend seen by the HSD executive team supporting a move to a carve-in for behavioral health services, including a list of all states that have adopted this structure;

(3) on the metrics currently under development for evaluating proposals;

(4) on the location of the 44 CSAs in the state, maximum distances that clients will need to travel to a CSA and free transportation to the CSAs available through the MCOs;

(5) on telehealth service requirements, such as Native language speakers;

(6) from the HSD general counsel regarding the contract's compliance with all statutory requirements; and

(7) on penalties to MCOs for avoidable delays in treatment or assessments.

★ Representative Kintigh requested that Ms. Mathis get information on how much the Corrections Department spends on inpatient behavioral health treatment services.

### **Autism Issues/Senate Memorial 20 and House Memorial 44 Report**

Gay Finlayson, autism programs education and outreach manager for the Center for Development and Disability at the University of New Mexico Health Sciences Center, presented the subcommittee with a report and recommendations in response to Senate Memorial 20 and House Memorial 44 from the 2012 legislative session, both of which called for development of a state autism spectrum disorder (ASD) service plan. Though the legislature has funded ASD services and studies since 2007, the incidence of ASD has since risen significantly in the general population to nearly one in 88 today, and the report recommends a \$9 million appropriation to adequately meet the increased demand for services. The appropriation would also cover the cost of creating an office of ASDs; adaptive skill building services through the HSD; ASD services through Centennial Care; diagnosis services and parent training programs through the Department of Health; HSD programs for non-disabled ASD adults; professional development through the Public Education Department; and a flex-fund program through the proposed office of ASDs.

On questioning from subcommittee members, Ms. Finlayson addressed the following concerns and topics.

*DD waiver.* ASD services are not provided under the DD waiver except as a related diagnosis in tandem with a developmental disability. Services are also not available for pervasive developmental disorder not otherwise specified and Asperger syndrome. While some people with ASD do meet the DD definition of intellectual disability — an IQ at or below 70 — many do not.

*Other states.* Pennsylvania is a leader in ASD services, with a state Office of ASDs as well as waiver services and insurance initiatives for ASD.

- ★ Senator Ortiz y Pino suggested that the subcommittee recommend legislation to the LHHS to create an office of ASDs.
- ★ Representative O'Neill suggested that the subcommittee recommend legislation to the LHHS on: (1) getting waiver services for those with ASD who are not intellectually disabled; and (2) providing ASD coverage through public employee health insurance plans.

### **Public Comment**

Dr. Matt Jones, a psychologist with the Gallup Indian Medical Center, presented his concern that although state agencies say they work with Native Americans, he does not see real coordination or collaboration taking place, and said that PTSD in the Native American community must be put in the context of intergenerational historical trauma. Subcommittee members noted that they heard a presentation on intergenerational trauma during the 2011 interim.

Ms. Finlayson spoke of "abysmal" case management available in New Mexico under Medicaid, Medicare and the Coordination of Long-Term Services, or CoLTS, program. She urged the subcommittee to make the MCOs accountable for all contracted services, including case management.

In general discussion, subcommittee members discussed the pros and cons of strengthening the oversight role of the legislature versus creating a health and human services oversight body similar to the Legislative Education Study Committee.

There being no further business, the subcommittee adjourned at 3:40 p.m.

**MINUTES  
of the  
SECOND MEETING  
of the  
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE**

**September 7, 2012  
University of New Mexico Science and Technology Building Rotunda  
Albuquerque**

**D** The second meeting of the Behavioral Health Services Subcommittee was called to order by Representative Ray Begaye, chair, on September 7, 2012 at 8:10 a.m. in the rotunda of the University of New Mexico (UNM) Science and Technology Building in Albuquerque.

**Present**

Rep. Ray Begaye, Chair  
Sen. Mary Kay Papen, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Nancy Rodriguez

**Absent**

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Bill B. O'Neill  
Sen. Gerald Ortiz y Pino

Rep. Mimi Stewart

**Staff**

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Theresa Rogers, Intern, LCS

**Guest Legislators**

Rep. James Roger Madalena  
Sen. Howie C. Morales

**Guests**

Additional guests are included on the guest list in the meeting file.

**Handouts**

Handouts and other written testimony are in the meeting file.

**Friday, September 7**

**Welcome**

UNM President Robert G. Frank, Ph.D., welcomed the subcommittee to the university and to the Science and Technology Center Campus, which he described as both a research center and technology incubator that is overseen by its own board of directors. He mentioned his past

experience establishing colleges of public health in Ohio and Florida, and he urged the subcommittee to work toward creating a New Mexico college of public health as a collaborative entity across the higher education institutions in the state. Dr. Frank introduced Lydia Ashanin, who handles his executive communications; staff members of the UNM Office of Government Relations, including Marc Saavedra, Tanya Giddings, Renee Santillanes and Matt Munoz; and UNM contract lobbyist Joe Thompson.

#### **Four Quadrant Clinical Intervention Model for Integrated Behavioral Health and Primary Care**

Steven Adelsheim, M.D., director of the UNM Center for Rural and Community Behavioral Health (CRCBH), gave a presentation on the work of the Behavioral Health Expert Panel convened by the Consortium for Behavioral Health Training and Research. The panel met during 2011 and 2012 to consider a model of integrated care for New Mexico and centered its discussions on a four-quadrant model of clinical integration that rates patient needs in both physical and behavioral health.

Panel members voiced the strongest support for a hybrid carve-in structure over both the total carve-in model used in the 1990s — in which there was no clear way to track behavioral health dollars — and the total carve-out model used today — in which health information cannot easily be shared across the physical health/behavioral health divide. The panel concluded that a greater percentage of behavioral health dollars should be spent on direct services than is currently the case and that the funding should be tracked and administered separately. There was support on the panel for local or regional governance as well as for a nonprofit, in conjunction with a state agency, to manage the state's behavioral health care system. In addition, the panel felt that the roles of all entities involved, including the Interagency Behavioral Health Purchasing Collaborative (IBHPC), the Behavioral Health Planning Council and local entities, must be clearly delineated. The panel concluded that there should be an increased focus on behavioral health services for children, with expanded early intervention programs; flexibility within the system to address the state's geography and its racial and ethnic diversity; strong efforts to reduce the stigma of behavioral health issues; and greater integration with the education system, tribes and tribal systems, the criminal and juvenile justice systems and jail diversion programs. The panel submitted its final recommendations to the Human Services Department (HSD), but Dr. Adelsheim could not say how the recommendations are addressed in the request for proposals for Centennial Care.

On questioning, Dr. Adelsheim, subcommittee members and Diana McWilliams, IBHPC acting chief executive officer and acting director of the Behavioral Health Services Division of the HSD, addressed the following concerns and topics.

*Panel meetings.* All of the panel's meetings were held in Albuquerque, with travel costs paid by the state. Members were not allowed to appoint designees.

*Treatment compliance.* The panel did not focus on treatment compliance but did note the need for better cooperation and referral systems within the juvenile and criminal justice systems.

*Substance abuse.* Research shows a high rate of psychological disturbance in long-term marijuana users, such as those who begin in adolescence. There is now an inpatient substance abuse treatment unit at Turquoise Lodge, the Department of Health detoxification and rehabilitation facility in Albuquerque. Co-occurring disorders are mentioned in the Centennial Care waiver, with substance abuse screening integrated into primary care.

*Centennial Care waiver.* The HSD intends to track and monitor behavioral health spending under the waiver. Non-Medicaid dollars, such as block grants, will continue to go to services for their targeted populations and will not be managed by the managed care organizations (MCOs). Psychotropic drugs are exempt from the formulary; generics will not be used if care would be compromised. The HSD held public meetings on the proposed waiver for more than a year, and, according to the HSD, the input was incorporated into the waiver. The waiver was drafted with the proposed expansion of Medicaid in mind.

*IBHPC.* The IBHPC meets quarterly and is focused on coordinating, rather than duplicating, efforts across agencies. It is also working to establish a statewide standard of care, common screening tools and protocols.

*Medical homes and behavioral health homes.* The IBHPC created core service agencies (CSAs) that meet the Centers for Medicare and Medicaid (CMS) definition for medical homes, with the limitation that the CSAs cannot turn someone away due to severity. The HSD application for behavioral health homes is on hold at the CMS pending further provider input.

*Tribal involvement.* Tribes need to have input into the waiver design and also be considered providers under the waiver. Some tribes, such as the Pueblo of Jemez, have their own health care systems.

- ★ Ms. McWilliams will provide the subcommittee with:
  - (1) a map that shows where substance abuse facilities and services are available in the state;
  - (2) the fiscal year 2014 budget for behavioral health services across agencies; and
  - (3) the budget for the Centennial Care waiver.
- ★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the Legislative Health and Human Services Committee (LHHS) to eliminate the IBHPC.

### **Behavioral Health Care for the Chronically Mentally Ill, Now and Under Centennial Care**

Patsy Romero, state president of the National Alliance for the Mentally Ill (NAMI), opened her presentation by noting that Senator Papen had received the 2012 State Legislator of the Year Award from the American Psychological Association Practice Organization for her work supporting behavioral health and public awareness. Ms. Romero then gave an overview of the state's three Medicaid transitions in the past 13 years and noted the impacts these have had on behavioral health services patients and providers. Ms. Romero noted that each of the previous models had problems that were addressed, with varying degrees of success in each subsequent model. She stressed her concern that the Centennial Care waiver application only mentions

behavioral health twice and that it is critical to include stakeholders in the system design to avoid problems seen in the past. She urged the subcommittee to push for a system that provides access to the same services across all health plans; includes detailed, enforceable contracts; links physical health providers with behavioral health providers; gives Medicaid recipients real information on services and costs; expands available services in rural areas; and includes a statewide system of crisis response teams.

On questioning, Ms. Romero and subcommittee members addressed the following concerns and topics.

**D** *Credentialing.* If there are five MCOs under Centennial Care, providers will have to be credentialed by five entities. It would be better to establish a single, statewide credentialing entity, with all MCOs required to accept providers credentialed by that entity.

*Stakeholder input.* Input from families and patients, not just providers, is important for the Centennial Care waiver.

**R** *Payments and administrative costs.* When provider payments are delayed or overpaid, providers are unable to get the unqualified audits required when pursuing grant funding. Administrative costs for behavioral health services providers will be higher under Centennial Care because there will be multiple MCOs, and this will leave less money for direct care.

*Serious emotional disturbance (SED).* Each provider conducts its own test for SED. Patients who are disturbed but do not meet a provider's criteria for SED must get services through a CSA, though that would not include short-term stand-alone case management services.

**A** *Work force and provider issues.* There are not enough psychiatrists and psychiatric nurses to meet the demand for services under Centennial Care. Ninety-five percent of the state's psychiatrists are in the Albuquerque area, and patients in rural areas must either travel or go without services. Comprehensive care coordination can be done by paraprofessionals rather than registered nurses or physicians. The Legislative Finance Committee could consider expansion of health care professions programs at the state's universities.

**F** *Integrated care.* Patient-centered health care systems that integrate physical and behavioral health, such as Project Hope and an accountable care collaborative in northern New Mexico, make it possible to easily share information among providers.

- ★ Senator Morales suggested that the subcommittee advocate for the inclusion of crisis response teams in Centennial Care.
- ★ Ms. Romero will provide a list of NAMI's concerns about Centennial Care prior to the next legislative session.

## **Monitoring the Delivery of Behavioral Health Services**

Howard Dichter, M.D., gave a presentation on the Early Warning Rapid Management Program (EWP), a tool for highlighting problems in Medicaid managed care systems that has been implemented in Pennsylvania, Oklahoma, Wisconsin and the District of Columbia. By collecting data sorted by subgroups such as MCOs, providers and regions, and by reporting data within three months following collection, the EWP allows states to quickly respond to problems, such as delays in provider payments or complaints about a provider's services. It also gives trend and effectiveness portraits, such as whether substance abuse patients in community living, outpatient, residential or detoxification settings continue their treatment over time. In addition to helping states evaluate and improve their managed care systems, the EWP helps providers improve as well by allowing them to compare themselves to other providers within the system.

On questioning, Dr. Dichter and subcommittee members addressed the following concerns and topics.

*Substance abuse detoxification and treatment.* Based on EWP data, the most effective substance abuse treatment setting is community living with multiple levels of care provided by a single agency, beginning with detoxification. In Oklahoma, the value of medical detoxification is now in question; it strains emergency rooms and takes up beds, and very few patients go on into treatment. Data indicate that a more effective approach would be to provide detoxification services in a medical facility that also houses personnel from a community mental health agency offering continued treatment after release.

*Complaints and surveys.* Pennsylvania's Medicaid system includes a review committee that meets quarterly to address complaints, and the committee includes a subcommittee on behavioral health. The committee includes results from consumer and provider surveys in its quarterly reports, which are available to the public.

*Data collection and accessibility.* New Mexico needs to collect data about its Medicaid managed care system and make data accessible to the public and the advocacy community. Data should not be collected by the MCOs but, rather, by an independent entity.

*State hospital admissions.* The EWP can look at data on how many patients who are transported by county sheriffs to the state hospital for a three-day stay subsequently receive services within seven days of release.

- ★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the LHHS to require that Medicaid data be collected and made available to the public and to require that the data be reported to the legislature.

## **Minutes**

On a motion by Senator Papen, seconded by Senator Ortiz y Pino, the minutes for the August 16, 2012 meeting of the subcommittee were adopted without objection.

## **Native American Suicide Prevention and Report on Statewide Clearinghouse for Native American Suicide Prevention (Senate Bill 417)**

Doreen Bird, community-based participatory research specialist, and Utahna Belone, Americorp Vista leader, both with the CRCBH, gave a presentation on Native American suicide prevention efforts and the statewide clearinghouse created pursuant to Senate Bill 417 of the 2011 regular legislative session. The clearinghouse is located in the CRCBH and received its initial operational funding in fiscal year 2013. To date, the clearinghouse staff has held collaboration meetings with several tribal entities and is planning initiatives around the state to provide culturally appropriate behavioral health training; data management assistance for tribes; grant-writing assistance; and outreach that addresses cultural stigma about suicide and promotes an awareness of warning signs. Data reported by the Department of Health show the 2011 rate of Native American youth suicides at 35 per 100,000 population of youth ages 15-24, and, for this reason, clearinghouse efforts will include a strong focus on youth.

On questioning from subcommittee members, the presenters, along with Dr. Adelsheim and Chris Fore, Ph.D., director of the Indian Health Service (IHS) Tele-Behavioral Health Center of Excellence, addressed concerns about funding for local suicide prevention programs. Tribal communities can get suicide prevention grants through the IHS Methamphetamine and Suicide Prevention Initiative. There are also Garrett Lee Smith grants available to all communities through the federal Substance Abuse and Mental Health Services Administration.

- ★ Senator Ortiz y Pino suggested that the subcommittee recommend legislation to the LHHS setting aside suicide prevention program funding that is not braided into physical health care funding in Centennial Care.

## **IHS Perspective on Behavioral Health Services Under Centennial Care and Telehealth for Behavioral Health**

Dr. Fore and Avron Kriechman, M.D., assistant professor of psychiatry in the UNM School of Medicine and professor in the New Mexico Highlands University School of Social Work, gave a combined presentation on IHS concerns about Centennial Care and about providing behavioral health services via a telehealth network.

Given the shortage of behavioral health providers in the IHS system, the majority of behavioral health services are provided by those trained in physical health. In a recent survey, all IHS physical health providers reported treating behavioral health cases. In the Albuquerque area, IHS behavioral health services are funded at only 48 percent of need, and because it is a line item in the overall IHS budget, it is often left out of funding increases that go to other parts of the budget.

Tribes did not have real input into the Centennial Care waiver application. The HSD did not consult with tribes, and even after tribes submitted written and verbal concerns regarding behavioral health services under Centennial Care, their concerns were not included in the "Concerns" section of the final waiver application. One major issue is that Native Americans in the state will be automatically enrolled in MCOs under Centennial Care, even though 80 percent

are currently opted out of Medicaid because they receive care through the IHS. There is also no retroactive or presumptive eligibility to cover times when eligibility may lapse. Even though the IHS can apply for reimbursement for services provided, getting paid is another matter: OptumHealth did not reimburse the IHS until directed to do so by the state, and OptumHealth is still \$900,000 in arrears for invoices dating back to 2010. Tribes are concerned that a requirement for timely and accurate payments does not appear as a criterion in the Centennial Care MCO selection process. They are also concerned that there is no acknowledgment of language or cultural barriers and that unrealistic requirements are included; for example, MCOs are required to make quarterly visits or monthly phone calls to the mentally ill, but many Native Americans live in extremely remote areas or have no telephones.

The UNM Telepsychiatry Program was created to help provide services in remote areas, with health care providers, educators and family members in more than 80 rural communities participating to date. The video- and phone-conferencing program, which works in partnership with Project ECHO, aims to develop local capacity for behavioral health services through a combination of direct psychiatric services, consultation, training and supervision. Trainers include not only psychiatrists but also psychologists, nurses, social workers, counselors, anthropologists, epidemiologists, sociologists and clinical researchers.

The IHS Tele-Behavioral Health Center of Excellence, which is based in Albuquerque, provides services to tribal communities nationwide and helps tribes to get their own telehealth programs in place. Recent research has shown a better client response for tele-behavioral health services than for services provided in person: the no-show rate for tele-behavioral health appointments was 10 percent while the no-show rate for in-person appointments was 35 percent. Of the clients who received tele-behavioral health services, 94 percent reported they would have gone without services entirely had the tele-behavioral health system not been in place. The system saved the IHS \$75,000 in 2011 in provider driving costs, and 2012 data show contact with patients has increased 171 percent over the previous year. The presenters urged the subcommittee to consider appropriating funds to upgrade telephone and internet capabilities in tribal communities that still lack the infrastructure to participate in the tele-behavioral health system.

On questioning from subcommittee members, the presenters and subcommittee members addressed the following concerns and topics.

*Treatment foster care (TFC).* Some in the TFC community are concerned that children need in-person contact rather than tele-behavioral health services. Many Native American TFC children are sent to non-tribal families and communities because the state requires a TFC child to have his or her own bedroom; in addition, the lack of internet connectivity in many Native American homes precludes provision of TFC services via the tele-behavioral health system. The center for excellence does not emphasize tele-behavioral health services as a replacement for in-person services but only to supplement care and to facilitate information-sharing among professionals working with a patient.

*Telehealth systems.* Five Sandoval Indian Pueblos, Incorporated, has a telehealth system in place; the Pueblo of Jemez has telehealth equipment but is not using it. Alaska has a strong telehealth system that reaches communities throughout the state and is culturally appropriate, and telehealth services are reimbursed under the state's Medicaid program at the same rate as in-person services. Legislators need training on telehealth systems prior to passing telehealth-related legislation.

*Opt in, opt out.* Under the federal Patient Protection and Affordable Care Act, Native Americans who choose to opt out of managed care will not be penalized because the IHS is considered their provider. Under Centennial Care, all Native Americans will be automatically assigned to an MCO and must actively opt out.

On invitation of the chair, Ms. McWilliams clarified that OptumHealth does pay interest to providers on avoidable late payments effective to the date when full information to process the claims is received. Fines on those late payments, however, are paid to the state, not the provider.

On invitation of the chair, Maria Clarke, health and human services director at the Pueblo of Jemez, elaborated on potential problems in Centennial Care's automatic MCO enrollment for Native Americans, saying that tribal clinics such as the one at the Pueblo of Jemez will not know where patients have been assigned, and the reimbursement process will be seriously hampered. In addition, different members in one family may be assigned to different MCOs. The Pueblo of Jemez has requested a consultation with the CMS and has been told that the agency is looking closely at New Mexico's waiver application in part because of concerns raised by tribes.

Michael Hely, LCS staff attorney, advised the subcommittee that the HSD is seeking to exclude three-month retroactive eligibility for Native Americans in the Centennial Care waiver.

- ★ Dr. Fore will provide a copy of the IHS concerns regarding Centennial Care that were submitted to the HSD.
- ★ Senator Ortiz y Pino proposed that the subcommittee suggest to the LHHS that it send a letter to the CMS urging it to disapprove the Centennial Care waiver application.

### **Early Intervention and Resources**

Dr. Adelsheim gave a presentation on early intervention programs for identifying mental illness in children, informing the public about mental illness and changing how communities address the issue. Three-fourths of lifetime mental illnesses manifest themselves prior to age 24, and half of them show up by age 14. Mental illness currently costs U.S. families \$247 million annually, and it is projected to be the leading cause of disability in the world by 2020. Implementing an early intervention program in New Mexico that reaches every child in the state would cost only \$800,000 a year.

The Massachusetts Child Psychiatry Access Project (MCPAP), which is funded through the state's Medicaid program, works to help primary care providers identify and address childhood psychiatric problems in the no-stigma setting of a primary care clinic. The program

supports primary care providers with telephone consultations, patient visits within a week of referral and assessment results within 24 hours of a visit. Dr. Adelsheim recommended the MCPAP as a model for New Mexico to adopt, in addition to its current Early Intervention and Resources Linking Youth (EARLY) Program. The EARLY Program focuses on identifying childhood psychosis, which is treatable and of a much shorter duration if caught early. New Mexico also participates in the Recovery After an Initial Schizophrenia Episode, or RAISE, Program created by the National Institute of Mental Health.

On questioning from subcommittee members, Dr. Adelsheim and the members addressed the following concerns and topics.

*Diagnoses and triggers.* Schizophrenia can be diagnosed prior to age 18, though some psychiatrists will only label the patient as having "traits". Some mental illnesses are genetic and some are prenatal, as suggested by recent research finding an increased incidence of autism and schizophrenia in children with older fathers. Childhood schizophrenia is extremely rare.

*Drug use.* Because the brain continues to develop into the early twenties, the use of any drugs, illegal or prescribed, can affect its development.

*Screening.* The MCPAP was developed because Massachusetts was sued over a lack of mental illness screening in its Medicaid Early Periodic Screening, Diagnosis and Treatment Program. Such screening should be part of school-based health programs and the juvenile justice system as well. Prior to an initial visit, school-based health clinics are required to give teens a health survey that includes substance abuse screening questions. Medical students do coursework and a rotation in psychiatry, but primary care providers need more training than that, especially training in how to ask about mental health issues.

*Residential treatment.* Some feel that residential treatment outside the home should be reinstated because leaving a child in the home leaves the child in the problem; others point to a lack of evidence that residential treatment is effective because the child's support system disappears when the child is released.

*Medication.* Psychiatrists are under pressure to find short, quick solutions, and overmedication can be a problem. Sometimes children are put on medication because a teacher is overwhelmed in the classroom.

*Early Detection and Intervention for the Prevention of Psychosis (EDIPP) Program.* New Mexico's EARLY Program falls within the EDIPP Program funded by the Robert Wood Johnson Foundation. New Mexico now has a psychosis clinic for early assessments but no funding stream to keep it going. Other states use a combination of state and federal funding for their programs, and New Mexico's Medicaid system could be structured to provide the necessary funding. There is no way to know definitively whether early intervention prevents mental illness or whether the person would have recovered anyway.

- ★ Ms. McWilliams will provide the subcommittee with:
  - (1) mental health assessments required under Centennial Care; and
  - (2) information on behavioral health per capita spending in all states.
- ★ Dr. Adelsheim will provide the subcommittee with information on California Proposition 63, which imposes a tax on high-income residents and earmarks the funds for early intervention programs.
- ★ Senator Ortiz y Pino proposed that the subcommittee suggest legislation to the LHHS to create and fund a program in New Mexico similar to the MCPAP.

### **Public Comment**

Ms. Clarke and Dave Panana, nurse manager at the Pueblo of Jemez health clinic, urged the subcommittee to advocate for directing the per-member-per-month funding for their clinic's clients to the clinic rather than sending it to the MCOs under Centennial Care. They felt that the clinic provides better case management and better, more culturally appropriate services to its clients than the MCOs will provide.

On invitation of the chair, Ms. McWilliams stated that tribes can be designated as CSAs under Centennial Care.

- ★ Ms. McWilliams will provide the subcommittee with information on whether tribes qualify as CSAs under Public Law 638, the Indian Self-Determination and Education Assistance Act.
- ★ Senator Rodriguez will advocate for tribes to be designated as CSAs.

There being no further business, the subcommittee adjourned at 4:20 p.m.

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

**October 18, 2012  
North Gymnasium, Mesilla Valley Hospital  
Las Cruces**

The third and final meeting of the Behavioral Health Services Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Mary Kay Papan, vice chair, on October 18, 2012 at 8:45 a.m. in the north gymnasium of Mesilla Valley Hospital in Las Cruces.

**Present**

Sen. Mary Kay Papan, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Nancy Rodriguez

**Absent**

Rep. Ray Begaye, Chair

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Bill B. O'Neill

Sen. Gerald Ortiz y Pino  
Rep. Mimi Stewart

**Staff**

Shawn Mathis, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Theresa Rogers, Intern, LCS

**Guests**

The guest list is included in the subcommittee meeting file.

**Thursday, October 18**

**Welcome**

Brian Hemmert, chief executive officer (CEO) of Mesilla Valley Hospital, welcomed the subcommittee and described the services available at the hospital, which serves about 2,000 clients of all ages each year with its acute psychiatric services, treatment foster care (TFC) program and residential treatment center. Shantel, a client at the hospital, read a poem about how treatment at the hospital has helped her move beyond her difficult early experiences.

On questioning, Mr. Hemmert and subcommittee members addressed the following concerns and topics.

*TFC parent homicide.* The Children, Youth and Families Department (CYFD) has concluded its investigation into an incident in which two girls who were released from Mesilla

Valley Hospital into a TFC home killed their foster mother. The police are still investigating the case. There was a post-action analysis.

*Hospital facilities and clients.* The hospital is a secure facility more akin to an Alzheimer's unit rather than a juvenile detention center. Two clients have escaped in the past 15 months. The hospital is required by law to accept patients with psychiatric problems regardless of their ability to pay and may then transfer them to the New Mexico Behavioral Health Institute (NMBHI) in Las Vegas. The hospital takes both Medicaid and Medicare clients, though there is no Medicaid reimbursement for clients ages 18 through 64. The hospital has 120 beds, 32 of which are in the residential treatment center. The hospital's daily census last year ranged from 44 to 96 clients. The majority of referrals to the hospital come from emergency rooms statewide. Two to three clients a week are transferred to the NMBHI. The decision to release an adolescent client into the community is made by the client's treatment team.

*Detoxification and substance abuse.* The hospital received 731 calls in July for its detoxification services; Medicaid patients are referred to state facilities for detoxification. The state could develop a Medicaid waiver to cover detoxification services. Sixty to 70 percent of the hospital's adolescent clients have a history of substance abuse, and prescription drug abuse is increasing, mostly among adults. The hospital does not use suboxone for withdrawal.

*Hospital funding.* The hospital receives payment via private insurance, Medicaid, Medicare and indigent funds, and it provides approximately \$1 million per year in uncompensated care. Returning clients who have unpaid balances may still receive care, and the hospital will continue to seek payment.

*Crisis triage center.* Hospital staff have attended meetings for the regional crisis triage center but have concerns about its sustainability.

On invitation of the chair, Roque Garcia, CEO of Southwest Counseling Center, stated that the majority of foster care placements are successful; the cases that make the headlines are the cases that go wrong, such as the incident in which the TFC children killed their TFC mother.

- ★ On a motion by Representative Kintigh, seconded by Senator Rodriguez, the subcommittee unanimously voted to send a letter to the New Mexico congressional delegation asking it to revise the federal mandate that prohibits Medicaid reimbursement for psychiatric services for people ages 18 through 64.
- ★ Mr. Hemmert will provide information on:
  - (1) hospital policies regarding what triggers a client's release to TFC;
  - (2) whether the CYFD is involved in the decision to release;
  - (3) how the hospital responds when an incident occurs;
  - (4) how many Medicaid and Medicare clients have been served; and
  - (5) the hospital's 30-day readmission rate.

**New Mexico State University (NMSU) Community Mental Health and Wellness Clinic**

Esther Devall, Ph.D., NMSU Family and Consumer Sciences Department, and David C. Holcomb, Ph.D., NMSU assistant professor of family and child science, gave a presentation on

the community health and wellness clinic at NMSU. The clinic is jointly operated by the NMSU College of Agricultural, Consumer and Environmental Sciences (ACES) — whose graduate students train at the clinic in marriage and family therapy — and the College of Education — whose master's and doctoral students train at the clinic in counseling, school counseling and counseling psychology. The clinic will expand its training opportunities in the future to include students in social work and psychologists working toward their prescriptive licensure. The clinic serves both students and members of the southern New Mexico community, where mental health services are in such short supply that people often end up on six-month waiting lists.

**D** On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*Substance abuse.* Substance abuse, overeating, gambling addictions and video game addictions are all forms of self-medication. There can be a long-term impact on the developing brain of substance abuse, and, without early intervention, some of the impact can be irreversible. NMSU requires that freshmen take a class on alcohol abuse and violence. The university offers a program for licensed alcohol and drug abuse counseling, or LADAC, which does not require a college degree; an interdisciplinary degree in drug abuse counseling for master's and doctoral candidates who already have a license in another discipline; and family strengthening programs to help prevent or intervene early in adolescent substance abuse.

*Criminal justice system.* Referrals for behavioral health services are important for offenders, and programs need to be expanded to make more slots available. Assigning mandatory community service in combination with behavioral health services is an effective approach.

*Clinics.* The ACES and the College of Education each has its own clinic; there is also a new four-bedroom unit in the NMSU family housing area that will soon be too small to meet the need for residential services. Clients served at the housing unit are screened; no dangerous clients, such as sex offenders, are accepted at the facility. Graduate students working in the clinics are closely supervised, and only predoctoral interns are assigned to serious mental health cases. The program's "social justice" mission is to help people become productive, content members of the community.

### **School-Based Behavioral Health Panel**

Frank Mirabal, vice president of the Educational Support Division of Youth Development, Incorporated (YDI), Mary Ramos, M.D., University of New Mexico (UNM) Department of Pediatrics, and Jack Siamu, senior associate director of the Prevention, Intervention and Treatment Division of YDI, gave a presentation on school-based health center (SBHC) behavioral health services. Approximately 20,000 New Mexico students annually receive behavioral health services through the state's 56 SBHCs, which have been successful because they address both behavioral health and educational issues and they are easily accessible to any student. YDI's Elev8 Program, a community school program implemented in several middle schools around the state, has noted nearly a 20 percent rise in requests for behavioral health services in the past two years at SBHCs in Elev8 schools. Operational funding for SBHCs was reduced for fiscal year (FY) 2013 to \$2.61 million from a high of \$3.53 million in FY 2009.

The presenters requested that an additional recurring \$2.5 million be appropriated to the Office of School and Adolescent Health in the Department of Health (DOH) in FY 2014 for behavioral health services at SBHCs in schools that have been rated C, D or F. The additional funding would allow SBHCs to operate five days a week rather than two days, as they currently do.

On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*Grant Middle School.* Grant Middle School in the Albuquerque Public School District is a full-service community school with funding from the New Mexico Community Foundation and other sources for before- and after-school programs coordinated by YDI. The school also participates in the UNM early warning data system of academic predictors for graduation, including absences, truancy and involvement with the juvenile justice system. If a student's record is flagged by the system, the school calls the family to recommend at-school resources.

*After-school activities.* After-school activities can help prevent youth crime, most of which is committed between 3:00 p.m. and 6:00 p.m.

*School grading system.* School superintendents are concerned that under the Public Education Department's school grading system, only one person has the information on how grades are assigned. The superintendents need information on criteria and how they are used.

*SBHCs.* Eight or nine SBHCs are located in Albuquerque, and the rest are spread around the state. Some visits to SBHCs are for puberty adjustments rather than mental health issues. Minors cannot be treated at an SBHC without parental consent; exceptions to this include abuse or neglect, for which treatment and reporting are required, and behavioral health and reproductive health services, both of which are confidential by law. A minor 14 years old or older may receive two weeks of verbal therapy, after which time parental consent is required. Unlike primary care clinics, SBHCs screen for behavioral health issues at every visit. Group settings for dealing with adolescent behavioral health issues have been successful when groups consist of students who are all the same age. SBHCs will issue requests for proposals for additional behavioral health services if the state appropriates an additional \$2.5 million, and UNM could bid for those service contracts.

*YDI.* YDI provides programs statewide, though the majority of its programs are in Bernalillo, Valencia, Sandoval and Tarrant counties.

*Adolescent suicide.* New Mexico's rate of adolescent suicide attempts has consistently stayed above the national average. Nearly half of the adolescents who attempt suicide require subsequent medical treatment.

*Truancy.* The Albuquerque Public School District has only four truancy liaisons to conduct home visits with families; the district needs 100.

- ★ On a motion by Senator Beffort, seconded by Senator Papan, the subcommittee voted unanimously to send a letter to the principal of Grant Middle School to ask what before- and after-school programs exist for students.
- ★ Dr. Ramos will verify statistics provided by the Centers for Disease Control and Prevention regarding adolescent use of ecstasy and methamphetamine.

### **Connecting College Students to Behavioral Health Services**

Phillip Bustos, vice president for student services at Central New Mexico Community College (CNM), and Ann Lyn Hall, executive director of CNM Connect, gave a presentation on behavioral health services available at and through CNM. The CNM health center had more than 6,300 visits during the 2011-2012 school year, and nearly one-fourth of those visits were for behavioral health issues. The school's current behavioral health initiatives include a behavioral health intervention team; a post-crisis response team; a restorative justice model; the Vet Success Program; mutual health training for faculty and staff; and webinars on classroom management. In addition, the CNM Connect Program works to help students with a variety of concerns, including behavioral health issues, that might lead a student to drop out.

On questioning, Mr. Bustos stated that of the 2,000 military veterans enrolled at CNM, 894 are enrolled in the Vet Success Program.

### **Behavioral Health for Children of Military Families**

Kourtney Vaillancourt, Ph.D., assistant professor and clinical director of the NMSU Marriage and Family Therapy Program, Merranda Marin, Ph.D., NMSU Family and Child Science Department, and Shawn Ticho, U.S. Army child, youth and school services coordinator, gave a presentation on behavioral health services available for children of military families. Approximately two million children nationwide have had a parent deploy to either Afghanistan or Iraq, and many of these children display increased anxiety, anger, depression and changes in academic performance. Deployment can also have a negative effect on families, with increased parental stress and a greater incidence of child abuse. The NMSU Marriage and Family Therapy Program has created Operation Military Kids in partnership with Army Child and Youth Services and 4-H to provide services and programs for children of military families in southern New Mexico. One outreach effort is the Together Everyone Achieves More, or TEAM, Program, which targets issues related to parental deployment such as depression and risk-taking behaviors in middle and high school students at White Sands Missile Range. Future efforts include implementing an online parenting education course for military families and further research into identifying family distress associated with deployment; the effects of transitions back home on children; and differences and similarities among active duty, National Guard and military reserve families.

On questioning, Mr. Ticho stated that children of military families stationed at White Sands Missile Range travel to Fort Bliss, Texas, for behavioral health services.

### **Treatment Foster Care Panel**

Beverly Nomberg, L.I.S.W., CEO of La Familia-Namaste, and Kate Banks, former TFC parent, gave a presentation on the origins and structure of TFC, which places children with serious behavioral health issues in foster homes with adults who are licensed to provide a certain

level of treatment in the home. TFC was originally conceived as a long-term placement; however, in the late 1990s, it became a managed care program and now has a 24-month limit. Under managed care, it has become more difficult to place a child in TFC, and many children whose behavior merits the highest level of TFC care are placed in the lower, less expensive level. Fair hearings are available through the Human Services Department (HSD) for guardians who question the level of care assigned to a TFC child or a denial of TFC altogether, but the hearings are an expensive process. With OptumHealth denying TFC applications at its current rate and pushing TFC children into lower levels of care, some TFC programs around the state can no longer afford to stay open.

**D** On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*TFC costs.* Level 1 TFC care costs \$165 per day, and Level 2 costs \$125 per day. The average annual cost per TFC child for FY 2010 through FY 2011 was \$30,000. TFC agencies in southeastern New Mexico have closed due to the impact of the lower reimbursement rates for Level 1, and those children must now be placed outside their geographical region.

*TFC levels, placements and emancipation.* It is not customary to admit a child to TFC at Level 2 because this level implies a child is functioning well enough for discharge to adoption. TFC programs make recommendations as to a child's appropriate level of care, but it is the managed care organizations that make the final decision. If two children are to be placed in one home, they should be related. Forty-five percent of TFC children go on to adoptive homes, and 40 percent go back to their families of origin. Some teenagers prefer group homes to foster care. There are few programs available for children who emancipate from TFC; more Section 8 housing and independent living programs are needed.

*TFC denials.* More TFC applications are being denied than approved. 2012 data from southern New Mexico show eight TFC denials and two approvals. Some children who are denied TFC go into regular foster care, and some get services from tribal agencies.

*Regular foster care.* The CYFD creates a treatment plan for all foster children, but behavioral health services are not always available for them.

*Medication.* TFC children are more likely to be on medication than children in regular foster care. Alternative treatments such as acupuncture are being used with some children to reduce the use of medication.

On invitation of the chair, Elizabeth Martin, CEO of OptumHealth, stated that:

(1) the TFC girls who killed their TFC mother were not OptumHealth clients; and  
(2) OptumHealth's TFC denial rate is three percent; denials are made either because there is no medical necessity or because the paperwork is incomplete, and those who are denied go into community-based programs.

On invitation of the chair, Diana McWilliams, acting CEO of the Interagency Behavioral Health Purchasing Collaborative (IBHPC) and acting director of the Behavioral Health Services Division of the HSD, stated that:

- (1) a discharge plan is done on each child leaving TFC;
- (2) transition services will be provided for each TFC child when OptumHealth's contract expires in December 2013 and Centennial Care begins in 2014; and
- (3) the decision to place a child in either Level 1 or Level 2 care is made based on clinical need.

On invitation of the chair, George Davis, M.D., director of psychiatry for the CYFD, stated that TFC children tend to have a history of involvement with the juvenile justice system, residential treatment, group homes and protective services; and that TFC agencies are liable for any incidents involving TFC children.

- ★ Ms. McWilliams will:
  - (1) provide an analysis of where TFC children go when they leave TFC; and
  - (2) conduct research to determine in which managed care organization the two TFC girls were enrolled when they killed their TFC mother.
- ★ Dr. Davis will provide information on what incident precipitated the initial TFC placement for the two girls who killed their TFC mother.
- ★ Ms. Martin will provide outcome information on children who are denied TFC.

### **Behavioral Health Programs for Children and Adolescents: Child Welfare and Juvenile Justice**

Julia M. Kennedy, Psy.D., juvenile justice facilities behavioral health director for the CYFD, and Dr. Davis gave a presentation on behavioral health programs for children and adolescents in child welfare and juvenile justice programs. Approximately 60 percent of incarcerated juveniles in New Mexico have a mental health diagnosis, and 95 percent report some kind of developmental trauma, ranging from abuse, neglect, bullying, being a witness to violence, including murder, or being removed from their homes. A common course for children in "the system" is first to be removed from the home and placed in protective custody, then to be referred for behavioral health treatment and finally to be involved with the juvenile justice system, thus engaging with all three of the state's services for children: social, behavioral health and juvenile justice. CYFD programs for this population include Cambiar, formerly the "Missouri Model"; Phoenix, a life skills program; Alcoholics Anonymous and Narcotics Anonymous; the Substance Abuse Community Reintegration Program; general educational development testing; one-on-one therapy; special education and vocational training; family involvement programs; the Child Trauma Academy; and transitional services up to age 21.

On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*Juvenile justice system and facilities.* The assumption that children are in the juvenile justice system because the child protective system (CPS) "failed them" is an oversimplification; one-half of the children in the juvenile justice system were never referred to the CPS. There is

often no continuity between referrals in the system, and providers should review a child's records thoroughly to understand that child's situation. It has been difficult to fill some positions at CYFD facilities because staff members have been assaulted; residents who commit such an assault cannot be transferred to a higher-level facility until after such an incident occurs. Desert Hills is a managed care facility for girls who cannot be placed in a state facility and is not a secure facility. Gender-specific programming has worked well, and the CYFD has contracted with a psychologist to train staff on gender-specific issues. There has been an increase in girls in the juvenile justice facilities, partly because of a lack of community resources for them.

**D** *Children's Code.* Though certain low-intensity interventions have been successful, some criminal justice professionals feel the Children's Code should include aggressive early intervention that is not possible under current law — for example, requiring certain mothers to participate in structured treatment programs as a condition of taking a baby home from the hospital after birth. Those professionals also feel the courts should use the arrest of a parent as an opportunity to intervene.

*Schools.* Health curricula in high schools should include more information on mental health. Bullying prevention programs are required in each school district but are not being implemented. Schools need to include instruction on how to raise children.

*Diagnoses.* A child's diagnosis is sometimes changed by a consensus diagnostics committee that reviews the child's files.

On invitation of the chair, Ms. McWilliams and Ms. Martin stated that:

(1) the HSD is overseeing the transfer of TFC clients from the Carlsbad TFC agency that has closed; and

(2) Partners in Wellness, which comprises Teambuilders, Carlsbad Mental Health, Presbyterian Medical Services and YDI, provides services for adults in Los Lunas.

### **Review of Behavioral Health Services for Adult Offenders**

Jon R. Courtney, Ph.D., program evaluator at the Legislative Finance Committee (LFC), gave a presentation on adult corrections facilities and presented the subcommittee with an LFC report titled *Reducing Recidivism, Cutting Costs and Improving Public Safety in the Incarceration and Supervision of Adult Offenders*, which is included in the meeting file. The report recommends that the Corrections Department (CD) and the IBHPC move toward a system of evidence-based treatment programs and that the legislature consider legislation requiring that most funding go to such programs, with a four-year phase-in period. It also recommends that the CD, the IBHPC and OptumHealth work to expand the community-based provider network. Dr. Courtney also pointed out that the IBHPC should work to recover \$1 million in overpayments to OptumHealth for non-Medicaid services in FY 2010 and FY 2011.

On invitation of the chair, Aurora Sanchez, deputy secretary of corrections, clarified that the \$1 million in overpayments were, in part, a result of reporting and transition issues in 2010. The CD now has a full-time employee working to reconcile the account with OptumHealth.

- ★ Ms. McWilliams will provide projections for behavioral health spending in corrections facilities.

### **Southern New Mexico Crisis Intervention**

Ron Gurley, executive director of the Forensic Intervention Consortium of Dona Ana County, gave a presentation on crisis intervention in southern New Mexico. According to guidelines set by the National Association of the Mentally Ill, New Mexico needs an additional 400 inpatient psychiatric beds to adequately meet demand. Because of this lack of beds, many people needing psychiatric services end up housed in jails around the state. The Centennial Care waiver will allow for five-year demonstration projects, and Mr. Gurley suggests that the state redirect most of the Medicaid dollars spent on the mentally ill to an internal block grant demonstration project to be administered by local entities such as the Dona Ana County Local Behavioral Health Collaborative. The funds could be used for jail diversion programs, temporary housing, mobile crisis intervention services, family training, coverage for the uninsured and increased pay for providers. Mr. Gurley also noted that amendments are necessary in Chapter 43 NMSA 1978 to allow for assisted outpatient treatment and a 72-hour assessment period.

On questioning, Mr. Gurley and subcommittee members noted that county commissions have the authority to increase the threshold for indigent claims; Assertive Community Treatment programs are an alternative to jail for the mentally ill; and a treatment guardian can file an order of enforcement to get the police to deliver a mentally ill person to doctor appointments.

On invitation of the chair, Ms. McWilliams reported that:

- (1) New Mexico is ranked twenty-third in per capita spending on behavioral health at \$93.51; and
- (2) Centennial Care's provider penalties for avoidable payment delays are \$10,000 per month if performance is 75 percent to 94 percent and \$25,000 per month if performance is under 75 percent.

- ★ On a motion by Representative Kintigh, seconded by Senator Sanchez, the subcommittee unanimously voted to ask the IBHPC to meet with Mr. Gurley to address the needs he noted in his presentation.

### **Public Comment**

Earl Nissen, chair of the Teen Pregnancy Prevention Work Group of Dona Ana County, spoke in support of proposed funding to the DOH for behavioral health services at SBHCs in schools rated C, D or F.

Pamela Field, psychiatric nurse, spoke of the fragmented array of services available for the mentally ill in Dona Ana County and the need for more beds and more safe housing. She noted that Camp Hope is available to the homeless but not others.

There being no further business, the subcommittee adjourned at 5:40 p.m.

DISABILITIES CONCERNS SUBCOMMITTEE MINUTES

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

**October 9, 2012**

**Isleta/Jemez Room, Albuquerque Convention Center  
Albuquerque**

The second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Representative Antonio Lujan, chair, on October 9, 2012 at 9:40 a.m. in the Isleta/Jemez Room of the Albuquerque Convention Center.

**Present**

Rep. Antonio Lujan, Chair  
Sen. Nancy Rodriguez, Vice Chair  
Rep. Danice Picraux

**Absent**

Sen. Rod Adair  
Rep. Nora Espinoza  
Sen. Mary Kay Papen

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Rebecca Griego, Records Officer, LCS  
Theresa Rogers, Intern, LCS

**Guest Legislator**

Sen. Gerald Ortiz y Pino

**Guests**

Additional guests are included on the guest list in the meeting file.

**Handouts**

Handouts and other written testimony are in the meeting file.

**Tuesday, October 9**

**Welcome**

Anthony Cahill, Ph.D., director of disability and health policy at the University of New Mexico (UNM) School of Medicine, welcomed the subcommittee and thanked members for scheduling the meeting to coincide with the Southwest Conference on Disability at the convention center.

## **Home- and Community-Based Waiver Programs: Mi Via and Self Direction; Money Follows the Person**

Julie Weinberg, director, Medical Assistance Division, Human Services Department (HSD), gave an update on Medicaid home- and community-based services (HCBS) programs, including Mi Via and Money Follows the Person. New Mexico spends 80 percent of its long-term care dollars on HCBS programs, the highest percentage in the nation. In fiscal year 2012, the state spent \$42 million on the Mi Via Program and served 1,073 people, the majority of whom either are on the C waiver or have traumatic brain injuries. In order to transition from a nursing facility to HCBS under the current system, an individual must already occupy a C waiver slot; this requirement will disappear under Centennial Care, and managed care organizations (MCOs) will receive incentives to enroll people in HCBS. Centennial Care is designed to expand access to HCBS to all Medicaid-eligible persons who qualify for nursing facility level of care regardless of whether they are receiving it. In the case of those who must enter nursing facilities for any reason, MCOs contracted under Centennial Care will help them transition into HCBS.

On questioning, Ms. Weinberg and subcommittee members addressed the following concerns and topics.

*Coordinated Long-Term Services Program's C waiver.* The C waiver, formerly the "Disabled and Elderly waiver", is now named for the applicable section in the federal Social Security Act. The waiver must be budget-neutral. Two hundred fifty people on the waiver's waiting list have been moved into C waiver slots, and they were not required to enter a nursing facility first. A person qualifies for the C waiver if the person meets the nursing facility level of care and has an income too high to qualify for Medicaid on the basis of income.

*Centennial Care.* Participants receiving HCBS on the developmental disabilities (DD) waiver, as well as DD waiver participants enrolled in the Mi Via Program, will not be included in Centennial Care. The rest of the Mi Via Program will come under Centennial Care, where it is expected to double in enrollment. The medically fragile waiver will be included in Centennial Care. There are currently 12 Medicaid waiver programs. Centennial Care is designed to align Medicaid and Medicare services as a way to address New Mexico's fast-growing elderly population. The original Centennial Care waiver application referred to "benefit boundaries" for HCBS; however, this language was revised in the final version, which now ties the limit on HCBS to the cost of providing those services in a nursing facility. The Centers for Medicare and Medicaid Services found the revised Centennial Care waiver application in compliance with all transparency requirements and will rule on the application this month.

*HCBS.* Agencies contracting with the MCOs will provide HCBS. Care coordinators will work with participants and their guardians to find the necessary services and base their choices on need, not on cost reduction.

*Mi Via.* The Mi Via Program will be streamlined under Centennial Care; participants will be able to use an online system to simplify payments and payment requests. There has been a problem with some electronic checks being rejected, and the HSD is working with the federal government to replace the check system with a debit card system. Assessments under the Mi Via Program will be conducted by the MCOs. The Mi Via Program costs less than nursing facility care, which can cost \$4,000 to \$6,000 per month depending on the level of care needed.

*Personal care option.* Fourteen thousand to 17,000 Medicaid enrollees receive services under the personal care option.

*Medicaid budget, population and eligibility.* Fifty percent of the Medicaid budget goes to services for the elderly, the disabled and dual eligibles; these groups account for 17 percent of all Medicaid enrollees. Medicaid currently serves one in four people in New Mexico. The governor did not request that the eligibility level be reduced to 100 percent of the federal poverty level; however, the state did inquire of the federal Department of Health and Human Services whether Medicaid would still get federal funding if eligibility were set at 100 percent.

*Supports Intensity Scale (SIS).* A new rule was approved that adopts the SIS as the standard assessment tool for DD waiver participants. A person can appeal an SIS assessment, but such an appeal can be difficult for someone who is impaired. Full due process is available to anyone who appeals an assessment.

- ★ Marc Kolman, deputy director, Developmental Disabilities Supports Division (DDSD), Department of Health (DOH), will provide information on whether family members of DD waiver participants assessed at a B level on the SIS may be reimbursed as service providers.
- ★ Ms. Weinberg will provide information on how many people have appealed their SIS assessments.

### **Public Comment**

Nat Dean, a disability advocate speaking for herself and also on behalf of Vidya Karen Cicchini, spoke of the need to amend the state's law regarding assistance dogs to align it with language found in the federal Americans with Disabilities Act of 1990, which places clear requirements on handlers and prohibits certain dog behavior.

Gay Finlayson, autism programs education and outreach manager for the Center for Development and Disability at the UNM Health Sciences Center, informed the subcommittee that Representative Bill B. O'Neill will sponsor a bill in the upcoming legislative session to require that autism and Asperger's syndrome services be covered under state employee insurance plans. She also pointed out that these services need to be part of any health plan under the state's health insurance exchanges and that many individuals with Asperger's syndrome do not qualify for Medicaid.

Sheila Johnson, disability advocate, spoke in favor of imposing an income threshold for family members providing HCBS under the DD waiver in order to disqualify anyone who can afford to pay others to provide those services.

Doris Husted, public policy director for Arc of New Mexico, stated that spending 80 percent of the state's long-term care dollars on HCBS is not enough and that many developmentally disabled individuals are not enrolled in a waiver program and will need support under Centennial Care. She recommended that a disabilities supports advisory committee be created to advise the DOH on fixing the assessment and decision-making systems in Centennial Care as it is implemented. She also noted that any reassessments conducted now are under the old waiver rather than under Centennial Care, which will not be implemented until 2013.

Tanishar Gallegos thanked the subcommittee for its work and spoke of her work with a community outreach program for the deaf in Albuquerque.

#### **Advocates on HCBS: Self-Direction and Mi Via**

Ken Collins, program manager at the Gallup branch of the San Juan Center for Independence and vice chair of the Statewide Independent Living Council, presented concerns that independent living centers, which are operated by the Vocational Rehabilitation Division of the Public Education Department, were left out of the Centennial Care waiver development. He recommended that these centers take over the Mi Via Program because they are already helping participants with payment problems in the program. He also recommended that the reimbursement structure within Mi Via be changed so that money for services is given directly to the individuals, who would then be responsible for making payments themselves. Under the current system, services are paid for by third-party contractor Xerox, which does not always pay bills correctly or on time.

On questioning, Mr. Collins and subcommittee members addressed additional issues in the Mi Via Program. The program includes multiple layers of consultants, monitors and approvers, all of which are for-profit entities; it would be less expensive if the independent living centers provided these services. Hearings that should be held in person are often held over the telephone. The San Juan Center for Independence has helped many individuals submit their invoices for reimbursement to Xerox, but often no payment is made. Maximum reimbursable hours for services in the program do not take into account the realities of many rural areas; for example, bathing a person in a house with no plumbing takes longer because water must be heated on a stove, but that extra time is not reimbursed.

- ★ Senator Rodriguez suggested that Mr. Collins and Ms. Weinberg meet to discuss concerns regarding the independent living centers' involvement with Centennial Care and problems with payments under the Mi Via Program.
- ★ Senator Ortiz y Pino suggested that the subcommittee urge the HSD to create a debit card system for payments in the Mi Via Program, to be overseen by the independent living centers.

## **Public Comment**

Ms. Dean questioned the HSD's decision to withdraw New Mexico's grant application under the federal Money Follows the Person Program.

Peter Cubra, disability rights attorney, presented the subcommittee with a handout from the DDS explaining how its contractor, Human Research Institute (HRI), translates SIS scores into service packages for individuals on the DD waiver. Mr. Cubra applied the HRI process to 70 SIS reports and got different results, and he questioned the service package determinations made for those individuals.

Jim Jackson, executive director of Disability Rights New Mexico, reminded the subcommittee that the reason New Mexico spends 80 percent of its long-term care dollars on HCBS is because the legislature made the decision years ago to move the developmentally disabled out of state institutions and into the community. He also stated that there are still 17,000 individuals on the C waiver waiting list; 250 recently moved into C waiver slots, but those who do not meet the waiver's income requirements are leaving their community settings to enter nursing facilities in order to qualify for the waiver.

## **Disability History and Awareness Month**

On invitation of the chair, Shane Bower of New Mexico Disability Youth Leaders gave a presentation on his organization's efforts to find a legislative sponsor for a joint memorial declaring October as "Disability History and Awareness Month". He noted that his group has developed a curriculum for use in middle and high schools and is in the process of training teachers on the topic. The Albuquerque Public School District has already approved the curriculum and is helping to develop it further, and the Bloomfield School District has expressed an interest. The group has also spoken with the Bernalillo County Parks and Recreation Department. The curriculum can be modified for other age groups, and a basic template can be created for use in all school districts.

- ★ Senator Ortiz y Pino suggested that the joint memorial be expanded to include a clause stating that the curriculum has already been developed.

## **Equity in Long-Term Services and the Technical Assistance Program**

Jim Parker, director of the Governor's Commission on Disability (GCD), gave a presentation on the need to reconfigure and refocus long-term services and supports for people with disabilities. Instead of requiring that a person be on a waiver in order to receive services in a community setting, waivers should be required for a person to receive services in a nursing facility. The state should strive for equity in funding and reimbursements across all long-term services and supports waiver programs, with an emphasis on helping people with disabilities manage their own lives. The Mi Via Program has, over time, shifted control away from recipients and toward program administrators — at the same time the national trend has gone in the other direction, toward empowering recipients to take control of their own lives. Mr. Parker spoke against what he characterized as an "overprotective" model currently in place, saying it is

time to consider the "dignity of risk" for recipients. Mr. Parker also presented a list of nonprofit entities around the state that recently received quality of life grant awards from the GCD for programs that promote independence for people with disabilities.

Guy Surdi, disability specialist with the GCD, spoke about the New Mexico Technical Assistance Program (NMTAP), which moves this month from the Public Education Department's Vocational Rehabilitation Division to the GCD. The NMTAP receives federal funding for three small-loan programs that help people with disabilities purchase assistive technology and modify their homes. A fourth program gives donated computer equipment to people with disabilities. Public schools are supposed to make assistive devices available to students with disabilities, though the devices are not included in individual education plans. Assistive technologies include iPads, which now have prediction software that helps people communicate regardless of their ability to type. This sort of technology is critical to the success of long-term services and supports under the Centennial Care waiver, but the topic is not fully addressed in the waiver application. Both presenters spoke in favor of legislation to create a funding stream for the NMTAP so that high-cost items that are not covered by Medicaid, Medicare or the Department of Veterans Affairs can be purchased. A possible funding stream could be a \$5.00 fee for disabled parking placards.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*NMTAP.* The program was transferred to the GCD because the Public Education Department was charged with eliminating its ancillary programs. Medicare pays only for certain basic assistive devices. Training on the use of these devices is critical, but there is no funding stream for training. Even though schools are required to provide assistive technology information and services for students with disabilities, many school personnel and social workers are not aware that the technology exists. Assistive technology can make employment possible for people with disabilities; for example, a quadriplegic individual currently works from home as a monitor for four other people with disabilities via a camera system that feeds into his home. Many assistive devices are custom-made and language-appropriate, and some touch-screen devices can be programmed with demonstration videos of tasks the user must perform for daily living.

*Mi Via Program and independent living centers.* Moving administration of the Mi Via Program to the state's independent living centers would be a good financial move; the centers would need extensive training up front, but it would result in a better system. Portales and Silver City need independent living centers.

### **Voting Rights and Individuals Living with Disability**

Anthony Alarid, GCD architectural specialist, Mr. Hely and Mr. Jackson gave a presentation on challenges faced by people with disabilities when they vote. Mr. Alarid informed the subcommittee that, after first asking counties to thoroughly assess their polling places for

accessibility, the GCD conducted its own review of 1,200 polling places statewide and found barriers the counties had missed in their assessments. Many have been corrected, but some have not. One solution is to create centrally located voting centers that are fully accessible for people with disabilities, such as one found in Bernalillo County.

In rulings during the 1960s and 1970s, the U.S. Supreme Court recognized voting as a fundamental right and held that states cannot invidiously discriminate when setting voter qualifications; it also held that a state must show a compelling state interest if it is to prohibit certain persons from voting. The Americans with Disabilities Act of 1990 further requires that restrictions on voting be made on an individual basis. The Constitution of New Mexico includes language that bars "idiots" and "insane persons" from voting, and these terms have been used in the past to refer to people with developmental disabilities; however, "idiot" is not defined in the constitution or in statute, and state law requires that a certificate of insanity be filed with a county clerk before a person can be prohibited from voting for being "insane". If a disabled person's ability to vote is challenged at the polls, that person may still vote on a provisional paper ballot. People with disabilities may also be accompanied in the voting booth, with certain restrictions.

Disability Rights New Mexico works to protect voting rights for people with disabilities through outreach, voter registration, education and training. It also gives individual assistance to voters with disabilities and will have a group of poll watchers at various precincts on election day. Mr. Jackson expressed concerns about a push to require photo identification for voters, stating that obtaining such identification is difficult for people with disabilities. He also noted that there are very limited circumstances in which a person might be legally declared insane and, therefore, unable to vote.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*"Idiots" and "insane persons" language.* There have been three attempts to amend the Constitution of New Mexico to remove this language, but all have failed. The most recent attempt, in 2010, gained a majority of votes but failed to receive the three-fourths' majority necessary to amend that particular section of the constitution. The section is generally ignored for this and other provisions that do not apply anymore, such as the minimum voting age of 21 years old.

*Assistance dogs.* The GCD has not received calls complaining about assistance dogs at polling places; it does, however, train poll workers on the issue.

### **Public Comment**

Derek Scott of the Multiple Sclerosis (MS) Government Relations Committee spoke in favor of including MS in the Centennial Care waiver and urged the subcommittee to reject proposals that would have a negative impact on people with MS, such as income caps for MS services. He described housing difficulties for people with MS and urged the subcommittee to

strengthen tenant protection laws, including requiring that landlords get business licenses and be trained on disabilities issues.

Theresa O'Rourke, a family living provider, described the iPad as a much less expensive technology for people with disabilities than the DynaVox, which can cost as much as \$9,000.

Nannie Sanchez thanked the subcommittee for its support of the DD waiver and spoke of her SIS assessment coming in at a B level, which means she will no longer receive certain services.

**D** There being no further business, the subcommittee adjourned at 3:25 p.m.

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

**September 13, 2012  
State Capitol, Room 321  
Santa Fe**

The first meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Representative Antonio Lujan, chair, on September 13, 2012 at 9:15 a.m. in Room 321 of the State Capitol.

**Present**

Rep. Antonio Lujan, Chair  
Sen. Nancy Rodriguez, Vice Chair  
Rep. Nora Espinoza  
Sen. Mary Kay Papen

**Absent**

Sen. Rod Adair  
Rep. Danice Picraux

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Rebecca Griego, Records Officer, LCS

**Guest Legislators**

Sen. Dede Feldman  
Sen. Linda M. Lopez  
Sen. Howie C. Morales

**Guests**

Additional guests are included on the guest list in the committee file.

**Handouts**

Handouts and other written testimony are in the meeting file.

**Thursday, September 13**

**Concerns About the Developmental Disabilities (DD) Waiver Program**

Anna Otero-Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, Lisa Cisneros-Brow, M.S., speech and language pathologist with the Therapy Providers' Network, Laurie Ross-Brennan, speech and language pathologist, Peter

Cubra, attorney, and Joe Stone, New Mexico Waiver Provider's Association member, presented concerns regarding recent and proposed changes in the DD waiver program.

In spring 2012, as part of a two-year process of redesigning the DD waiver, the Developmental Disabilities Supports Division (DDSD) of the Department of Health (DOH) proposed cuts in the waiver program that would result in significant reductions in services. The announcement came immediately following adjournment of the 2012 legislative session, and the DD advocacy community, whose concerns about the redesign had already been largely ignored, was left with no opportunity to appeal the changes through the legislature.

In addition to proposed cuts in services, the DDSD began using the Supports Intensity Scale (SIS) assessment tool both to determine the level of supports needed by an individual and to allocate resources packaged into eight modules to match the eight levels of need within the SIS framework. Between the prepackaged services and the proposed cuts in the program, the DD population faces up to an 83 percent reduction in services. Some individuals already in the program have been rated by the SIS at a much higher level of independence/lower level of need than they were under previous assessments and have lost necessary services because of what their families feel are erroneous assessments. Advocates point to a lack of training for agency personnel in how to administer the SIS as one of the reasons for scoring errors; they also point out there is no formal process or time line in place for appealing SIS scores and assigned service packages.

There have been two reimbursement rate reductions in the DD waiver program in the past 10 years, leaving rates 32 percent behind inflation at this point. The recent "rate study" performed for the DOH by Burns and Associates was actually a "rate survey"; cost data were ignored when submitted by providers, and the proposed new rate structure does not reflect the true cost of providing services.

Mr. Cubra described and debunked five myths concerning the DD waiver program: (1) the state spends too much money on each person enrolled; (2) the state will assess needs and assign services in a scientific and precise way; (3) a person's SIS score alone determines the services group to which he or she will be assigned; (4) the service packages are adequate to serve the needs of those assigned to the group; and (5) no one will be harmed by the reduction in services. He presented SIS data from 1,881 New Mexico DD waiver participants showing that the state has a DD population with higher needs (mean score of 104.2) than the nation as a whole (mean score of 97.96). Based on these and other data, he questioned the DOH's assertion in its May 2012 Developmental Disabilities Medicaid Waiver Briefing Paper that "Results of the SIS assessments in New Mexico are statistically similar to the results of the SIS Norm Group and other states' SIS results, demonstrating a bell-shaped curve of the Supports Needs Index."

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*The SIS.* The Human Research Institute (HRI) recommended that New Mexico implement the SIS over a five-year period and that it begin by testing those on the DD waiting list, but neither recommendation was followed. When an SIS assessment is performed, the individual being tested may be accompanied by family members, guardians or other invitees. Many assessments are performed without advance notice to those other parties; for example, The Arc of New Mexico is legal guardian to nearly 200 individuals but is not notified when SIS assessments are performed. Many unaccompanied individuals cannot request a reassessment because they are either nonverbal or are unaware they are being assessed. SIS scores at the F or G level are sent through a verification committee, which decides either that the scores are valid or that a reduced service level is appropriate. Reassessments also go through the verification committee. The algorithm used in the scoring process is not released to anyone.

*Prior authorization.* Treatment for certain life-threatening conditions, such as aspiration, does not require prior authorization.

*Cuts in services and rates.* According to documents obtained via an Inspection of Public Records Act (IPRA) request, the Centers for Medicare and Medicaid Services (CMS) stated in May that New Mexico cannot reduce services or rates until it submits an amendment to its DD waiver application. The CMS must act on this amendment by October 1, 2012. The DOH stated that it will not reduce services sooner than March 1, 2013 and will hold meetings on the new services plan in January and February 2013. It is possible that the proposed cuts in the DD waiver would violate the Americans with Disabilities Act of 1990.

*DD waiver waiting list.* There are approximately 6,000 names on the waiting list, which needs cleaning because some people have died or moved. Those on the list who are Medicaid-eligible can get services through the disabled and elderly waiver or personal care option while on the DD waiting list. Some people have been dropped from the waiting list because they were unable to respond — in one case, because the person was nonverbal — when contacted by the DOH.

*Paid family caregivers.* Family members may be hired as paid caregivers in the DD waiver program. Depending on the level of care required by the developmentally disabled family member, the caregiver may be precluded from earning a living outside the home.

*Service providers.* All DD service providers in the state need to come together and present their concerns to the governor as a single group, giving suggestions on where they think cuts can be made without harming clients.

*Advisory Committee on Quality Supports for Individuals with Developmental Disabilities and Their Families (ACQ).* The ACQ, which was created to review and guide the DOH's development of supports and services for the DD population, has not met in a year. At one time, it had a subgroup that considered the SIS and supported its use.

Representative Espinoza suggested that the DOH clean up the DD waiver waiting list and provide the subcommittee with a list of DD services providers statewide.

- ★ Secretary of Health Catherine D. Torres will provide the subcommittee with the names of members who served on the ACQ subgroup that recommended using the SIS.

### **Public Comment**

Sheila Johnson, a home-based provider for her developmentally disabled daughter, told the subcommittee that her daughter's recent SIS erroneously rated her as able to live independently. When Ms. Johnson requested a reassessment, she was told she could not bring anyone; she was also told to "shut up" by the person who administered the original SIS.

Cecilia Garcia, who works with persons with disabilities, spoke of clients whose experience with the SIS was so degrading it brought them and their parents to tears, not because of the test itself but because of how it was administered. She acknowledged the need for cuts in the waiver program, but she does not support making cuts without input from providers.

Debra Frasca, director of community programs at Life Quest, Incorporated, in Silver City, told the subcommittee that Life Quest had to discontinue its supportive living services because it can no longer afford to provide these services due to current and proposed regulations and cuts in the DD waiver program.

Jim Shotwell, L.I.S.W., spoke of the SIS's tendency to miscategorize in a way that does not meet an individual's needs. He has met with the DOH and is concerned that the department does not see the long-term impact of the DD waiver changes on providers.

Rumaldo Ortiz, a family living provider, described how the proposed DD waiver changes would do away with family living services and require all providers to be hired by an employer of record. He described problems with this requirement and with certain application questions, and he requested that the state provide consultations to help people such as himself transition into the new system.

Doris Husted, public policy director for The Arc of New Mexico, stated that she was a member of the ACQ subgroup that chose the SIS and that she initially supported its use. Since that time, she has seen significant problems with the SIS, including instances in which her organization was told that an individual to be tested need not attend the test. The Arc of New Mexico has asked the DDS to address this and to address complaints from individuals and family members regarding personal and cultural disrespect during SIS tests.

Mike Kivitz, president and chief executive officer of Adelante Development Center, Incorporated, spoke of the disproportionate effect rate cuts will have on direct service providers, whose salaries are already low. He described the Burns and Associates "rate study" as flawed

and suggested that the needs of the DD population will not be served if rates are cut at the same time that service requirements are increased.

Greg Bundrick, L.I.S.W., presented a graph of the New Mexico SIS data broken out by group and described it as a chicken wing rather than a bell curve. He noted that the SIS is administered primarily by out-of-state contractors and that it would be less expensive and more culturally appropriate to have the test administered by New Mexico residents. He also stated that the DDS plans to change language in the New Mexico Administrative Code regarding the right to a fair hearing and that, according to the DDS, one's right to appeal a decision under the current DD waiver ends when the new waiver is adopted.

Mark Johnson, chief executive officer of Easter Seals El Mirador, suggested an across-the-board cut of eight percent in the DD waiver, with individuals and their families allowed to make the decision on what services to forgo and what services to continue.

Edward Kaul, chief executive officer of ARCA New Mexico, presented concerns about the accuracy of SIS scores and suggested that the algorithm used for scoring be made public.

#### **Update on the DD Waiver Program**

Secretary Torres and Cathy Stevenson, director of the DDS, gave a presentation on proposed changes in the DD waiver program. According to a time line presented to the subcommittee, redesign of the waiver program began in 2009 with stakeholder participation, and the CMS approved the state's waiver application in July 2011. Since that time, the SIS was adopted and Burns and Associates conducted a rate study in which only 18 percent of all providers in the state participated. The DOH also held community meetings on waiver changes, posted proposed regulations and rate changes for public comment and held a formal hearing on proposed regulations. By the end of the year, the DOH will finalize contracts with the American Association of Intellectual and Developmental Disabilities for administering the SIS, with Ascend Management Innovations for training in-state SIS assessors and with Molina Healthcare for prior authorization services. The DOH will also train providers on new service standards under the waiver and continue outreach to the DD community. Full implementation of the new DD waiver program will begin in January 2013, with all DD waiver participants enrolled in the new system by April 30, 2014.

The presenters noted that New Mexico's average cost of nearly \$75,000 per person in the home- and community-based services waivers through 2010 is the sixth-highest in the country. One goal of the new waiver is to use those resources to serve a larger population by adopting service packages linked to SIS ratings. They described each of the eight service packages as having three components: (1) a base budget, for which funding is capped by the individual's SIS group rating; (2) a professional services budget, which requires prior authorization and includes an annual cap for each service type; and (3) a budget for other services, which also caps each service type.

In closing, the presenters listed the DOH's responses to feedback from the rate study and proposed rate changes, ranging from making adjustments to allowable hours for certain services to changing certain milestone payments to hourly payments. They also reviewed the steps by which disputes will be resolved under the new waiver.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*The SIS.* It currently costs the state \$895 per person to administer the SIS; because this includes the cost of training, the cost will go down as assessors administer more tests. The state did not have the resources to administer the SIS to everyone on the DD waiver waiting list, as recommended by HRI; the DDS chose, instead, to administer it to those already enrolled in the program. Scores were not given to the first 500 individuals who were given the test because the process had not yet been validated; case managers now give raw scores to the tested individuals and their families. The algorithm that is used to determine what service package a person will receive based on the person's raw score is proprietary and not released. The DOH will post information on its web site to explain the testing and scoring process. The SIS is not the only assessment tool available, and some states develop their own. SIS data show New Mexico has a DD population with higher needs than the national average because initial enrollment in the waiver was prioritized to bring in those with the highest needs first.

*Reassessments.* Reassessment requests are handled through DOH regional offices. Requesting an SIS reassessment can be a burden for families. Providers are prohibited from requiring that someone be reassessed. Of the 2,000 individuals who have been assessed so far, 400 have requested a reassessment, and the DDS is contacting all of those individuals.

*Costs.* The new waiver was designed to be cost-neutral. The DOH does not yet know if there will be cost savings from implementing service packages, but it is projecting a savings of \$20 million in fiscal year 2016. The DOH will have some increases in administrative costs as more individuals are enrolled in the DD waiver program.

*Rate study.* The rate study was designed as a survey of both rates and the work force.

*Services.* Each individual's service package will focus on a primary therapy for a year, which can be changed if there is a change in condition during the year. Service package groups A and B cover high-functioning individuals who do not need family living services; if a person currently in a supportive living residence is assessed at either the A or B group level, that person must move out of the supportive living setting. The service packages do have some flexibility; however, per regulation, it is the individual's support team that makes the final decision on what services to include. The new waiver is aimed at providing appropriate services, not minimal services. There are no national DD services standards.

*Transition plans.* Contingency plans to cover transitions, such as a supportive living facility closing down, must be in place six months in advance.

*The ACQ.* The ACQ is currently being reappointed and new members vetted. It has not met in a year due to turnover. Members who do not agree with the DOH should be included.

*Funding for DD services.* The state should find additional funding for the DD waiver program. By dropping the annual per-person expenditure from \$75,000 to \$68,000 in order to cover individuals on the waiting list, the state will be providing services to one group with disabilities at the expense of another group with disabilities. The DOH has made a \$5 million budget request earmarked for moving people off the DD waiting list, some of whom have been on the list for enormous lengths of time.

Secretary Torres stated that all SIS assessors have been trained in cultural competencies and advised anyone who has had a problem with an assessor to contact the DOH. She said she has never heard of any problems with the SIS assessors but would meet with all of them and give them the subcommittee's concerns. Ms. Stevenson advised those who feel there is a discrepancy between their actual abilities and their SIS assessment to call the DDS.

On invitation of the chair, Mr. Cubra quoted the *State of the States Report* national average cost of \$524 per day for DD care in state institutions.

Representative Lujan stated for the record that the Human Services Department (HSD) was invited to testify as part of the DD waiver update presentation but refused, and he further stated that he finds this lack of cooperation with the legislature inexcusable. The legislature cannot perform its due diligence without complete information, which the presentation failed to provide because the HSD did not participate. He described the lack of cooperation as unfortunate and a poor reflection of how the state treats its most vulnerable population.

- ★ Ms. Stevenson will provide information on:
  1. the average monthly cost of home- and community-based care versus nursing home care; and
  2. the rate survey, which is also available online.
- ★ Secretary Torres will provide the subcommittee with a list of individuals who have requested reassessment, including verification that the DDS has contacted them.

### **Money Follows the Person**

Disability advocates Nat Dean, Daniel Eckman and Adam Shand gave an update on the Money Follows the Person (MFP) Program, which shifts Medicaid long-term care spending for the disabled and elderly from institutional care to home- and community-based services. The program was initiated as a federal demonstration grant in 2005 and renewed in 2010 as part of the federal Patient Protection and Affordable Care Act. It has yet to be implemented in New Mexico, however, despite the fact that the Money Follows the Person in New Mexico Act was

signed into law in 2006 and the state has received more than \$24 million in federal funding to implement it.

The HSD officially withdrew New Mexico from the MFP Program via a letter to the CMS dated May 31, 2012. Three months prior to sending the withdrawal letter, the HSD held a stakeholder meeting to gather input on implementing the program and on use of the federal grant funds; six weeks prior to sending the withdrawal letter, the HSD issued proposed rules for implementing the program. One week after sending its letter of withdrawal, the HSD held another stakeholder meeting, yet it did not mention at the meeting that it had already withdrawn New Mexico from the program; stakeholders discovered this fact a few days later in the course of an IPRA request on another matter. The HSD's stated reason for withdrawal was that it found the program incompatible with its pending Centennial Care waiver, despite making a presentation in 2011 to the Medicaid Advisory Committee indicating that the MFP Program would be a component of Centennial Care.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*MFP Program funding.* There is some money for the MFP Program in the HSD budget, though it is not a line item.

*MFP Program withdrawal.* The subcommittee chair and vice chair sent a letter to Secretary of Human Services Sidonie Squier requesting that she appear at the meeting to explain the withdrawal from the MFP Program. Secretary Squier refused to attend and responded that it was not cost-effective for New Mexico to accept the federal MFP money. There has been no press coverage on the withdrawal. The CMS might reinstate the grant if the HSD reconsiders its withdrawal and if the money has not already been allocated to another state.

On invitation from the chair, Jim Jackson, executive director of Disability Rights New Mexico, advised the subcommittee that:

- (1) there was no consumer involvement in the HSD's decision to withdraw from the MFP Program;
- (2) the federal MFP "grant money" was actually not a grant but was the combined amount of money the state would have received for several programs because of an increase in the state's federal match triggered by its participation in the MFP Program; and
- (3) the only path to receiving home- and community-based services through the Medicaid Disabled and Elderly waiver program is a 90-day stay in a nursing home and that even after the individual is released from the nursing home, the money does not follow the person but stays with the nursing home bed.

On invitation from the chair, Jim Parker, director of the Governor's Commission on Disability, spoke in favor of reversing how long-term care is perceived by establishing home- and

community-based services as the norm and nursing home care as the last resort. He noted that Texas has done a very good job implementing its MFP Program.

On invitation from the chair, Ms. Husted advised the subcommittee that the original MFP Program included the DD population in intermediate care facilities for the mentally retarded and that the eventual exclusion of this population from the program was a blatant attempt to keep them from moving into community settings.

**D** ★ Senator Lopez suggested that the subcommittee propose to the Legislative Health and Human Services Committee that it send a letter to the HSD asking whether the department conducted any evaluation of the need for the MFP Program before withdrawing, whether any documentation exists and how many people currently receiving institutional care would qualify to be moved to home- and community-based services under the MFP Program.

There being no further business, the subcommittee adjourned at 3:00 p.m.

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

**October 9, 2012**

**Isleta/Jemez Room, Albuquerque Convention Center  
Albuquerque**

The second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Representative Antonio Lujan, chair, on October 9, 2012 at 9:40 a.m. in the Isleta/Jemez Room of the Albuquerque Convention Center.

**Present**

Rep. Antonio Lujan, Chair  
Sen. Nancy Rodriguez, Vice Chair  
Rep. Danice Picraux

**Absent**

Sen. Rod Adair  
Rep. Nora Espinoza  
Sen. Mary Kay Papen

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Rebecca Griego, Records Officer, LCS  
Theresa Rogers, Intern, LCS

**Guest Legislator**

Sen. Gerald Ortiz y Pino

**Guests**

Additional guests are included on the guest list in the meeting file.

**Handouts**

Handouts and other written testimony are in the meeting file.

**Tuesday, October 9**

**Welcome**

Anthony Cahill, Ph.D., director of disability and health policy at the University of New Mexico (UNM) School of Medicine, welcomed the subcommittee and thanked members for scheduling the meeting to coincide with the Southwest Conference on Disability at the convention center.

## **Home- and Community-Based Waiver Programs: Mi Via and Self Direction; Money Follows the Person**

Julie Weinberg, director, Medical Assistance Division, Human Services Department (HSD), gave an update on Medicaid home- and community-based services (HCBS) programs, including Mi Via and Money Follows the Person. New Mexico spends 80 percent of its long-term care dollars on HCBS programs, the highest percentage in the nation. In fiscal year 2012, the state spent \$42 million on the Mi Via Program and served 1,073 people, the majority of whom either are on the C waiver or have traumatic brain injuries. In order to transition from a nursing facility to HCBS under the current system, an individual must already occupy a C waiver slot; this requirement will disappear under Centennial Care, and managed care organizations (MCOs) will receive incentives to enroll people in HCBS. Centennial Care is designed to expand access to HCBS to all Medicaid-eligible persons who qualify for nursing facility level of care regardless of whether they are receiving it. In the case of those who must enter nursing facilities for any reason, MCOs contracted under Centennial Care will help them transition into HCBS.

On questioning, Ms. Weinberg and subcommittee members addressed the following concerns and topics.

*Coordinated Long-Term Services Program's C waiver.* The C waiver, formerly the "Disabled and Elderly waiver", is now named for the applicable section in the federal Social Security Act. The waiver must be budget-neutral. Two hundred fifty people on the waiver's waiting list have been moved into C waiver slots, and they were not required to enter a nursing facility first. A person qualifies for the C waiver if the person meets the nursing facility level of care and has an income too high to qualify for Medicaid on the basis of income.

*Centennial Care.* Participants receiving HCBS on the developmental disabilities (DD) waiver, as well as DD waiver participants enrolled in the Mi Via Program, will not be included in Centennial Care. The rest of the Mi Via Program will come under Centennial Care, where it is expected to double in enrollment. The medically fragile waiver will be included in Centennial Care. There are currently 12 Medicaid waiver programs. Centennial Care is designed to align Medicaid and Medicare services as a way to address New Mexico's fast-growing elderly population. The original Centennial Care waiver application referred to "benefit boundaries" for HCBS; however, this language was revised in the final version, which now ties the limit on HCBS to the cost of providing those services in a nursing facility. The Centers for Medicare and Medicaid Services found the revised Centennial Care waiver application in compliance with all transparency requirements and will rule on the application this month.

*HCBS.* Agencies contracting with the MCOs will provide HCBS. Care coordinators will work with participants and their guardians to find the necessary services and base their choices on need, not on cost reduction.

*Mi Via.* The Mi Via Program will be streamlined under Centennial Care; participants will be able to use an online system to simplify payments and payment requests. There has been a problem with some electronic checks being rejected, and the HSD is working with the federal government to replace the check system with a debit card system. Assessments under the Mi Via Program will be conducted by the MCOs. The Mi Via Program costs less than nursing facility care, which can cost \$4,000 to \$6,000 per month depending on the level of care needed.

*Personal care option.* Fourteen thousand to 17,000 Medicaid enrollees receive services under the personal care option.

*Medicaid budget, population and eligibility.* Fifty percent of the Medicaid budget goes to services for the elderly, the disabled and dual eligibles; these groups account for 17 percent of all Medicaid enrollees. Medicaid currently serves one in four people in New Mexico. The governor did not request that the eligibility level be reduced to 100 percent of the federal poverty level; however, the state did inquire of the federal Department of Health and Human Services whether Medicaid would still get federal funding if eligibility were set at 100 percent.

*Supports Intensity Scale (SIS).* A new rule was approved that adopts the SIS as the standard assessment tool for DD waiver participants. A person can appeal an SIS assessment, but such an appeal can be difficult for someone who is impaired. Full due process is available to anyone who appeals an assessment.

- ★ Marc Kolman, deputy director, Developmental Disabilities Supports Division (DDSD), Department of Health (DOH), will provide information on whether family members of DD waiver participants assessed at a B level on the SIS may be reimbursed as service providers.
- ★ Ms. Weinberg will provide information on how many people have appealed their SIS assessments.

### **Public Comment**

Nat Dean, a disability advocate speaking for herself and also on behalf of Vidya Karen Cicchini, spoke of the need to amend the state's law regarding assistance dogs to align it with language found in the federal Americans with Disabilities Act of 1990, which places clear requirements on handlers and prohibits certain dog behavior.

Gay Finlayson, autism programs education and outreach manager for the Center for Development and Disability at the UNM Health Sciences Center, informed the subcommittee that Representative Bill B. O'Neill will sponsor a bill in the upcoming legislative session to require that autism and Asperger's syndrome services be covered under state employee insurance plans. She also pointed out that these services need to be part of any health plan under the state's health insurance exchanges and that many individuals with Asperger's syndrome do not qualify for Medicaid.

Sheila Johnson, disability advocate, spoke in favor of imposing an income threshold for family members providing HCBS under the DD waiver in order to disqualify anyone who can afford to pay others to provide those services.

Doris Husted, public policy director for Arc of New Mexico, stated that spending 80 percent of the state's long-term care dollars on HCBS is not enough and that many developmentally disabled individuals are not enrolled in a waiver program and will need support under Centennial Care. She recommended that a disabilities supports advisory committee be created to advise the DOH on fixing the assessment and decision-making systems in Centennial Care as it is implemented. She also noted that any reassessments conducted now are under the old waiver rather than under Centennial Care, which will not be implemented until 2013.

Tanishar Gallegos thanked the subcommittee for its work and spoke of her work with a community outreach program for the deaf in Albuquerque.

#### **Advocates on HCBS: Self-Direction and Mi Via**

Ken Collins, program manager at the Gallup branch of the San Juan Center for Independence and vice chair of the Statewide Independent Living Council, presented concerns that independent living centers, which are operated by the Vocational Rehabilitation Division of the Public Education Department, were left out of the Centennial Care waiver development. He recommended that these centers take over the Mi Via Program because they are already helping participants with payment problems in the program. He also recommended that the reimbursement structure within Mi Via be changed so that money for services is given directly to the individuals, who would then be responsible for making payments themselves. Under the current system, services are paid for by third-party contractor Xerox, which does not always pay bills correctly or on time.

On questioning, Mr. Collins and subcommittee members addressed additional issues in the Mi Via Program. The program includes multiple layers of consultants, monitors and approvers, all of which are for-profit entities; it would be less expensive if the independent living centers provided these services. Hearings that should be held in person are often held over the telephone. The San Juan Center for Independence has helped many individuals submit their invoices for reimbursement to Xerox, but often no payment is made. Maximum reimbursable hours for services in the program do not take into account the realities of many rural areas; for example, bathing a person in a house with no plumbing takes longer because water must be heated on a stove, but that extra time is not reimbursed.

- ★ Senator Rodriguez suggested that Mr. Collins and Ms. Weinberg meet to discuss concerns regarding the independent living centers' involvement with Centennial Care and problems with payments under the Mi Via Program.
- ★ Senator Ortiz y Pino suggested that the subcommittee urge the HSD to create a debit card system for payments in the Mi Via Program, to be overseen by the independent living centers.

## **Public Comment**

Ms. Dean questioned the HSD's decision to withdraw New Mexico's grant application under the federal Money Follows the Person Program.

Peter Cubra, disability rights attorney, presented the subcommittee with a handout from the DDS explaining how its contractor, Human Research Institute (HRI), translates SIS scores into service packages for individuals on the DD waiver. Mr. Cubra applied the HRI process to 70 SIS reports and got different results, and he questioned the service package determinations made for those individuals.

Jim Jackson, executive director of Disability Rights New Mexico, reminded the subcommittee that the reason New Mexico spends 80 percent of its long-term care dollars on HCBS is because the legislature made the decision years ago to move the developmentally disabled out of state institutions and into the community. He also stated that there are still 17,000 individuals on the C waiver waiting list; 250 recently moved into C waiver slots, but those who do not meet the waiver's income requirements are leaving their community settings to enter nursing facilities in order to qualify for the waiver.

## **Disability History and Awareness Month**

On invitation of the chair, Shane Bower of New Mexico Disability Youth Leaders gave a presentation on his organization's efforts to find a legislative sponsor for a joint memorial declaring October as "Disability History and Awareness Month". He noted that his group has developed a curriculum for use in middle and high schools and is in the process of training teachers on the topic. The Albuquerque Public School District has already approved the curriculum and is helping to develop it further, and the Bloomfield School District has expressed an interest. The group has also spoken with the Bernalillo County Parks and Recreation Department. The curriculum can be modified for other age groups, and a basic template can be created for use in all school districts.

- ★ Senator Ortiz y Pino suggested that the joint memorial be expanded to include a clause stating that the curriculum has already been developed.

## **Equity in Long-Term Services and the Technical Assistance Program**

Jim Parker, director of the Governor's Commission on Disability (GCD), gave a presentation on the need to reconfigure and refocus long-term services and supports for people with disabilities. Instead of requiring that a person be on a waiver in order to receive services in a community setting, waivers should be required for a person to receive services in a nursing facility. The state should strive for equity in funding and reimbursements across all long-term services and supports waiver programs, with an emphasis on helping people with disabilities manage their own lives. The Mi Via Program has, over time, shifted control away from recipients and toward program administrators — at the same time the national trend has gone in the other direction, toward empowering recipients to take control of their own lives. Mr. Parker spoke against what he characterized as an "overprotective" model currently in place, saying it is

time to consider the "dignity of risk" for recipients. Mr. Parker also presented a list of nonprofit entities around the state that recently received quality of life grant awards from the GCD for programs that promote independence for people with disabilities.

Guy Surdi, disability specialist with the GCD, spoke about the New Mexico Technical Assistance Program (NMTAP), which moves this month from the Public Education Department's Vocational Rehabilitation Division to the GCD. The NMTAP receives federal funding for three small-loan programs that help people with disabilities purchase assistive technology and modify their homes. A fourth program gives donated computer equipment to people with disabilities. Public schools are supposed to make assistive devices available to students with disabilities, though the devices are not included in individual education plans. Assistive technologies include iPads, which now have prediction software that helps people communicate regardless of their ability to type. This sort of technology is critical to the success of long-term services and supports under the Centennial Care waiver, but the topic is not fully addressed in the waiver application. Both presenters spoke in favor of legislation to create a funding stream for the NMTAP so that high-cost items that are not covered by Medicaid, Medicare or the Department of Veterans Affairs can be purchased. A possible funding stream could be a \$5.00 fee for disabled parking placards.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*NMTAP.* The program was transferred to the GCD because the Public Education Department was charged with eliminating its ancillary programs. Medicare pays only for certain basic assistive devices. Training on the use of these devices is critical, but there is no funding stream for training. Even though schools are required to provide assistive technology information and services for students with disabilities, many school personnel and social workers are not aware that the technology exists. Assistive technology can make employment possible for people with disabilities; for example, a quadriplegic individual currently works from home as a monitor for four other people with disabilities via a camera system that feeds into his home. Many assistive devices are custom-made and language-appropriate, and some touch-screen devices can be programmed with demonstration videos of tasks the user must perform for daily living.

*Mi Via Program and independent living centers.* Moving administration of the Mi Via Program to the state's independent living centers would be a good financial move; the centers would need extensive training up front, but it would result in a better system. Portales and Silver City need independent living centers.

### **Voting Rights and Individuals Living with Disability**

Anthony Alarid, GCD architectural specialist, Mr. Hely and Mr. Jackson gave a presentation on challenges faced by people with disabilities when they vote. Mr. Alarid informed the subcommittee that, after first asking counties to thoroughly assess their polling places for

accessibility, the GCD conducted its own review of 1,200 polling places statewide and found barriers the counties had missed in their assessments. Many have been corrected, but some have not. One solution is to create centrally located voting centers that are fully accessible for people with disabilities, such as one found in Bernalillo County.

In rulings during the 1960s and 1970s, the U.S. Supreme Court recognized voting as a fundamental right and held that states cannot invidiously discriminate when setting voter qualifications; it also held that a state must show a compelling state interest if it is to prohibit certain persons from voting. The Americans with Disabilities Act of 1990 further requires that restrictions on voting be made on an individual basis. The Constitution of New Mexico includes language that bars "idiots" and "insane persons" from voting, and these terms have been used in the past to refer to people with developmental disabilities; however, "idiot" is not defined in the constitution or in statute, and state law requires that a certificate of insanity be filed with a county clerk before a person can be prohibited from voting for being "insane". If a disabled person's ability to vote is challenged at the polls, that person may still vote on a provisional paper ballot. People with disabilities may also be accompanied in the voting booth, with certain restrictions.

Disability Rights New Mexico works to protect voting rights for people with disabilities through outreach, voter registration, education and training. It also gives individual assistance to voters with disabilities and will have a group of poll watchers at various precincts on election day. Mr. Jackson expressed concerns about a push to require photo identification for voters, stating that obtaining such identification is difficult for people with disabilities. He also noted that there are very limited circumstances in which a person might be legally declared insane and, therefore, unable to vote.

On questioning, the presenters and subcommittee members addressed the following concerns and topics.

*"Idiots" and "insane persons" language.* There have been three attempts to amend the Constitution of New Mexico to remove this language, but all have failed. The most recent attempt, in 2010, gained a majority of votes but failed to receive the three-fourths' majority necessary to amend that particular section of the constitution. The section is generally ignored for this and other provisions that do not apply anymore, such as the minimum voting age of 21 years old.

*Assistance dogs.* The GCD has not received calls complaining about assistance dogs at polling places; it does, however, train poll workers on the issue.

### **Public Comment**

Derek Scott of the Multiple Sclerosis (MS) Government Relations Committee spoke in favor of including MS in the Centennial Care waiver and urged the subcommittee to reject proposals that would have a negative impact on people with MS, such as income caps for MS services. He described housing difficulties for people with MS and urged the subcommittee to

strengthen tenant protection laws, including requiring that landlords get business licenses and be trained on disabilities issues.

Theresa O'Rourke, a family living provider, described the iPad as a much less expensive technology for people with disabilities than the DynaVox, which can cost as much as \$9,000.

Nannie Sanchez thanked the subcommittee for its support of the DD waiver and spoke of her SIS assessment coming in at a B level, which means she will no longer receive certain services.

**D** There being no further business, the subcommittee adjourned at 3:25 p.m.

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

**November 9, 2012  
State Capitol, Room 321  
Santa Fe**

The third and final meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee was called to order by Senator Nancy Rodriguez, vice chair, on November 9, 2012 at 10:10 a.m. in Room 321 of the State Capitol in Santa Fe.

**Present**

Sen. Nancy Rodriguez, Vice Chair  
Sen. Rod Adair

**Absent**

Rep. Antonio Lujan, Chair  
Rep. Nora Espinoza  
Sen. Mary Kay Papen  
Rep. Danice Picraux

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Kathleen Dexter, Researcher, LCS  
Rebecca Griego, Records Officer, LCS  
Theresa Rogers, Intern, LCS

**Guest Legislators**

Rep. James Roger Madalena  
Sen. Gerald Ortiz y Pino

**Guests**

Additional guests are included on the guest list in the meeting file.

**Handouts**

Handouts and other written testimony are in the meeting file.

**Friday, November 9**

**Concerns Regarding the State Medical Cannabis Program**

Steven Jenison, M.D., chair of the Medical Advisory Board to the New Mexico Medical Cannabis Program, was unable to attend the meeting, so his presentation was canceled.

## **Medical Cannabis Fund and Programming Status Update**

Ken Groggel, manager, Department of Health (DOH) Medical Cannabis Program, and Chris Woodward, assistant general counsel, DOH, gave an update on the Medical Cannabis Program. Since its inception in July 2007, the program has grown to include more than 8,000 active patients, with more than 3,000 of those patients holding personal production licenses. Monthly enrollment increased substantially in the past three years — after holding steady at fewer than 20 new patients per month for the first two years of the program, enrollment now averages nearly 350 new patients per month. Patients enrolled in the program live in all of the state's counties and are being treated for nearly 20 different conditions, the most common being posttraumatic stress disorder, chronic pain and cancer.

On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*Cannabis producers.* Aside from patients who have obtained personal production licenses that allow them each to grow four mature plants and up to 12 seedlings, there are 23 licensed nonprofit producers in the state, each authorized to cultivate up to 150 mature plants. Former Secretary of Health Catherine Torres denied all pending producer applications in 2012 based on a DOH assessment that demand for cannabis within the program was being met by the current producers. Some of the applicants who were denied have filed suit against the DOH. There have been no audits to date of personal production licensees.

*Eligibility.* Eligibility for the program is determined through diagnosis by a licensed medical professional; diagnoses by alternative medical personnel are not valid. A qualifying patient receives a medical cannabis identification card that must be renewed annually by the patient's physician.

- ★ Mr. Groggel will check to see if cultural or ethnic data exist regarding enrollees in the Medical Cannabis Program.

## **Public Comment**

David Schmidt of the Drug Policy Alliance informed the subcommittee that the alliance meets monthly to discuss concerns about the Medical Cannabis Program and report those concerns to the DOH. He stated that the adequacy of the cannabis supply is questionable given the number of new patients entering the program monthly, and he suggested that the most effective way to increase supply immediately would be to increase the number of plants each producer is allowed to grow.

Sheila Johnson, whose developmentally disabled daughter was recently scheduled for a Supports Intensity Scale (SIS) reassessment, reported to the subcommittee that she was told not to bring any of her daughter's support providers, including medical personnel.

Cecilia Garcia, a developmental disabilities (DD) services provider, noted that the DOH is proceeding with its new SIS-determined supports structure without giving families and DD services providers any budget information that would allow them to plan for services. She also noted that the SIS is being administered by nonprofessionals and that she has seen job postings on craigslist.org for people with no DD training to work as SIS administrators.

Jessica Gelay, policy coordinator for the Drug Policy Alliance, described for the subcommittee some of the complexities involved in ensuring an adequate supply of medical cannabis, noting that a chronic pain patient who uses medical cannabis to make a topical salve needs more cannabis than is allowed under the personal production license.

### **Governor's Commission on Disability (GCD) Legislative Update and Technology Assistance Program**

Jim Parker, director of the GCD, and Mr. Hely reviewed legislation proposed by the GCD for the 2013 legislative session and the status of the Technology Assistance Program, which moved from the DOH to the GCD in October.

Legislation proposed by the GCD includes:

- (1) a bill amending the Assistance Animal Act to rename it the "Service Animal Act" and conform its language to federal law;
- (2) a bill to provide for administrative and replacement fees for certain disability motor vehicle placards, with a portion of the fees appropriated to the Disability Fund for purchasing assistive technology; and
- (3) a joint memorial declaring October as "Disability History and Awareness Month".

Mr. Parker also presented recommendations from the task force convened pursuant to House Memorial 111 (2009) regarding disabled parking and from the State Use Act Task Force regarding state contracts with people with disabilities and membership on the State Purchasing Council.

On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*Service animal certification.* Service animals are trained, but no certification is required.

*Disability placard fees.* Placard fees directed to the Disability Fund might be construed as a "tax by another name", and the bill could be challenged on that point unless the title is amended to reflect the tax aspect. A similar fee in Florida was challenged because the collected fees went into the state's general fund. In New Mexico, the collected fees would go into the Disability Fund and benefit people with disabilities rather than serve as a general state revenue stream.

- ★ Senator Rodriguez and Representative Madalena will sponsor the joint memorial designating October as Disability History and Awareness Month.
- ★ Senator Rodriguez and Representative Madalena will sponsor the Service Animal Act bill, and Jim Parker will provide talking points.

### **State Use Act**

Nancy Bearce, executive director, Horizons of New Mexico, Mike Kivitz, president and chief executive officer (CEO), Adelante Development Center, and Ron Edwards, owner of Focus Advertising Specialties, gave an update on the State Use Act. Enacted in 2005, the State Use Act gives preferences in state contracting to people with disabilities and requires that 75 percent of the labor within any given contract be performed by people with disabilities. As the designated central nonprofit agency under the act, Horizons of New Mexico (formerly New Mexico Abilities) promotes and secures employment for people with disabilities by helping them negotiate state contracts. It also acts as a financial intermediary between contractors and the state by paying contractors for their work within 14 days of invoicing, then waiting for reimbursement from the state for those payments. Horizons receives no operational funding from the state for its services; its revenue derives from a 5% administrative fee added to the contracts it manages. There are currently 110 contractor members under Horizons providing employment for 351 people with disabilities, with 90 current contracts totaling nearly \$7.5 million.

On questioning, the presenters clarified that the contracts issued through the State Use Act are for services (such as paper shredding and document scanning) and that the Department of Finance and Administration has interpreted the act to mean that Horizons and its members have the right of first refusal on all state services contracts.

On invitation of the chair, Jim Jackson, executive director of Disability Rights New Mexico, noted that the vast majority of the dollar value for state contracts under the State Use Act go to a few large nonprofits that employ people with disabilities, and he recommended that the contracts be spread around more to include individual contractors. He also related the recent exposé of a Carlsbad-based nonprofit whose CEO was earning \$1 million in salary while the people with disabilities who worked for him were earning minimum wage.

### **Microboards and Employment Initiatives for Individuals Living with Disabilities**

Nannie and Rosemarie Sanchez, disabilities advocates, gave a presentation on establishing microboards for individuals with disabilities and on employment initiatives. Following a year of meetings with the New Mexico Waiver Provider's Association (NMWPA), the Bernalillo County Commission agreed to appropriate \$100,000 for five positions within county government for individuals with disabilities; the provider association is following up with a training program for both the new employees and their employers. Such employment opportunities help individuals with disabilities become active and self-sufficient members of the community at large. To ensure transparency in the allocation of funds for disabilities services, the NMWPA suggests that the legislature create a disability oversight subcommittee of the

Disabilities Concerns Subcommittee, with both legislator and non-legislator members, to oversee services provided to individuals with disabilities.

Parents who are concerned that disability services for their children continue uninterrupted after the parents die can establish a "microboard" — a three- to five-person group that serves as an alternative to guardianship. While microboards are becoming more common in the U.S. and other states recognize microboards in statute, New Mexico does not. Nannie Sanchez is the only individual with a disability in New Mexico who has a microboard.

### **Employment for Blind Individuals and Individuals Living with Disabilities**

Ralph Vigil, acting director of the Vocational Rehabilitation Division (DVR) of the Public Education Department, and Greg Trapp, executive director of the Commission for the Blind, gave a presentation on employment opportunities for individuals with disabilities, including the blind. The DVR has three employment programs for individuals with disabilities: the centers for independent living; the Disabilities Determination Services Program; and vocational rehabilitation. The Disabilities Determination Services Program is funded entirely with federal money and, as such, is vulnerable to cuts if the federal government goes off the so-called "fiscal cliff". The Vocational Rehabilitation Program is now having to prioritize by disability severity rather than by time on the waiting list, in part because of a funding shortage. The program has a 23% staff vacancy rate that might be reduced to 10% by the end of 2012. A cost-benefit analysis of employment programs for individuals with disabilities shows that \$1.00 of state spending results in \$3.00 of savings, as these individuals become less dependent on social services.

Programs within the Commission for the Blind have helped 450 people find employment, a success rate that places New Mexico tenth among all states for the ratio of blind people who are employed. The commission has an independent living program and offers training for individuals as they transition into employment. The Technology for Children Program, which is jointly administered by the commission and the DOH, provides assistive technology for blind children. The Randolph-Sheppard Act Program — a contract under the State Use Act — employs blind individuals as food vendors in state and federal properties, including Kirtland Air Force Base. Despite the success of these and other programs, the unemployment rate for individuals who are blind or have other disabilities is very high — 15% in 2011 — in part because of relatively low participation.

- ★ Mr. Vigil will follow up with an audience member who has a disability and has had difficulty getting a response from the DVR regarding a computer she needs for employment. Mr. Kivitz will meet with her regarding the Back in Use Computer Recycling Program through the GCD.

### **Guardianships and Conservatorships**

Marsha Shasteen, an attorney with the Senior Citizens' Law Office, Leonie Rosenstiel, Ph.D., M.P.H., guardianship advocate, and Fern J. Goodman, general counsel at the

Administrative Office of the Courts (AOC), gave a presentation on issues relating to guardianships and conservatorships. While guardianships were originally conceived as a way to protect the elderly and individuals with disabilities from abuse and exploitation, some guardianship arrangements themselves become abusive and exploitative. Efforts to expose such problems are hampered by statutory provisions that impose secrecy on guardianship proceedings and courts that either limit the parties who are able to participate or give greater weight to a guardian's testimony than to others speaking on behalf of a protected person. The presenters recommended various changes to New Mexico statute to provide better protection for those under guardianship and pointed to Massachusetts and Florida as two states that have already amended their statutes in this way.

House Memorial 61 (2012) requested that the AOC conduct criminal background and credit checks on and annually track guardians and conservators. The AOC has one part-time employee dedicated to these tasks and, as of December, will have all courts statewide using an automated reporting system that facilitates tracking of guardians and conservators. A pilot study auditing guardianship cases in the Second Judicial District revealed many alarming situations and the need for a comprehensive monitoring system.

On questioning, the presenters and subcommittee members addressed the following topics and concerns.

*Guardianship arrangements.* The protected person retains all legal rights that are not assigned to the guardian. The guardian controls family access to the protected person, and a family must go to court to override a guardian's denial of access. Guardianships can be ordered by a court in a variety of circumstances, including cases of abuse or neglect by family members. Unlike a power of attorney, which can be revoked by the issuer, a guardianship arrangement can only be changed by court action.

*Guardianship statutes.* Under New Mexico statute, a guardian has the authority to treat the protected person as a minor child. Arizona statute requires reports from guardians; New Mexico statute does not. New Mexico requires monitoring of group homes but not of private guardianships. New Mexico does not require that guardians be bonded or certified, and the New Mexico Guardianship Association is working to change this.

On invitation of the chair, Mr. Jackson noted that Disability Rights New Mexico worked unsuccessfully to reform state statutes in 2009 to require reporting from guardians and to strengthen the role of guardians ad litem.

- ★ Frank Fajardo, director of the Guardianship Program at the Developmental Disabilities Planning Council (DDPC), will provide information on guardians of last resort through the DDPC.

## Public Comment

Tim Carver, chief financial officer for the San Juan Center for Independence in Farmington, spoke of the problems caused by funding cuts since 2009 and urged the subcommittee to restore funding for independent living services to fiscal year 2009 levels.

Jenna Vizcaya, a behavioral support consultant, spoke about a culture of negligence caused by a weak protective services system in the state; conflict of interest among medical personnel who are used as expert witnesses in guardianship proceedings while under contract to guardianship agencies; diminished information in health records since enactment of the federal Health Information Portability and Accountability Act of 1996; and high staff turnover in group homes.

Stuart Stein, an attorney, presented seven recommended amendments to guardianship statutes pertaining to sequestration, reports, guardians ad litem and statutory priority of interested parties. A list of his recommendations appears in the meeting file.

Marsha Southwick expressed concern about the overly broad statutory control granted to guardians over a person and the person's estate.

Senator Rodriguez read written statements submitted by two members of the public who remained anonymous for fear of reprisal as they point out problems their families have had with guardianship arrangements. Copies of their statements appear in the meeting file.

Venus Masci spoke about problems she has had with her mother's conservator, whom she is taking to court. She noted that a conservator has full authority over a person's finances and that an irrevocable will can be changed by the settlor.

Doris Husted, public policy director for the Arc of New Mexico, informed the subcommittee that the court decides when a person needs both a guardian and a conservator and that some guardians do not charge for their guardianship services.

Ms. Shasteen noted that special needs trusts can be established for certain expenses.

RubyAnn Esquibel, principal analyst with the Legislative Finance Committee, reported that the Office of Guardianship of the DDPC has a \$4 million budget for court-ordered guardians of last resort.

Joe Bob Nunez pointed out that family members can only dispute or alter a guardianship arrangement if they have the money to go to court over the matter.

Having no further business, the subcommittee adjourned at 5:30 p.m.

ENDORSED LEGISLATION

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Legislative Health and Human Services Committee  
2013 Endorsed Legislation

	202 #	Topic or Short Title	Description	Appropriation?	Sponsor
1	190233.1	Anesth. Assistants	Allow anesthesiologist assistants to practice statewide	No	S. Cisneros
2	190299.1	Credentialing entity	Single statewide entity for HMO provider credentialing	No	S. Ortiz y Pino
3	190336.2SA	Service Animal Act	Rename Assist. Animal Act to Service Anim. Act; dogs & horses only	No	S. Rodriguez
4	190337.2	Placards fees	Disabilities placard fees to disability & MVS funds	No	R. Mig. Garcia
5	190445.2	HIA-based HIX	Health Ins. Alliance as health ins. exchange (HIX)	No	R. Stewart
6	190447.2	Small empl. 1 to 100	Change def. of "small employer" to include 1-100 employees	No	
7	190449.1	Single-risk pool	Specifies a single-risk pool for all health insurance in state	No	
8	190454.1	Uninsured charges	Limits charges for uninsured patients to 115%/Medicare	No	S-E. O'Neill
9	190455.1	Fund DV prevention	\$4 million to coalition against domestic violence	Yes	S. Lopez
10	190457.1	SM: FF workplace	SM requesting continuation of family-friendly workplace study	No	S. Rue
11	190458.2	Family-friendly work	\$75,000 to BBER for family-friendly workplace TF & awards	Yes	S. Rue
12	190459.1	ASC inspections	\$250,000 to DOH to inspect ambulatory surgical centers	Yes	S. Ortiz y Pino
13	190460.1	Home visiting	CYFD to offer home visiting statewide regardless of income, etc.	Yes	S. Ortiz y Pino
14	190462	Medicaid EOB	Require HSD to send Medicaid recipients explanations of benefits	No	S. Ortiz y Pino
15	190480.1	Large employer @ HIX	After 2017, large employers may purchase on HIX	No	S. Lopez
16	190481.2	Ins. Code changes	Changes to Insurance Code to conform to federal PPACA	No	R. Stewart
17	190484.2	Medicaid expansion	Expand Medicaid up to 238% FPL for "childless adults" per PPACA	No	S. Keller
18	190658.1	Autism benefits	Mandates state employee health plan coverage for autism	No	S-E. O'Neill
19	190667.2	Dental therapy	Amend Dental Health Care Act & other laws for dental therapy	No	R. Roch
20	190690.1	ASC infections	Require providers to comply w/CDC guidelines re: amb. surgical ctrs.	No	R. Stewart
21	190691.1SA	UNM telemedicine	\$1.6 million to fund project ECHO	Yes	S. Beffort
22	190692.2	Health Security Act	Health Security Act -- single-payer health care	No	S. Cisneros
23	190699.1	Mem.: ASC cont. ed.	Memorial: Lic. boards prof. edu. on amb. surg. ctr. inf. control	No	R. Stewart
24	190705.1	UNM med school	\$1,342,900 to retain faculty at UNM med school	Yes	S. Beffort
25	190706.1	UNM nursing school	\$2,881,700 to UNM HSC to add 24 new student slots in FY 2014 & 2015	Yes	S. Beffort
26	190707.1	UNM BA/DDS program	\$400,000 to UNM HSC to fund bachelors-to-DDS program	Yes	R. Mig. Garcia
27	190708.1	UNM CWA	Center for health workforce analysis and IT	Yes	S-E. Candelaria
28	190710.1	UNM HERO	\$496,600 for UNM health extension offices (HERO program)	Yes	S. Ortiz y Pino
29	190711.1	UNM OMI funding	\$565,100 to Office of the Med. Investigator for transport & utilities	Yes	S. Kernan
30	190712.1	UNM public health	\$250,000 to UNM to plan college of public health	Yes	R. Stewart
31	190726.1	UNM dev. delay	\$2.2 million to UNM for dev. delay centers of excellence	Yes	S-E. Candelaria
32	190729.1	DOH school health	\$1 million to DOH to fund school-based health centers	Yes	S. Lopez

Legislative Health and Human Services Committee  
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33	190731.1	Adult day care	\$1 million to ALTSD to fund adult day care in areas of central NM	Yes	S. Lopez
34	190732.1	Sexual assault svc.	\$1 million to DOH for sexual assault services, training, prevention	Yes	S. Lopez
35	190739.1	Teen pregnancy	\$500,000 to DOH to fund prevention program to prevent teen births	Yes	S. Lopez
36	190753.1	Preg. women SA svc.	Licensure only for sub. abuse facilities offering parity for preg. women	Yes	S. Lopez

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