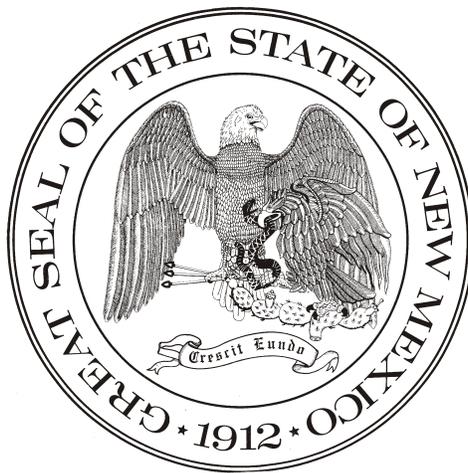


**Legislative Health and Human Services  
Committee**

**2011  
INTERIM REPORT**



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

# **2011 INTERIM REPORT LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

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## **EXECUTIVE SUMMARY AND LEGISLATIVE PROPOSALS**

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## SUMMARY

The Legislative Health and Human Services Committee (LHHS) focused on the following major areas this interim: Medicaid; health care reform implementation; and agency oversight.

The Human Services Department's (HSD) cabinet secretary, staff and contractors presented during the interim on the HSD's proposal to redesign the state's Medicaid program and to update its information technology systems to accommodate the Medicaid program changes, as well as a possible state health insurance exchange. The committee received testimony from experts, stakeholders, community advocates and the general public on elements of the proposed Medicaid redesign, though the HSD did not commit to any concrete features of the redesign during the interim.

The committee reviewed the actions taken to implement the federal Patient Protection and Affordable Care Act of 2010 (PPACA). It held extensive hearings on the possibility of creating a state health insurance exchange. It heard testimony from community stakeholders and the New Mexico Office of Health Care Reform, as well as other state agencies and out-of-state experts on PPACA-inspired health care delivery and finance changes; health insurance mandates and rate review; changes to the New Mexico Insurance Code and the potential for enacting legislation pursuant to the PPACA to create new health care coverage for low-income individuals who are not eligible for Medicaid; attendant care services for disabled individuals eligible for Medicaid; and a nonprofit health care coverage plan to be offered on a state health insurance exchange.

In fulfillment of the committee's oversight role, the cabinet secretaries and staff of the Aging and Long-Term Services Department, the Children, Youth and Families Department, the Department of Health (DOH), the HSD and the Workforce Solutions Department presented status reports and legislative recommendations before the committee throughout the interim.

The committee also reviewed matters relating to: Native American health; the state's substance abuse epidemic; health care work force development; innovations in health care delivery and finance; public health; human services needs and programs; long-term services; teen pregnancy; prescription drug affordability; and recent proposed changes to the state's tort and malpractice laws.

In addition to holding three meetings at the State Capitol in Santa Fe, the committee visited and heard public comment in the Pueblo of Taos; in the Town of Taos, hosted by the University of New Mexico-Taos campus; in the Town of Silver City, hosted by Western New Mexico University; and in the City of Albuquerque, where it held two days of hearings at the South Valley Family Health Commons, hosted by First Choice Community Healthcare.

The Disabilities Concerns Subcommittee met twice during the interim, once in Santa Fe and once on the site of the Southwest Conference on Disability at the Albuquerque Convention Center. It heard extensive testimony on the status of long-term services in the state, focusing particularly on the developmental disabilities Medicaid waiver and on the long waiting lists

associated with all of the home- and community-based waivers. Disability policy experts and staff from the HSD, the DOH, the New Mexico Developmental Disabilities Planning Council, the Governor's Commission on Disability and the Independent Living Resource Center presented testimony before the subcommittee. The subcommittee generated a great deal of interest among and input from individuals living with disabilities and in the disability rights advocacy community.

The New Mexico Legislative Council created the Behavioral Health Services Subcommittee, which met twice during the interim — once at the State Capitol and once at the Mesilla Valley Hospital in Las Cruces. It reviewed the status of behavioral health services delivered through the Interagency Behavioral Health Purchasing Collaborative's contract with the single statewide behavioral health managed-care entity, OptumHealth New Mexico. This testimony included review of the corrective action plan under which OptumHealth has been operating. It heard testimony from the executive director of the collaborative, HSD staff and stakeholders on the possibility of reintegrating behavioral health benefits with physical health benefits in the Medicaid redesign. The subcommittee devoted substantial attention to the state's substance abuse epidemic. The subcommittee also heard testimony on criminal justice diversion programs for individuals living with mental illness; behavioral health care delivery and finance innovations; and on the behavioral health care work force.

## **WORK PLAN AND MEETING SCHEDULE**

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**2011 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  
Rep. Bernadette M. Sanchez  
Rep. James E. Smith  
Rep. Mimi Stewart

**Work Plan and Focus for 2011**

The Legislative Health and Human Services Committee (LHHS) proposes to concentrate on the following major areas this interim: the Human Services Department's (HSD) proposal to redesign the state's Medicaid program; behavioral health care delivery in the state; and the state's continued response to the federal Patient Protection and Affordable Care Act of 2010 (PPACA).

In addition to these major issue areas, the committee proposes to hear testimony on medical malpractice and recent proposed changes to the state's tort and malpractice laws. The committee proposes to hear testimony on dental health care, including new laws and recent proposals to create and expand scopes of practice for allied professionals in dental practice. The committee wishes to examine the state of child protective services and the incidence of child abuse and review the adequacy of funding for emergency medical services in the state. The committee also proposes to discuss teen pregnancy and programs that address teen pregnancy.

The committee proposes to continue its oversight of health and human services agencies by receiving testimony from the Aging and Long-Term Services Department, the Children, Youth and Families Department, the Department of Health, the Human Services Department and the Workforce Solutions Department regarding the direction of these departments under Governor Martinez's administration.

Organizational Meeting

The committee began the interim with an organizational meeting in which it received testimony from the HSD regarding the department's plans and contract for Medicaid redesign. The committee also discussed its work plan proposal.

Medicaid and Other Public Programs

The HSD has signed a contract with Alicia Smith & Associates, a private contractor, to assist the HSD in a redesign of Medicaid. The full details of the HSD's redesign plan have not been finalized, but the HSD has stated that it may reduce the current number of federal waivers and managed care contractors currently operating and pursue greater roles for "personal responsibility" for recipients and a greater role for small businesses. The LHHS will have questions about such things as changes in benefits, eligibility, reimbursement and administration. The committee would also like to know whether the HSD will be ready to implement the PPACA's requirement in 2014 that all residents with incomes at 138% of the federal poverty level (FPL) or lower be made eligible for Medicaid and whether the redesign will include both behavioral and physical health coverage or only physical health coverage.

The committee proposes to inquire about the HSD's plans to cover childless adults with incomes between 134% FPL and 200% FPL and about the continued viability of programs such as premium assistance for children and for pregnant women.

The committee also proposes to hear testimony regarding the status of the HSD's ISD2 system and other information technology upgrades for Medicaid redesign and health reform implementation.

#### Behavioral Health

The New Mexico Legislative Council appointed a Behavioral Health Subcommittee of the LHHS at its June 29 meeting. It will meet twice during the 2011 interim.

The committee proposes to hear testimony about ongoing concerns of behavioral health care service consumers and their families; the provider community regarding the Interagency Behavioral Health Purchasing Collaborative (Collaborative) and members of the behavioral health advocacy community; and the state's single statewide managed care contractor, OptumHealth of New Mexico (OptumHealth). The committee also proposes to receive testimony about the ongoing efforts to address serious provider payment issues and other performance concerns that are being overseen by Alicia Smith and Associates, the "monitor" appointed pursuant to the Collaborative's contract with OptumHealth.

The committee proposes to hear testimony from Collaborative leadership regarding its issuance of an RFP for a new statewide behavioral health services entity.

In the First Session of the Fiftieth Legislature, House Bill 432 was passed, instructing the Collaborative to consider implementing a pilot project whereby behavioral health providers would collaborate with a risk-bearing entity with which the Collaborative would contract directly. During the pilot project, in areas of the state where it is implemented, the provider-run entity would provide services and bear risk in lieu of OptumHealth. The committee proposes to hear testimony on the Collaborative's intentions and progress regarding the implementation of this pilot project.

The committee also proposes to examine the serious challenges the state faces in the areas of substance abuse and youth suicide.

#### Health and Human Services in Native American Communities

The committee proposes to hear testimony on several issues relating specifically to Native American health. The committee proposes to hear testimony on health disparities and legislation to address them, including 2011 legislation to address the highly disproportionate rate of youth suicide in tribal communities. The committee proposes to hear testimony on how tribal entities are working to improve health in their communities, including a site visit to Pueblo of Taos. The committee proposes to hear how telehealth and other innovations in service delivery are having an impact on health in tribal communities as tribal, state and federal governments and private actors provide services. The committee also proposes to hear testimony regarding the special status that Native Americans have under the federal Indian Health Care Improvement Act and the PPACA, including the right to establish insurance exchanges outside of any state or federal exchange.

#### The State Response to the PPACA

Many of the matters that the committee proposes to review relate to the many responsibilities that the PPACA and related state laws impose upon the Insurance Division of the Public Regulation Commission. The committee proposes to receive testimony from the superintendent of insurance and staff regarding rules that the division is supposed to promulgate pursuant to many health insurance mandates in the PPACA that preempt many of the state's insurance laws. The committee further proposes to discuss the division's steps to implement the new state law that redesigns the health insurance rate review process and the division's efforts to implement an office of ombudsman and consumer assistance programs pursuant to grants it received from the federal Department of Health and Human Services.

The committee would like to consider what the state's options are in light of the governor's veto of health insurance exchange legislation passed in the First Session of the Fiftieth Legislature, including whether a state exchange, a federally run exchange or an innovation waiver pursuant to Section 1332 of the PPACA is most feasible.

The committee proposes to consider the impact of health coverage expansions through Medicaid and private insurance in the state.

In light of an expected increase in demand for health services, the committee wishes to continue examining the state's needs for additional health care work force and data collection, including work force data to be collected pursuant to the passage of Senate Bill 14 (Laws 2011, Chapter 152).

The committee proposes to 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.

The committee also proposes to examine new federal regulations and amendments that the federal government issues pursuant to the PPACA.

In addition, the committee wishes to review the status of federal grant applications or projects implemented pursuant to the PPACA.

### Prescription Drugs

The committee proposes to focus on prescription drugs, including new legislation to provide for parity in anticancer medication and prescription drug donations under certain conditions. The committee also proposes to hear testimony pursuant to a memorial that requests the creation of a working group to develop standards for electronic prior authorization request transactions for drugs and devices.

### **Disabilities Concerns Subcommittee**

The Disabilities Concerns Subcommittee (DCS) proposes to continue its examination of the status of the Developmental Disabilities (D/D) Waiver Program. At a special meeting on June 24, 2011, the DCS proposes to hear testimony regarding the federal Department of Health and the Human Services' submission of a new D/D waiver to the federal Centers for Medicare and Medicaid Services. Members of the disabilities community have raised concerns about what they claim is a lack of public input into the new waiver application.

The subcommittee's examination will focus on the D/D program's extensive waiting list; the system for service allocations; the quality of services delivered to individuals living with developmental disabilities; and job training and creation, including business start-ups run by individuals who are developmentally disabled.

The subcommittee proposes to review the status of long-term services provided under the Medicaid Personal Care Option Entitlement Program and those provided pursuant to federal Medicaid home- and community-based services waivers, including the Coordinated Long-Term Services (CoLTS) Program in light of a growing aging and disabled population and the HSD's Medicaid redesign efforts. The subcommittee also proposes to look at the potential for increasing the number of individuals served and the quality of those services under federal Community First Choice Program grants pursuant to the PPACA.

The DCS proposes to receive testimony from the Governor's Commission on Disability on the services provided through that office and the status of funding for those programs.

## 2011 Approved Meeting Schedule

<u>Date</u>	<u>Location</u>
June 14	Santa Fe
July 6-8	Pueblo of Taos/Town of Taos
August 17-18	Silver City
October 5-6	Albuquerque
November 2-4	Santa Fe
November 30-December 1	Santa Fe

### **Disabilities Concerns Subcommittee**

#### Members

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

<u>Date</u>	<u>Location</u>
June 24	Santa Fe
October 7	Albuquerque

### **Behavioral Health Services Subcommittee**

#### Voting Members

Sen. Mary Kay Papen, Chair  
Rep. Ray Begaye, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Bernadette M. Sanchez

#### Advisory Members

Sen. Sue Wilson Beffort  
Sen. Dede Feldman  
Rep. Antonio Lujan  
Rep. James Roger Madalena

<u>Date</u>	<u>Location</u>
August 19	Las Cruces
December 2	Santa Fe

## **AGENDAS**

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**2011 Interim Report  
Legislative Health and Human Services Committee**

Revised: May 25, 2011

**TENTATIVE AGENDA  
for the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**Organizational Meeting  
June 14, 2011  
Room 322, State Capitol  
Santa Fe**

**Tuesday, June 14**

- 10:00 a.m.    **Call to Order**
- 10:05 a.m.    **Welcome and Introductions**
- 10:10 a.m.    **Review and Discussion of Work Plan, Meeting Dates and Locations for 2011 Interim**  
—Michael Hely, Staff Attorney, Legislative Council Service (LCS)
- 10:30 a.m.    **2011 Legislation Summary**  
—Michael Hely, Staff Attorney, LCS
- 11:00 a.m.    **Health and Human Services Programs Fiscal Overview and Outlook**  
—Ruby Ann Esquibel, Principal Analyst, Legislative Finance Committee
- 12:00 noon    **Lunch**
- 1:30 p.m.    **Medicaid Redesign**  
—Sidonie Squier, Secretary of Human Services  
—Alicia C. Smith, J.D., Alicia Smith and Associates
- 3:00 p.m.    **Public Comment**
- 4:00 p.m.    **Adjournment**

Revised: May 25, 2011

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

**June 24, 2011  
Room 322, State Capitol  
Santa Fe**

**Friday, June 24**

- 10:30 a.m.     **Call to Order, Welcome and Introductions**
- 10:35 a.m.     **Developmental Disabilities Waiver**  
—Mikki Rogers, Director, Developmental Disabilities Supports Division,  
                  Department of Health  
—Bob Beardsley, Deputy Director, Medical Assistance Division, Human  
Services  
                  Department
- 12:30 p.m.     **Public Comment**
- 1:30 p.m.     **Adjournment**

Revised: July 5, 2011

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

**July 6-8, 2011  
Taos**

**Wednesday, July 6:**

**Taos Pueblo Community Center, 220 Rotten Tree Road, Taos, New Mexico 87571**

- 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.     **Committee Welcome and Invocation**  
—Nelson Cordova, Governor, Pueblo of Taos  
—Paul Martinez, Cacique, Pueblo of Taos  
—Edwin Concha, War Chief, Pueblo of Taos
- 10:00 a.m.    **Pueblo of Taos Health and Human Services Programs and Priorities**  
—Maxine Nakai, Director, Health and Community Services, Pueblo of Taos
- 10:30 a.m.    **State-Tribal Support for Quality Health Care**  
—Barbara Alvarez, Policy Analyst, Indian Affairs Department  
—Priscilla Caverly, Office of Health Care Reform, Human Services Department  
                  (HSD)
- 11:00 a.m.    **Native American Health Policy Development**  
—Roxane Spruce-Bly, Director, Bernalillo County Native American Health  
                  Commission  
—Ken Lucero, Director, Robert Wood Johnson Foundation Center for Native  
                  American Health Policy
- 11:30 a.m.    **Off-Reservation Indian Health**  
—Roxane Spruce-Bly, Director, Bernalillo County Native American Health  
                  Commission
- 12:00 noon    **Lunch**

- 2:00 p.m.     **Suicide Prevention and Native American Youth**  
—Steven Adelsheim, M.D., Director, Center for Rural and Community Health,  
University of New Mexico (UNM)
- 2:30 p.m.     **Substance Abuse and Mental Health Services Administration Grants for  
Behavioral Health Services in Tribal Communities; Strategic Initiative**  
—Steven Adelsheim, M.D., Director, Center for Rural and Community Health,  
UNM  
—Harrison Kinney, Executive Manager, Behavioral Health Services Division,  
HSD  
—Esther Tenorio, Director, Circles of Care Grant, Pueblo of San Felipe
- 3:30 p.m.     **Tewa Women United: A Holistic, Culturally Competent Model of Healing**  
—Kathy Sanchez, Program Manager, Environmental Health and Justice
- 4:00 p.m.     **Public Comment**
- 4:30 p.m.     **Recess**

**Thursday, July 7:**

**Rio Grande Room "A", Taos Convention Center, 121 Civic Plaza Drive, Taos, New Mexico  
87571**

- 9:00 a.m.     **Call to Order**
- 9:05 a.m.     **Patient Protection and Affordable Care Act (PPACA) and Health Insurance  
Legislation and Regulation:**  
• **PPACA Insurance Mandates; Alignment of State Laws and Regulations**  
• **Rate Review: Implementation of SB 208**  
• **Consumer Advocacy; Status of Development of the Office of Ombudsman**  
—John Franchini, Superintendent of Insurance, Public Regulation  
Commission (PRC)  
—Craig Dunbar, Chief Deputy Superintendent, PRC  
—Christine Baca, Bureau Chief, Managed Health Care Bureau, Insurance  
Division, PRC
- 12:00 noon    **Lunch**
- 1:00 p.m.     **Health Care Reform and Hospitals**  
—Jeff Dye, President, New Mexico Hospital Association
- 1:30 p.m.     **Health Care Reform and Business**  
—Gary Oppedahl, Chair, Health Committee, Association of Commerce  
and Industry

- 2:00 p.m.     **HSD Information Technology and the State's Response to PPACA**  
—Brian Pietrewicz, Chief Information Officer, HSD  
—Priscilla Caverly, Office of Health Care Reform, HSD
- 3:30 p.m.     **New Mexico Medical Insurance Pool and Federal High Risk Pool Update**  
—DeAnza Sapien, Esq., New Mexico Medical Insurance Pool
- 4:00 p.m.     **Health Care Work Force Programs at UNM-Taos**  
—Jim Gilroy, Dean of Instruction, UNM-Taos  
—Catherine O'Neill, Ed.D., Executive Campus Director, UNM-Taos  
—Marty Hewlett, Ph.D., Area Coordinator, Health Sciences, UNM-Taos  
—Kathy Falkenhagen, M.S.N., R.N., Director of Nursing Programs, UNM-Taos
- 4:30 p.m.     **Public Comment**
- 5:00 p.m.     **Recess**

**Friday, July 8:**

**Rio Grande Room "A", Taos Convention Center, 121 Civic Plaza Drive, Taos, New Mexico 87571**

- 9:00 a.m.     **Call to Order**
- 9:05 a.m.     **Department of Health (DOH) Oversight; Public Health Funding; Health Wellness and Prevention; Information Technology**  
—Dr. Catherine Torres, Secretary of Health  
—Sean Pearson, Acting Chief Information Officer, DOH
- 11:00 a.m.    **Health Care Reform and PPACA Update; Status of Grant Tracking and Applications**  
—Vicky Howell, Ph.D., Director, Office of Performance, DOH
- 12:30 p.m.    **Lunch**
- 1:30 p.m.     **Office of Health Care Reform Stakeholder Panel: Consumer, Provider, Medicaid and Insurer Stakeholders**  
—Mike Wallace, Chair, Insurance Stakeholders Group  
—Jane Wishner, Esq., Chair, Consumer Stakeholders Group  
—Gail Evans, Chair, Medicaid Stakeholders Group
- 3:00 p.m.     **Health Care Reform in the Taos Community**  
—Michael Kaufman, M.D., and Jemery Kaufman, M.D., New Mexico Medical Society
- 3:30 p.m.     **Public Comment**

4:00 p.m.    **Adjourn**

Revised: August 15, 2011

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

**August 17-18, 2011  
Silver City**

**Wednesday, August 17: Room ABC, Besse-Forward Global Resource Center, Western  
New Mexico University (WNMU), Silver City**

- 9:00 a.m.      **Call to Order**
- 9:05 a.m.      **Welcome and Introductions; Voting on Approval of Minutes**
- 9:15 a.m.      **Reinventing Medicaid Through Medical Home**  
—Mary Takach, M.P.H., R.N., Program Director, National Academy for State  
Health Policy
- 11:15 a.m.     **Transportation to Hidalgo Medical Services (HMS)**
- 11:30 a.m.     **Groundbreaking for Integrated Primary Care Clinic, Tour and Lunch at  
HMS; Transport back to WNMU**
- 1:30 p.m.      **HMS: Community Health Teams and Community Health Workers**  
—Charlie Alfero, Chief Executive Officer, HMS; Director, Center for Health  
Innovation (CHI), HMS  
—Carmen Maynes, Director, Community Organization Development, CHI, HMS
- 2:00 p.m.      **Forward New Mexico: Work Force Development**  
—Tamera Ahner, Work Force Development Coordinator, CHI, HMS  
—Darrick Nelson, M.D., Chief Medical Officer, CHI, HMS  
—Brian Bentley, Chief Executive Officer, Gila Regional Medical Center
- 3:00 p.m.      **Panel Discussion: Accountable Care Organization Models**  
—Charlie Alfero, Chief Executive Officer, HMS; Director, CHI, HMS  
—Michael Hely, Staff Attorney, Legislative Council Service
- 4:30 p.m.      **Public Comment**
- 5:00 p.m.      **Recess**

**Thursday, August 18: Room ABC, Besse-Forward Global Resource Center, WNMU, Silver City**

- 9:00 a.m.      **Call to Order**
- 9:05 a.m.      **Tour of WNMU Department of Nursing Building**
- 9:15 a.m.      **Update and Panel Discussion on Medicaid Redesign**  
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department  
—Alicia Smith, Esq., President, Alicia Smith and Associates  
—Brian Bentley, Chief Executive Officer, Gila Regional Medical Center  
—Karen Carson, M.D., BCA Medical Associates; President, New Mexico Pediatric Society  
—Bill Jordan, Policy Director, New Mexico Voices for Children  
—Quela Robinson, Staff Attorney, New Mexico Center on Law and Poverty
- 12:00 noon    **Lunch**
- 12:30 p.m.    **Public Comment**
- 1:00 p.m.      **Status of Department of Health Program Contracts; Disabled Children Services; Prenatal Services; Immunizations; Tuberculosis Treatment; and Buprenorphine Treatment for Incarcerated Individuals**  
—Catherine Torres, M.D., Secretary, Department of Health
- 2:30 p.m.      **New Mexico Health Policy Commission: Health Care Work Force Data Collection**  
—Jerry Harrison, Ph.D., Acting Director, New Mexico Health Policy Commission; Executive Director, New Mexico Health Resources
- 3:30 p.m.      **Patient Protection and Affordable Care Act: Federal Fund and Grant Opportunities**  
—RubyAnn Esquibel, Principal Analyst, Legislative Finance Committee
- 4:00 p.m.      **Adjournment**

Revised: August 8, 2011

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

**August 19, 2011  
Las Cruces**

**Friday, August 19:**

**Mesilla Valley Hospital Gymnasium, 3751 Del Rey Boulevard, Las Cruces**

- 10:00 a.m.     **Call to Order; Welcome and Introductions**
- 10:10 a.m.     **Welcome from Brian Hemmert, Chief Executive Officer, Mesilla Valley Hospital; Tour of Mesilla Valley Hospital**
- 10:30 a.m.     **Interagency Behavioral Health Purchasing Collaborative (IBHPC) Update: OptumHealth Contract Report**  
—Linda Roebuck Homer, Executive Director, IBHPC  
—Diana McWilliams, Deputy Executive Officer, IBHPC  
—Michael Evans, Chief Executive Officer, OptumHealth New Mexico  
—Patsy Romero, Treasurer, National Alliance on Mental Illness (NAMI), New Mexico Affiliate  
—Becky Beckett, Advocate, Family Member of Behavioral Health Services Recipient
- 12:00 noon    **Working Lunch**
- 1:00 p.m.     **RFP for Statewide Entity; IBHPC Pilot Project**  
—Linda Roebuck Homer, Executive Director, IBHPC  
—Diana McWilliams, Deputy Executive Officer, IBHPC  
—Patsy Romero, Treasurer, National Alliance on Mental Illness (NAMI), New Mexico Affiliate  
—Becky Beckett, Advocate, Family Member of Behavioral Health Services Recipient  
—Roque Garcia, Chief Executive Officer, Southwest Counseling Center, Inc.  
—David Hedgcock, Executive Director, Providence of Arizona, Inc.
- 2:30 p.m.     **Opioid Addiction Treatment and Payment**

—Eugene Marciniak, M.D., Region 5 Health Officer, Department of Health

2:45 p.m. **Opioid Addiction and Drug Policy**

—William Wiese, M.D., M.P.H., Director, Institute for Public Health, University  
of New Mexico Health Sciences Center

3:30 p.m. **Substance Abuse and Crime Prevention**

—William Wiese, M.D., M.P.H., Director, Institute for Public Health, University  
of New Mexico Health Sciences Center

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

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

Revised: October 4, 2011

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

**October 5-6, 2011  
South Valley Family Health Commons — Classroom  
2001 Centro Familiar SW  
Albuquerque**

**Wednesday, October 5**

- 9:30 a.m.     **Call to Order**
- 9:35 a.m.     **Welcome and Introductions; Approval of August Minutes**
- 9:50 a.m.     **Welcome to South Valley Family Health Commons**  
—Bob DeFelice, Chief Executive Officer, First Choice Community Healthcare  
(FCCH)  
—Paul Luna, Chairman, Board of Directors, FCCH
- 10:00 a.m.    **Update from the New Mexico Office of Health Care Reform; Options for a  
State Health Insurance Exchange**  
—Daniel Derksen, M.D., Director, Office of Health Care Reform
- 11:30 a.m.    **Lunch**
- 12:30 p.m.    **Proposed Federal Rules and Developments on Health Insurance Exchanges**  
—Marge Petty, Regional Director, Region VI, United States Department of  
Health and Human Services (HHS)  
—Jay Angoff, Senior Advisor to Secretary Kathleen Sebelius, HHS
- 2:00 p.m.     **Colorado Health Insurance Exchange Development**  
—Shawn Raintree, Operations Manager, Colorado Health Insurance Exchange
- 3:00 p.m.     **Public Comment**

3:30 p.m.     **Tour of South Valley Family Health Commons**  
—Melissa Manlove, Chief Operations Officer, FCCH  
—Santiago Macias, M.D., Assistant Medical Director, FCCH; Clinical  
Supervisor, South Valley Health Commons

4:00 p.m.     **Recess**

**Thursday, October 6**

9:00 a.m.     **Call to Order**

9:05 a.m.     **Early Childhood Services Data**  
—Peter Winograd, Ph.D., Director, Center for Education Policy Research,  
University of New Mexico College of Education  
—Mimi Aledo-Sandoval, Senior Fiscal Analyst, Legislative Finance Committee  
(LFC)

10:00 a.m.    **Child Protective Services Investigation and Report; Formal Action Plan**  
—Michael Weinberg, Program Evaluation Manager, LFC  
—Jared Rounsville, Director, Protective Services Division, Children, Youth and  
Families Department (CYFD)

11:30 a.m.    **Lunch**

12:30 p.m.    **CYFD: Update on Programs and Priorities**  
—Yolanda Berumen-Deines, Secretary, CYFD  
—Edna Reyes-Wilson, Deputy Secretary, CYFD  
—Bob Tafoya, Chief of Staff, CYFD

2:00 p.m.     **Family-Friendly Workplace (House Memorial 1 — Regular Session, 2011)**  
—Giovanna Rossi Pressley, President, Collective Action Strategies, LLC  
—Jessica Aranda, Program Director, Southwest Creations Collaborative  
—Lee Reynis, Ph.D., Director, Bureau of Business and Economic Research,  
University of New Mexico

2:30 p.m.     **Casa de Salud — Justice, Access, Support and Solutions for Health**  
—Zane Maroney, Clinic Administrator, Casa de Salud

3:30 p.m.     **Plan for a Nonprofit Co-Op Health Insurance Plan**  
—Nandini Pillai Kuehn, Ph.D., M.H.A., President, Board of Directors, New  
Mexico Health Connections  
—Rick Thaler, Member, Board of Directors, New Mexico Health Connections

4:30 p.m.     **Public Comment**

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

Revised: October 4, 2011

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

**October 7, 2011  
Albuquerque Convention Center — Picuris Room  
Albuquerque**

**Friday, October 7**

- 9:00 a.m.     **Call to Order**
- 9:05 a.m.     **Welcome and Introductions; Approval of June Meeting Minutes**
- 9:10 a.m.     **Long-Term Services: Status of Coordinated Long-Term Services; Hilltop Institute Report**  
—Julie Weinberg, Director, Medical Assistance Division, Human Services Department (HSD)  
—Gil Yildiz, Executive Director, Independent Living Resource Center
- 11:00 a.m.    **Long-Term Services: Status of the Medicaid Personal Care Option**  
—Julie Weinberg, Director, Medical Assistance Division, HSD  
—Charles Sallee, Deputy Director, Legislative Finance Committee  
—Ellen Pinnes, J.D., Consultant, New Mexico Disability Coalition
- 12:00 noon    **Lunch — Ballroom — Keynote Address: The Future Is Now: Full Inclusion for People with Disabilities**  
—Dale Dileo, Director, Training Resource Network
- 1:45 p.m.     **Business Opportunities for Individuals Living with Developmental Disabilities**  
—Ruthie Marie Beckwith, Tennessee Microboards Association, Inc.  
—Nannie and Rosemarie Sanchez, Advocates

- 2:30 p.m.     **Developmental Disabilities Training and Job Placement Programs**  
—James Maes, Parent of a 14-Year-Old Son with Development Disabilities  
—Connie DeHerrera, Director, Center for Self Advocacy, Developmental  
Disabilities Planning Council  
—Susan Copeland, Ph.D., Associate Professor, Special Education Program,  
College of Education, University of New Mexico
- 3:00 p.m.     **Disabilities Services and the Disability Trust Fund**  
—Jim Parker, Director, Governor's Commission on Disability
- 3:30 p.m.     **Public Comment**
- 4:00 p.m.     **Adjourn**

Revised: November 1, 2011

**TENTATIVE AGENDA  
for the  
FIFTH MEETING  
of the  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE  
November 2-4, 2011  
Room 307, State Capitol  
Santa Fe**

**Wednesday, November 2**

9:30 a.m.      **Call to Order, Welcome and Introductions, Approval of October Minutes**

9:45 a.m.      **Using the Basic Health Plan to Make Coverage More Affordable to Low-Income Households**

—Stan Dorn, J.D., Senior Fellow, Urban Institute

11:00 a.m.      **Public Comment**

11:30 a.m.      **Lunch**

1:00 p.m.      **Bachelor's to D.D.S. Degree Report**

—Gary Cuttrell, D.D.S., J.D., Chair, Department of Dental Medicine, University of New Mexico School of Medicine (UNM SOM)

—Peter Jensen, D.D.S., M.S., M.P.H., Director, Residency Program, Department of Dental Medicine, UNM SOM

2:30 p.m.      **Health Insurance Rate Review, Grievance Procedures and Ombudsman Programs**

—Christine Baca, Bureau Chief, Life and Health Rate and Form Filing Bureau and Managed Health Care Bureau, Insurance Division, Public Regulation Commission (ID/PRC)

—Craig Dunbar, Deputy Superintendent of Insurance, ID/PRC

—Ashley Purdy, Ombudsman, Consumer Assistance Program

4:00 p.m.      **Recess**

**Thursday, November 3**

9:30 a.m.      **Call to Order**

9:35 a.m.      **Anticancer Drug Pricing Parity (SB 385, 2011 Regular Session)**

- Barbara McAneny, M.D., Chief Executive Officer, New Mexico Oncology Hematology Consultants, Ltd.
- Sandra Adondakis, New Mexico Government Relations Director, American Cancer Society Cancer Action Network

- 10:30 a.m.    **Prescription Drug Donation (SB 37, 2011 Regular Session)**  
—Barbara McAneny, M.D., Chief Executive Officer, New Mexico Oncology Hematology Consultants, Ltd.  
—Bill Harvey, R.Ph., Executive Director, Board of Pharmacy
- 11:30 a.m.    **Public Comment**
- 12:00 noon    **Lunch**
- 1:30 p.m.     **Medical Malpractice: An Analysis of HB 267 (Regular Session, 2011)**  
—Teresa Ryan, Student, University of New Mexico School of Law
- 3:00 p.m.     **Adolescent Opioid Addiction (SM 56, 2011 Regular Session)**  
—Harrison Kinney, Ph.D., Director, Behavioral Health Services Division, Human Services Department  
—Linda Roebuck Homer, Chief Executive Officer, Interagency Behavioral Health Purchasing Collaborative
- 4:00 p.m.     **Prescription Drug Abuse**  
—Boyd Kleefisch, M.B.A, FACHE, Chief Operating Officer, New Mexico Medical Review Association (NMMRA)  
—Galina Priloutskaya, Ph.D., M.B.A., C.H.C.A, Director of Analytic Services and Drug Safety, NMMRA
- 5:00 p.m.     **Recess**

**Friday, November 4**

- 9:30 a.m.     **Call to Order**
- 9:35 a.m.     **Workforce Solutions Department: Update on Programs and Priorities**  
—Celina Bussey, Secretary, Workforce Solutions Department
- 11:00 a.m.    **Public Comment**
- 11:30 a.m.    **Lunch**
- 1:00 p.m.     **Aging and Long-Term Services Department Oversight**  
—Retta Ward, Secretary-Designate, Aging and Long-Term Services Department
- 2:00 p.m.     **Interim Report from the Disabilities Concerns Subcommittee (DCS)**

—Representative Antonio Lujan, Chair, DCS  
—Senator Nancy Rodriguez, Vice Chair, DCS

2:30 p.m.     **Adjourn**

Revised: November 29, 2011

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

**November 30-December 1, 2011  
Room 307, State Capitol  
Santa Fe**

**Wednesday, November 30**

- 9:00 a.m.     **Call to Order, Welcome and Introductions, Review of November 2-4 Meeting Minutes**
- 9:05 a.m.     **Prior Notice by Insurers Before Formulary Changes**  
—Senator Timothy Z. Jennings, President Pro Tempore, New Mexico State Senate
- 9:30 a.m.     **Medicaid Funding for Nursing Facilities**  
—Linda Sechovec, Executive Director, New Mexico Health Care Association
- 11:30 a.m.    **Public Comment**
- 12:00 noon    **Lunch**
- 1:30 p.m.     **Electronic Prior Authorization Form and Approval Standards**  
—Amber Pearce, Director, U.S. Public Affairs and State Government Relations  
—Kerrie Copelin, ALS Association  
—Carroll Howely, ALS Association
- 2:00 p.m.     **Money Follows the Person**  
—Daniel Ekman, Disability Advocate  
—Nat Dean, Disability Advocate  
—Adam Shand, Statewide Advisor, People First
- 2:45 p.m.     **Report on Teen Pregnancy**  
—Sylvia Ruiz, New Mexico Teen Pregnancy Coalition
- 3:00 p.m.     **Interim Report of Disabilities Concerns Subcommittee (DCS)**  
—Representative Antonio Lujan, Chair, DCS  
—Senator Nancy Rodriguez, Vice Chair, DCS
- 3:30 p.m.     **Review of Legislation**

5:00 p.m.      **Recess**

**Thursday, December 1**

9:00 a.m.      **Call to Order**

9:05 a.m.      **1115 Waivers**

- Jane Perkins, J.D., M.P.H., Legal Director, National Health Law Project
- Alicia Smith, President, Alicia Smith and Associates
- Quela Robinson, Staff Attorney, New Mexico Center on Law and Poverty
- Jim Jackson, Executive Director, Disability Rights New Mexico

11:00 a.m.      **Dialysis Services Income Tax Deduction**

- Roman Maes, J.D., Chief Executive Officer, New Mexico Public Relations, LLC
- Albert Babbitt, President, State Tax Services, LLC
- Scott Mickelson, Senior Manager, State Tax Services, LLC

11:15 a.m.      **Public Comment**

11:45 a.m.      **Lunch**

1:15 p.m.      **Review of Legislation**

4:30 p.m.      **Adjourn**

Revised: November 29, 2011

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

**December 2, 2011  
Room 307, State Capitol  
Santa Fe**

**Friday, December 2**

- 8:00 a.m.     **Call to Order, Welcome, Introduction and Approval of August Minutes**  
—Senator Mary Kay Papen, Chair
- 8:15 a.m.     **House Joint Memorial 17 Task Force — Reducing Number of People with  
Mental Health Disorders in Detention Facilities or Requiring Law  
Enforcement Intervention**  
—Grace Philips, Attorney, New Mexico Association of Counties  
—Chris Tokarski, Executive Director, Mental Health Resources, Inc.  
—Nils Rosenbaum, Crisis Intervention Team Psychiatrist, Albuquerque Police  
Department  
—Michael Hubert, Community Development Specialist, Office of Consumer  
Affairs
- 9:15 a.m.     **Substance Abuse Issues**  
—Tim Condon, Ph.D., Visiting Research Professor, Center on Alcoholism,  
Substance Abuse and Addictions, University of New Mexico
- 10:30 a.m.    **Posttraumatic Stress Disorder in Returning Military Personnel**  
—Linda Roebuck Homer, Chief Executive Officer, Interagency Behavioral  
Health Purchasing Collaborative  
—Harrison Kinney, Executive Manager, Behavioral Health Services Division,  
Human Services Department
- 11:30 a.m.    **Working Lunch — Interagency Behavioral Health Purchasing Collaborative  
Priorities and Budget**  
—Linda Roebuck Homer, Chief Executive Officer, Interagency Behavioral  
Health Purchasing Collaborative
- 1:00 p.m.     **New Mexico State University (NMSU) Psychiatric Nursing Program**

—Pamela Schultz, Ph.D., R.N., Associate Dean and Director, School of Nursing,  
NMSU

1:30 p.m. **Update on Psychopharmacology Training and Status of Prescribing  
Psychologists**

—Elaine LeVine, Ph.D., ABMP, Training Director of Masters in  
Psychopharmacology, NMSU

—Jonathan Schwartz, Ph.D., Department of Counseling and Educational  
Psychology, NMSU

—E. Mario Marquez, Ph.D., Prescribing Psychologist

2:00 p.m. **Civil Commitment Proceedings — Report from House Memorial 45 (2011)**

—Karen Meador, J.D., Senior Policy Director, New Mexico Behavioral Health  
Collaborative

3:30 p.m. **Public Comment**

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

# MINUTES

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

**June 14, 2011**  
**Room 322, 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, at 10:10 a.m. in Room 322 of the State Capitol.

**Present**

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

**Absent**

Sen. Gay G. Kernan

**Advisory Members**

Rep. Ray Begaye  
Rep. Eleanor Chavez  
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. Bernadette M. Sanchez  
Rep. Mimi Stewart

Sen. Rod Adair  
Rep. Paul C. Bandy  
Rep. Conrad D. James  
Sen. John C. Ryan

**Guest Legislator**

Sen. Stephen H. Fischmann

**Staff**

Michael Hely  
Karen Wells  
Lisa Sullivan  
Rebecca Griego

**Guests**

Carlie Duncan, Intern for Senator Kernan

The guest list is in the meeting file.

### **Handouts**

Handouts are in the meeting file.

### **Tuesday, June 14**

#### **Welcome and Introductions**

The chair invited members of the committee to introduce themselves. The chair introduced the staff and acknowledged the hard work that they do. Carlie Duncan, intern for Senator Kernan, was introduced.

#### **Review and Discussion of Work Plan, Meeting Dates and Locations for 2011 Interim**

Mr. Hely, staff attorney, Legislative Council Service (LCS), reviewed committee guidelines regarding how quora are made, how blocking measures are invoked, the travel restrictions imposed by the New Mexico Legislative Council, circumstances under which a subcommittee can be formed and how a special session will affect the interim work of the committee. The committee asked when and how often the Disabilities Concerns Subcommittee will meet. Mr. Hely clarified that the subcommittee will meet twice this interim and that details will be presented in the discussion of the work plan. Clarification was requested regarding whether any member could attend the Disabilities Concerns Subcommittee meeting. Mr. Hely stated that only appointed members can receive per diem and mileage for attendance unless a "wild card" attendance allowance were used. The legislative council has not yet clarified its policy this interim regarding the number of wild card days that members will be awarded.

Mr. Hely reviewed the work plan, providing detail on the content areas to be addressed that are included in the written plan. He noted that numerous requests have been received to address long-term services and that the chair would like the topic of prescription drugs to be added as well. Mr. Hely noted that oversight of health and human services agencies is included in the work plan. The proposed agenda items for the Disabilities Concerns Subcommittee were presented. It was noted that one day would be dedicated to the submission of the recent revisions to the developmental disabilities (DD) waiver and one day to cover a broad array of areas of concern to the disability community.

The chair asked for clarification of who the members of the Disabilities Concerns Subcommittee are. The appointed members are Representative Antonio Lujan, chair; Senator Rodriguez, vice chair; Senator Adair; Representative Espinoza; Senator Papen; and Representative Picraux. The chair requested that a report be brought from the subcommittee to the full LHHS. Committee members had the following questions and comments:

- whether behavioral health services will be included in the Medicaid redesign efforts;

- disappointment that the legislative council did not approve the creation of a behavioral health subcommittee;
- an observation that Alzheimer's disease and other age-related diseases will have an overwhelming impact on the health care delivery system in the future;
- a suggestion that the work plan be narrowed down in order to effectively cover a few critical issues;
- recognition of the serious issues facing behavioral health providers subsequent to the behavioral health contract with OptumHealth;
- support for prioritizing behavioral health issues and concerns;
- a suggestion that the LHHS meet, at least for updates and an informational meeting, during the special legislative session because the members will be present anyway; and
- a request that the committee receive testimony regarding the impact of the federal Patient Protection and Affordable Care Act (PPACA) on the Native American community and other issues critical to Native Americans and that the LHHS meet once at a pueblo.

Mr. Hely reviewed proposed meeting dates and locations. He noted that the July meeting is proposed to be held in Albuquerque, with one day at a pueblo, and that the August meeting is proposed to be held in Silver City and Las Cruces, and not Lordsburg and Clovis as presented in the work plan. The chair noted that Albuquerque is proposed for a meeting site due to the presence of unique and cutting-edge delivery system models in that area. Mr. Hely noted that arrangements have been made to visit Casa de Salud and the South Valley Clinic during the Albuquerque meeting. A suggestion was offered to hold the October meeting in Albuquerque instead of Santa Fe and that Clovis or some other rural community be substituted for the July meeting.

Committee members' questions and comments continued with:

- a suggestion that the committee should meet in Clovis or another rural area in lieu of Albuquerque; and
- a request that the legislative council be sent a message that a subcommittee on behavioral health be created in recognition of the substantial financial impact of behavioral health services in the state and to address other critical behavioral health issues.

At the request of the chair, Raúl E. Burciaga, director, LCS, was asked to address the committee on these points. He was informed of the concerns of committee members regarding the decision of the legislative council not to create a behavioral health subcommittee and the difficulty of the LHHS to cover all the content areas that are before it. Mr. Burciaga noted that the governor's line-item vetoes of funding for the Redistricting Committee and approval for the House Appropriations and Finance Committee to meet for one week before the short session in 2012 put a significant financial burden on the legislative budget. Due to the special session, the legislative council challenged all interim committees to fit the entire interim content into a shorter period of time. He advised that the committee can ask Mr. Hely to make an additional

request to the legislative council to reconsider its decision not to create a behavioral health subcommittee. Representative Espinoza made, and Senator Ortiz y Pino seconded, a motion to write a letter from the committee pursuant to that request. The motion was unanimously endorsed. Mr. Burciaga was asked if it is known whether meetings in Albuquerque cost the same as meetings in Santa Fe. The cost is virtually the same, he said, and a request to the legislative council for the LHHS to meet in October in Albuquerque can be made. The chair asked whether the committee objected to that request; there being no objection, the request will be made to hold the LHHS October meeting in Albuquerque. Mr. Burciaga was asked whether the LHHS could meet informally during the special session. He noted that when the legislature is in special session, the interim technically does not exist. Committee members would like that to be further explored. Mr. Burciaga said he will take that question to the legislative council. He noted that the governor may call for additional items beyond redistricting to be included in the special session. A suggestion was made that the Redistricting Committee meet only in Santa Fe and not travel statewide.

Clarification was requested regarding the closure of nursing homes in the state. Charlie Marquez, lobbyist for the New Mexico Health Care Association, stated that more than one nursing home on the east side of the state has closed due to financial constraints.

Mr. Hely requested clarification regarding the committee's preferred location of the July meeting. The chair asked the committee for permission to determine the exact location at a later time. The committee approved. Representative Picraux made, and Senator Papen seconded, a motion to adopt the work plan with the proviso that additional topics be addressed as time permits, specifically in those areas that have been discussed. A question was asked about how soon members can know what topics will be covered and when. Staff will send out agendas in as timely a manner as possible. General topic areas have been identified but are subject to change due to availability of presenters and other factors. The motion was unanimously adopted.

### **2011 Legislation Summary**

Mr. Hely provided a summary of the legislation that the LHHS endorsed and whether it was passed during the legislative session. He provided information about the ultimate disposition of bills that were not endorsed by the committee but that relate to health and human services. A request was made to provide the committee with a handout describing those non-endorsed items. The bill to create a health insurance exchange and a bill to reform the medical malpractice law that passed but were vetoed were highlighted. A desire was expressed for justification from the executive regarding the rationale for vetoes and pocket vetoes of important measures. Mr. Hely will provide copies of the veto messages.

### **Health and Human Services Programs Fiscal Overview and Outlook**

Ruby Ann Esquibel, principal analyst, Legislative Finance Committee (LFC), presented fiscal information regarding the budgets for the health and human services agencies in the state. She summarized the FY09 through FY12 general fund appropriations, highlighting the Medicaid program. A total of \$837.3 million was appropriated for Medicaid, with \$280 million provided to make up for federal American Recovery and Reinvestment Act of 2009 (ARRA) funds that

provided enhanced federal medical assistance percentage payments and that were lost when ARRA funding ended. The legislature appropriated supplemental funding for FY11, which is the current fiscal year. Medicaid enrollment is expected to increase because Medicaid is an entitlement program, which will affect the budget going forward. Temporary Assistance for Needy Families (TANF) grew by more than 47% between 2008 and 2011. Federal funding for the program substantially declined during that period. ARRA funds offset this decline but only for FY11. Cash assistance and child care programs were protected and not reduced. Overall TANF funding was reduced by 3.4% from the current operating year for Human Services Department (HSD) programs. State general funds were reduced for the Supplemental Nutrition Assistance Program (SNAP).

Mimi Aledo, senior fiscal analyst, LFC, spoke about budget decisions affecting the Children, Youth and Families Department. Home visiting, pre-kindergarten and domestic violence programs all were reduced.

Ms. Esquibel highlighted the impact to the Department of Health (DOH). The DOH received a general fund increase of \$30.2 million, largely to keep the DD waiver program whole following the loss of ARRA funds and to support state hospital facilities. She noted that the Coordination of Long-Term Services Program was transferred in the budget from the Aging and Long-Term Services Department to the HSD, which hopefully will result in greater efficiencies. Funding for aging network services was reduced.

Questions from committee members covered the following areas:

- clarification regarding the impact of the loss of state general fund dollars for SNAP; the legislature had hard decisions to make, and a balance was sought;
- clarification regarding the Medicaid Personal Care Option (PCO) Program; it will be included in the Medicaid redesign;
- clarification regarding a reduction in approved hours of service in the PCO Program;
- an observation that the governor vetoed a bill that would have reduced the general fund burden in the Family, Infant, Toddler Program by limiting coverage for those with health insurance;
- clarification regarding the budget impact of the veto of the Commission on the Status of Women;
- an observation that the DOH has experienced drastic reductions in previous years, especially in the area of public health and prevention; overall, general funds that were lost have been replaced by federal and other funds;
- the impact of the loss of ARRA funding; and
- clarification regarding the impact of increased funding for the DD waiver; about 70 additional people can be served.

Prior to the afternoon session of the meeting, Ms. Wells was recognized for her years of service to the LHHS and the LCS. She was presented with a certificate of appreciation upon her pending retirement.

## Medicaid Redesign

Sidonie Squier, secretary, HSD, and Alicia C. Smith, J.D., Alicia Smith and Associates, presented an overview of the HSD request for proposals and plan to redesign Medicaid. Secretary Squier introduced Matt Kennicott, HSD communications director. She described the purpose and status of Medicaid and the two-month process to submit a request for proposals and engage a contractor to redesign the program. Stakeholder input will be broadly sought in statewide meetings, through meetings with advocates and trade associations and through tribal consultations. She fully expects to make continuing reports to the LHHS on the progress of the redesign. Secretary Squier identified four principles upon which the modernization of Medicaid will be based, including: (1) the integration of all Medicaid services into a "second generation" of care for enrollees; (2) an increase in personal responsibility through the implementation of co-payments for certain services and incentives, such as medical savings accounts, to motivate positive behaviors; (3) the implementation of reimbursement reform through payment for positive health outcomes; and (4) an increase in administrative efficiencies through a single global waiver. The time line for the transformation process is to develop a road map for implementation by August 2011, with full implementation within 24 months. The HSD favors a "health home" model of service delivery, with sufficient wrap-around services to meet the needs of recipients. The HSD intends to consider carefully those clients with behavioral health needs. Secretary Squier asked for committee input on whether these services should be carved in or carved out of a global waiver. The goal is to design a program that is innovative, fair and appropriate to the unique needs of New Mexicans.

Committee members had questions and expressed concerns in the following areas:

- the full extent and amount of the contract; gathering information; preparing the waiver application; procurement issues; writing the contracts that will arise from the plan; evaluation of proposals; and the readiness of contractors to "go live" with the program by July 1, 2013. The full amount of the contract is \$1.7 million for 12 months to 18 months of work;
- the extent of transparency that is anticipated; full transparency is expected;
- how the contract is funded; it will be funded through federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) bonus dollars; no state general funds will be used;
- clarification of the principle of payment for outcomes; care will be taken to ensure that providers are not limited in ordering appropriate tests, but the expectation is that people will improve as a result of the care;
- clarification regarding how the department will implement the behavioral health provider-based managed pilot project that passed the legislature in 2011 (HB 432) (Laws 2011, Chapter 5); the department intends to implement it but objects to the large proportion of the state's population and geography included in the pilot;
- a desire that behavioral health be afforded priority attention and that the intent of HB 432 be respected;
- clarification regarding ways in which CHIPRA bonus funds are generally used; bonus payments are open-ended and may be used for a variety of purposes; they are not eligible for federal matching funds;

- whether the state has any unspent CHIPRA bonus funds; about \$13.5 million has been awarded, and about \$8 million is unspent; more information can be provided to the committee regarding how this money has been used;
- a concern about charging co-payments to very sick individuals;
- a request that the LHHS automatically receive updates on the progress to redesign Medicaid;
- clarification about Ms. Smith's contract to monitor OptumHealth's contract;
- clarification regarding ways in which Medicaid is allegedly in trouble and the future fiscal impact of the implementation of the PPACA on Medicaid;
- an observation that every dollar spent on Medicaid generates nearly three federal dollars and that making drastic changes to the program could be dangerous;
- clarification regarding the role of the legislature in Medicaid redesign; the HSD is actively seeking input from legislators and others;
- whether legislation will be needed to make the anticipated changes to Medicaid; this is not known at this time;
- why the governor vetoed a bill that embraces the principle of payment for outcomes;
- whether there are models to follow in the area of reimbursement reform such as payment for outcomes and how recipients will be incentivized to engage in healthier behaviors;
- whether there will be coordination between behavioral health services and physical health services;
- why the governor vetoed a medical home bill (HB 34) in light of the department's intention to implement a health home model of care;
- clarification regarding what is meant by a health home model of care; the concept is to build wrap-around services around the individual receiving care so that care is integrated and is tailored to the individual;
- an observation that the Medicaid redesign plan is very ambitious, and encouragement to simplify rather than complicate Medicaid;
- clarification regarding the approach to obtain stakeholders' input that will achieve "buy-in" on reform initiatives;
- whether a global waiver is just another name for a block grant; the answer is no; the department is looking at an 1115 Medicaid waiver, which is not a block grant; currently, the federal government does not allow block granting of Medicaid;
- whether other states are using medical savings accounts; yes; Florida is using them;
- whether other states are using pay-for-performance models; yes, California, Missouri and Tennessee are using them;
- a request for a brief written summary of how a global waiver would work and a comparison of what other states are doing, including the pros and cons and what is working and what is not;
- how this Medicaid redesign will differ from previous efforts;
- clarification regarding the intention to reduce the numbers of managed care organizations from seven to four;

- an observation that not all medical conditions are responsive to increased personal responsibility and that a Medicaid redesign must preserve enough resources to cover unanticipated and emergency medical services;
- a recommendation that the members of the LHHS be fully engaged in the Medicaid redesign process and that whatever final solution is recommended be accomplished through legislation;
- whether providers will be cut further with the Medicaid redesign;
- concerns regarding conditioning provider payments on good outcomes;
- comments regarding the seriousness of considering the specific needs of beneficiaries in reform efforts;
- clarification regarding how incentives will be rewarded to recipients;
- clarification regarding the bottom-line goals of reform; the goal is for New Mexicans to get quality care; there is no plan to cut medical services or enrollees;
- a concern that more areas in the state will be involved in public input sessions; there was a suggestion that more areas in northern New Mexico be visited;
- the point at which a decision will be made about whether to carve in or carve out behavioral health services; there will not be a decision before all stakeholders have had a chance to provide input;
- how it is anticipated that the principles of reform will be applied to behavioral health; special input sessions are planned through the Interagency Behavioral Health Purchasing Collaborative;
- a recommendation that the department inform each local chamber of commerce before holding town hall meetings;
- the importance of providing accessible communication avenues for individuals and family members who need information about Medicaid waivers and options; and
- a request for written clarification regarding the difference between a global waiver and a block grant and information regarding pay-for-performance models.

### **Public Comment**

Bill Jordan, policy director, New Mexico Voices for Children, expressed concern with the premise that Medicaid is unsustainable and a fear that the program will be cut. He emphasized the favorable economic impact of Medicaid.

Tim Carver, chief financial officer, San Juan Center for Independence, expressed appreciation for the opportunity to get involved at the beginning of the process.

Dick Mason, New Mexico Health Council Alliance, spoke in opposition to the DOH elimination of funding for health councils in New Mexico. An assessment is being conducted about the impact of eliminating these councils.

Barbara Webber, executive director, Health Action New Mexico, noted that the PPACA will significantly expand Medicaid and access to health care for the uninsured in New Mexico. She believes this will ultimately reduce the cost of health care. She urged health care

administrators to become actively involved in the process of reform. She noted that personal responsibility needs to be accompanied by collective responsibility.

Jane Wishner, executive director, Southwest Women's Law Center, offered comments about how to ensure the most valuable public input and that best practices be considered in any changes prior to implementation.

Nick Estes, policy analyst, New Mexico Voices for Children, stated that the Medicaid Coalition developed a one-page statement of principles to guide the department in the redesign process. He thanked the department for its accessibility.

Lydia Pendley, Health Care for All Coalition, expressed disappointment regarding the lack of approval by the legislative council for the SJM 1 Health Care Reform Working Group for another year.

Judy Williams, League of Women Voters of Santa Fe County, testified that the league has developed a guide to transparency in government. The league also supports Medicaid redesign and the PPACA. She noted that the league is eager to see more detail in the plan.

Michael Murphy, Independent Living Resource Center, expressed support for home- and community-based services and especially "money follows the person". He is worried that the global waiver will change the PCO Program into a waiver and not an entitlement.

Michael Keslin, New Mexico Allergy Society, is interested in having allergy testing and allergy specialty care as a benefit of Medicaid. Such services improve outcomes and lower costs of health care.

Guy Watson spoke as a citizen whose grandchildren are Medicaid recipients and whose brother, who committed suicide, was a Medicaid recipient at the time of his death. He expressed concern that the proposal to consider a Medicaid redesign is brought by two people from Florida and not from the state legislature. He urged greater involvement by legislators. He is further concerned that the department can make these changes without legislative input. He feels the program is working and does not need to be changed.

Harris Silver, retired physician and teacher of public health, expressed outrage as a concerned citizen. He described his own personal difficulty obtaining covered care through his insurance policy. He objected to several elements of the Medicaid redesign, including payment for outcomes, elements of personal responsibility and administrative efficiency efforts.

Christine Marchant, New Mexico Developmental Disabilities Planning Council, noted that the DD waivers waiting list now has 5,600 people awaiting services, and she projects that within five years, it will exceed 7,000 people. The people served by this waiver desire high-quality services. This population does not have the additional resources to pay for co-payments. She is concerned that a global waiver will limit flexibility.

Dr. Paul Lanier, Organizers in the Land of Enchantment (OLÉ), has read the materials provided by the department, but he does not understand them. He urged the department to use a fully transparent process.

Penelope Foran spoke on her own behalf. She expressed anger at the plan to redesign Medicaid. She also expressed appreciation for the legislators and the role they have played in having the hearing and allowing public input.

Terry Schleder, New Mexico Alliance for Retired Americans, informed the committee that retired public employees in New Mexico are now on Medicaid due to premium increases they cannot afford. Medicaid saves lives and saves money for the state.

Roqueeta Jones is concerned that the redesign effort is emerging from the executive branch and not the legislature. She is also concerned about the principle of personal responsibility. Even with daily exercise, her Navajo parents still have diabetes. Medicaid has worked well for her and her children.

Sherri Gonzales identified herself as the face of Medicaid. She would not be alive but for Medicaid. She noted, however, that it has been "hell" getting needed services, especially emotional support.

Itsy Kraft is on both Medicare and Medicaid. She was a stay-at-home mom who lost her health care insurance when she got divorced. She is very grateful for the access to services she now has. She urged paying for preventive care so that people do not get sick in the first place.

Patsy Romero, National Alliance for the Mentally Ill-New Mexico (NAMI), spoke about HJM 17 and the language that included NAMI in an effort to train providers. She referred to an alleged effort to exclude her from the task force for being an outspoken opponent of core service agencies.

Jim Jackson, executive director, Disability Rights New Mexico, acknowledged the legislature for doing its part to sustain Medicaid. He reiterated that the only way to get a home- and community-based waiver is to go into a nursing home first and that the waiting list is growing. He is nervous that putting the whole Medicaid program into one global waiver relieves the state from compliance with many regulations.

There being no further business, the meeting adjourned at 5:35 p.m.

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

**June 24, 2011  
Room 322, State Capitol**

The first meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee for the 2011 interim was called to order by Representative Antonio Lujan, chair, on Friday, June 24, 2011, at 10:35 a.m. at the State Capitol in Santa Fe.

**Present**

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

**Absent**

Sen. Rod Adair

**Guest Legislators**

Sen. Dede Feldman  
Sen. Gerald Ortiz y Pino

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Copies of all handouts and written testimony are in the meeting file.

**Friday, June 24**

**Call to Order**

Representative Lujan asked Mr. Hely to read a June 1, 2011 letter (see attached), submitted by Nannie and Rosemarie Sanchez, but containing no signature, regarding the state's developmental disabilities waiver (DDW). The unnamed parties to the letter: (1) praised the legislature for supporting the DDW; (2) urged transparency and input into the DDW renewal process; (3) raised concerns about the collaborative-consultive model of delivering therapeutic services; (4) suggested that clients and caregivers have greater control over individual budgets;

(5) asked the Department of Health (DOH) to provide information about how the DOH support intensity scale (SIS) would affect benefit levels and to provide clients with due process guaranties; and (6) recommended that the DOH conduct audits on standards and quality of care.

### **New Mexico DDW Overview and Proposed Changes**

Cathy Stevenson, deputy director, Developmental Disabilities Supports Division (DDSD), DOH, explained that administration of the DDW program is shared by the DOH and the Human Services Department (HSD) under a joint powers agreement. The DDSD acts as the general manager for the program.

Bob Beardsley, deputy director, Medical Assistance Division (MAD), HSD, explained that people in the DDW program, in contrast to those in the other Medicaid waiver programs, need assistance with two or more activities of daily living. Mr. Beardsley presented: (1) a general overview of the state DDW; and (2) an overview of proposed changes to the state DDW program. In the general overview, Mr. Beardsley touched upon the history, services, medical and financial eligibility requirements and enrollment and expenditures figures for and administration of the DDW program. In the overview of proposed changes to the DDW program, Mr. Beardsley discussed the proposed changes.

Subcommittee members expressed concerns that there have been no public hearings on the proposed changes to the DDW program. Ms. Stevenson replied that there was no procedure or authority for public hearings, and Mr. Beardsley added that there will be public hearings on proposed regulations after the HSD publishes the proposed regulations for the DDW renewal.

### **DDW Renewal**

Ms. Stevenson stated that the current DDW expires on June 30, 2011. Ms. Stevenson said that an explanation of the specifics of the renewal application would take two hours.

### **DDW Program Costs**

Ms. Stevenson stated that the DDW program currently costs an average of \$78,000 per person per year. Last year, the DDW program cost \$288 million, of which the state pays one-third (about \$96 million), while the federal government pays the rest. She asserted that the DDW program needs to be restructured: (1) to achieve cost neutrality; and (2) to include more people from the waiting list. Achieving either or both of those goals requires cost reductions.

Ms. Stevenson listed several cost-reduction measures to be implemented, including: (1) streamlined administration of the DDW program; (2) more accurate assessment tools; (3) tying budget amounts to established need; (4) identifying resources beyond waiver funding; (5) promoting the DDW program members' self-sufficiency and community inclusion; and (6) structuring paid services to supplement other sources of support.

### **Needs and Costs Assessments**

Ms. Stevenson stated that the assumption is that one-fourth of the people on the waiver are receiving more DDW services than they need. Subcommittee members asked whether that

assumption was based on the perception that faulty assessments were performed or that DDW enrollees lied about their needs. Ms. Stevenson responded that the assessment system is "broken". In response to the subcommittee's request for a clarification, Ms. Stevenson stated that maybe the assessments were not faulty but that maybe New Mexico has more DDW enrollees than other states do.

### **SIS Assessments**

Ms. Stevenson stated that the DOH and HSD already have begun studying ways to change the DDW program to reduce costs. The first method of study is a pilot project in which 500 adults currently are being assessed, through 2011, on an SIS. Ms. Stevenson stated that, in contrast to traditional assessments that measure developmental disabilities by the skills that individuals lack, the SIS assessments: (1) measure the DDW member's support needs in the areas of home living, community living, lifelong learning, employment, health, safety and social activities; (2) examine how DDW members protect and advocate for themselves; and (3) determine the nature and extent of extra support needed to deal with DDW members' medical and behavioral needs. The SIS assessments will be performed by a third party — the National Association of State Directors of Developmental Disabilities Services. The pilot program will be used to determine if the SIS may be used to assess the needs of all adults in the DDW program.

### **Service Rates Changes**

The second method of study matches assessed service needs to service rates. This rate study is being conducted by the Human Services Research Institute through subcontractor Peter Burns and Associates. In response to the subcommittee's request, Ms. Stevenson stated that she would arrange for the contract with the institute and Peter Burns and Associates to be posted on the HSD's web site.

Ms. Stevenson identified the following DDW program goals to be completed in 2011:

1. work with the federal Centers for Medicare and Medicaid Services to have the DDW renewal application approved by July 1, 2011;
2. complete the SIS pilot project;
3. start assessing the remaining DDW program enrollees with the SIS;
4. use the information from the SIS assessments to establish a baseline and to develop a prototype for budget methodology;
5. complete work to finalize rates to be used after the DDW is renewed;
6. use the rates and SIS assessment data to finalize a resource allocation model; and
7. transition DDW program enrollees to the restructured DDW program.

### **Reduction of Therapy Time and Levels of Care**

Additional cost-saving measures will include reducing the amount of time that therapists spend with each enrollee and reducing the total amount of therapy allowed per year.

### **DDW Program Waiting List**

Ms. Stevenson said that there are more than 5,000 people on the waiting list who qualify for the DDW program. In response to a question about whether the DDW wait list categorizes

persons based on severity of need for purposes of enrolling people in the DDW program based on severity of need, Ms. Stevenson explained that there are no categories of need and that the federal district court's decision in *Lewis v. New Mexico Department of Health*, 275 F. Supp. 2d 1319 (2003) requires the DOH and HSD to admit applicants to the DDW program according to the oldest date of application and certain exigent circumstances having nothing to do with the severity of the developmental disabilities of the applicant.

In contrast, Oregon is able to enroll all qualified applicants in its DDW program, resulting in no waiting list, but each enrollee receives less services than would be received in New Mexico, according to Ms. Stevenson.

### **Communication and Review**

In response to subcommittee concerns, Ms. Stevenson agreed to share with the subcommittee, as well as an independent reviewer, the data being collected and the results of the pilot project.

### **Public Comments**

Gregory Bundrick, a behavioral health consultant, is concerned that SIS assessments may not be performed in a way that is sensitive to New Mexicans' culture or specific care needs.

Albert Montoya, executive director of the Ability Center, hopes to see a reduction of the waiting list and improvement in the services provided.

Peter Cubra, plaintiffs' counsel in the *Jackson v. Los Lunas Center for Persons with Developmental Disabilities* case, hopes to see more service providers, not fewer, such as more nurses, more case managers and more health care coordination for people with complex medical needs, to avoid preventable deaths.

Robert Sterns's son is in the DDW program, and he wanted to thank the subcommittee for its continuing support of the program and to express his happiness with the services received.

Fritzy Hardy, whose daughter is in the DDW program, agreed that the system needs to be changed, but cautioned, "don't drop lives".

Nannie Sanchez, who is in the DDW program, informed the subcommittee about a group called "Family Providers" that meets every Monday to discuss DDW issues.

Rosemarie Sanchez, mother of Nannie Sanchez, suggested that the DOH conduct annual audits on service providers, many of whom, she believes, fail to provide adequate services.

Mary Sciumbato's son is on the Mi Via waiver, which costs \$12,000 per year less than the DDW program. She is concerned about the renewal application for enrollees, which is confusing and was sent out with very little turnaround time. She also requested at least two weeks' notice before the public hearings so that stakeholders can participate.

Doris Husted, who is employed by the Arc of New Mexico and has a son who changed enrollment from the DDW program to the Mi Via program, thanked the legislature for its time and funding. She pointed out that the current rate of taking 50 people off the waiting list each year means that it would take 100 years to get all 5,000 people off the waiting list. Some people on the waiting list get old and die while waiting to get into the DDW program, and their needs are never addressed while waiting.

Ellen Pinnes, lobbyist for the Disability Coalition, praised some aspects of the proposed restructuring of the DDW, including recognizing the need for a more reliable and focused assessment process, support of meaningful employment opportunities and better matching of needs with services. She also pointed out that New Mexico's DDW costs may differ from other states' costs because fewer DDW program enrollees are institutionalized. Finally, she suggested that the HSD create a task force to study reorganizing the waivers, as the DOH has.

Anna Otero-Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, stated that home- and community-based waivers should not be included in any global waiver and that the best way to get people off of the wait list is to end the *Jackson* lawsuit and stop paying legal fees for that case.

Shelly de Abreu has been a special education teacher for the Albuquerque Public School District and a DDW teacher for 13 years. She stated that she is an advocate of home-based living versus the institutionalization and group homes that cost much more than waiver programs.

1 June 2011

Legislative Health and Human Services Committee  
Sub-Committee on Disabilities  
c/o Mr. Michael Hely  
New Mexico Legislative Council Service  
State Capitol  
Santa Fe, New Mexico 87501

Dear Mr. Hely:

We would like to thank the Committee for their continued attention to issues impacting the state's Developmental Disabilities waiver (DDW) during the legislative interim. As family based caregivers, we would also like to thank the legislature for its sustained backing of the DDW-a program that provides critical life and wellbeing services to thousands of New Mexico's most vulnerable residents.

As New Mexico continues to face budget challenges and also begins to consider a redesign of the state Medicaid program, we ask that the legislature remain committed to ensuring that the DDW be a 'person centered' program that adequately meets the unique needs and exceptionalities of those who depend upon it to lead fuller and more rewarding lives.

To that end, we ask the Legislative Health and Human Services Committee, Sub-committee on Disabilities to consider the following topics during the legislative interim.

**DDW Re-Application process should be transparent and inclusive of client and caregiver input** New Mexico is currently submitting a re-application for a DDW to the federal Centers for Medicare and Medicaid Services (CMS) as required by federal regulation. While the Department of Health (DOH) has solicited written comments on the proposed re-application, the department should also conduct public hearings so as to provide a broader range of DDW clients and caregivers the opportunity to comment. As DDW caregivers must generally secure substitute care to attend such meetings, the DOH should provide advance notice of at least two-weeks to better ensure stakeholder participation.

**Implementation of the Collaborative-Consultative model of therapy raises concerns regarding quality of care and client safety** The DOH is moving towards implementing a collaborative-consultative model for delivering therapeutic services. This model would require therapists to train individual DDW clients and their caregivers to either self-administer or provide therapies. Family caregivers remain unclear of the rationale for adopting this service delivery model, and are concerned that it may negatively impact the quality of therapeutic care that clients receive. Further, this model also raises issues regarding client safety, as some therapies will no longer be directly provided by a trained and licensed therapist.

**Clients and their caregivers should have greater control over individual budgets** Currently, how much a client can spend on a given therapy or service is capped. In practice, this limits the

ability of clients and their caregivers to direct resources in a way that best supports the client's individual needs. Inevitably, clients and their caregivers are the best decision-makers when it comes to identifying and meeting the client's individual needs. As such, the department should consider ways to increase the role that clients and their caregivers play in allocating resources within annual individual budgets.

**The DOH should provide information regarding how implementation of the AAIDD Support Intensity Scale (SIS) may impact benefit levels, and provide clients with due-process guarantees**

The DOH is currently piloting use of the SIS as a new tool for identifying the level of benefits, and thus care, that clients receive. To date, the department has provided clients and caregivers with little information on how benefits levels may change as a result of a SIS analysis, nor how new benefit levels compare to existing tiers. The DOH should provide this information to clients and caregivers as soon as practicable.

Further, it is conceivable that a SIS analysis may recommend a reduction in benefits for some clients. In order to protect client interests in the benefits they currently receive, the DOH should provide clients with due-process protections. These could include, but are not limited to, the right to appeal a SIS benefits-level determination, and to have the issue decided by an impartial decision maker.

The DOH should also ensure that persons conducting the SIS are experienced in working with the exceptionality of the clients whom they are evaluating. Additionally, in order to ensure a transparent and client-centered evaluation process, the DOH should include caregivers in the selection of potential SIS evaluators.

**Quality audits on standards and quality of care should be conducted by the department**

Caregivers are concerned about the quality of care that clients receive in some program settings. Specifically, we ask the DOH to conduct quality audits of residential and day-habilitation facilities, as well as rehabilitation services. If the department is already engaged in this activity, then reports should be made available to the legislature and the public. This level of oversight is essential to ensuring the effective and efficient use of public funds, and to protecting client safety.

We are committed to working with the LHHS and the Sub-committee on these and other issues during the interim. If the Sub-committee's schedule allows, we would request the opportunity to make a presentation at the June 24th meeting on these issues and how they impact both DDW caregivers and clients.

Please do not hesitate to contact Jacob Candelaria ([jacob.candelaria@gmail.com](mailto:jacob.candelaria@gmail.com)) with any questions, comments or concerns; or to arrange our presenting before the sub-committee.

Sincerely, Families who Care.

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

**July 6-8, 2011  
Taos**

The second meeting of the Legislative Health and Human Services Committee (LHHS) for the 2011 interim was called to order by Senator Dede Feldman, chair, on Wednesday, July 6, 2011, at 9:50 a.m. at the Taos Pueblo Community Center.

**Present**

Sen. Dede Feldman, Chair  
Rep. Nora Espinoza  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Danice Picraux, Vice Chair  
Sen. Gay G. Kernan

**Advisory Members**

Rep. Ray Begaye  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill (July 7-8)  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Rep. James E. Smith  
Rep. Mimi Stewart (July 6-7)

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Sen. Mary Kay Papen  
Sen. John C. Ryan  
Sen. Bernadette M. Sanchez

**Guest Legislator**

Rep. Roberto "Bobby" J. Gonzales (July 7)

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

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Zelda Abeita, Library Assistant, LCS (July 6)  
Rebecca Griego, Records Officer, LCS (July 7-8)  
Ruby Ann Esquibel, Legislative Finance Committee (LFC)  
Greg Geisler, LFC

**Guests**

The guest list is in the meeting file.

### **Handouts**

Copies of all handouts are in the meeting file.

### **Wednesday, July 6**

#### **Call to Order**

Senator Feldman called the meeting to order and the committee received a welcome and invocation in English and Tiwa by Pueblo of Taos Governor Nelson Cordova, who was joined by Pueblo of Taos Cacique Paul Martinez and War Chief Edwin Concha.

#### **Native American Health Concerns**

Governor Cordova stated that health care is a basic human right to which all are entitled. He added that the provision of health care for Native Americans is not what it should be.

Pueblo of Taos Tribal Secretary Antonio Mondragon informed the committee that the pueblo holds monthly health education sessions on such subjects as diabetes in its community center.

Maxine Nakai, director of the Pueblo of Taos Department of Health and Community Services, discussed the provision of health care services to tribal members at the joint Taos/Picuris Health Center, which includes preventative and rehabilitative care, as well as child and adult protective services. Specialized care requires staff members to drive tribal members to medical specialists, resulting in approximately 5,000 miles of driving per month. The Pueblo of Taos wishes to receive capital outlay appropriations for the following facilities to improve the health of its members: (1) inpatient and outpatient substance abuse treatment facilities; (2) a fitness center; (3) a senior daycare center; and 4) a wellness center. Ms. Nakai believes that the pueblos can fund operations without an appropriation.

Ms. Nakai stated that the secretary of health needs to have a good working relationship with Native Americans and to understand their health needs. The chair invited Pueblo of Taos members to attend the committee's meeting on Friday, July 8, at which Secretary of Health Catherine Torres would be presenting.

Barbara Alvarez, a policy analyst for the Indian Affairs Department (IAD), represented IAD Secretary-Designate Arthur Allison at this meeting. She stated that in November, there will be a health prevention week focusing on the needs of Native Americans. Ms. Alvarez also reported that the IAD health position is currently open.

Priscilla Caverly of the Office of Health Care Reform (OHCR) in the Human Services Department (HSD), stated that the HSD will protect Indian Health Service (IHS) and self-governed tribal "638" entities established pursuant to the federal Indian Self-Determination and Education Assistance Act of 1975 (Public Law 93-638) from cost-containment measures that

will affect other populations. Ms. Caverly stated that there has been no OHCR director since Governor Susana Martinez took office, and the governor has discussed the possibility of absorbing OHCR into the Governor's Office. The committee asked whether the governor is opposed to health care reform. Ms. Caverly responded that the governor, in vetoing SB 38 (2011 regular session), said that she supported the health insurance exchange and health care reform but wanted more information.

Ms. Caverly stated that there would be public hearings at which Native Americans' input on the topic of health care reform would be solicited. The committee members expressed concern that many tribal members may not understand from a typical newspaper or public service announcement that health care reform could affect them. Ms. Caverly stated that she would relay that concern to her office.

Ken Lucero, a member of the Pueblo of Zia who is the director of the Robert Wood Johnson Foundation Center for Native American Health Policy, recommended the creation of a steering committee under HJM 40 entitled "Health Care Reform for Native Americans in NM". Mr. Lucero stated that a clearinghouse must be established to ensure that the federal Patient Protection and Affordable Care Act of 2010 (PPACA) funds properly flow to Native Americans. In addition, Mr. Lucero stated that the PPACA health insurance exchange provisions must be explained to tribal members so that they can make informed decisions.

Roxane Spruce-Bly, director of the Bernalillo County Off-Reservation Native American Health Commission, worked with Mr. Lucero on HJM 40. She agreed with Mr. Lucero that it would be challenging to educate Native Americans about the PPACA via telephone or web-based sites and that face-to-face explanations would work best.

Ms. Spruce-Bly asserted that the federal government is obligated to provide health care services as long as Native Americans' health is worse than that of the dominant population. Ms. Spruce-Bly updated the committee about Native American health statistics as compiled by the Bernalillo County Off-Reservation Native American Commission. She estimated that 30% of the Native Americans residing in the Albuquerque metropolitan area come from out-of-state tribes and are ineligible for contract health care services from the IHS. Ms. Spruce-Bly stated that this has resulted in approximately 66% of Native Americans in Bernalillo County obtaining Medicaid coverage. She asserted that Native Americans should not have to declare poverty under Medicaid to have health care coverage.

Ms. Spruce-Bly listed the inadequacies in the provision of Native American health care services as follows:

1. Contract health services that Native Americans are supposed to receive at the IHS are so poorly funded that two-thirds of claims are denied.
2. Medicaid coverage did not appear to improve the health outcomes of Native American babies in Bernalillo County, only one-third of whom are born with a significant health issue.

3. Native Americans are not receiving primary care services on a consistent or adequate basis (due to lack of access for multiple reasons), resulting in a higher propensity to visit the UNM Hospital emergency room when the health issue becomes a crisis.

4. Although 90% of Native American women in Bernalillo County receive assistance through the federal Woman, Infants and Children (WIC) program, they are still less likely than the general population to see a doctor.

5. There is a strong link between diabetes, substance abuse and another disease, such as depression, that needs to be addressed.

6. Native Americans are three times more likely than other populations to die from diabetes.

Ms. Spruce-Bly then listed some possible solutions:

1. Native American health claims must be billed differently — perhaps under a carve-out plan or a tribal self-insured plan in order to get federal payment for Native American health care through the federal trust obligation. A carve-out plan for Native American health care could work under the governor's proposed global waiver plan. For example, the State of Arizona inserted one line in its global waiver excluding it from applying to Native Americans.

2. School-based health centers that serve the entire child-to-adult community are needed because they provide local access and are effective.

3. A tribal collaboration with entities such as the First Community Clinics, the DOH and UNM in Bernalillo County to operate as a tribal 638 entity would be optimal because then the entities would be eligible for a higher rate of Medicaid reimbursement through their off-reservation service contracts.

4. For new mothers, bundling primary care services with the receipt of WIC would make sense. A pilot project in Hidalgo County is doing this.

5. An appropriation of \$330,000 per year in operational funds could provide home visit programs.

In response to committee concerns about whether a 638 facility in Bernalillo County could also serve non-Native Americans, Ms. Spruce-Bly agreed to provide to the committee information on how that could be done.

Mr. Lucero stated that tribal leaders need to decide whether to take positions on the Indian Health Care Improvement Act and the potential changes to delivery of Native American health care that the PPACA will require and deliver them to the governor. Committee members asked how many PPACA grants the state has applied for since the current governor took office, and Ms. Caverly agreed to provide that information to the committee.

### **Native American Suicide Prevention**

Dr. Steven Adelsheim, director of the Center for Rural and Community Behavioral Health (CRCBH) and a professor at the Department of Psychiatry at UNM, presented the statistics on Native American suicides in New Mexico. For every 100,000 people, the rate of suicide among Native Americans is 10.7% compared to 4.1% for the non-Native American population. Of the 54 youth suicides between 2007 and 2009 in New Mexico, 49% were Native

American. Dr. Adelsheim agreed to provide to the committee the data behind these statistics. According to his colleague, Doreen Bird from Kewa Pueblo, the data show that suicides tend to be committed by persons who suffer dysfunction in their families, abuse substances or know someone who has committed suicide. The last factor is significant because tribes are close-knit communities. In response to the committee members' questions, Ms. Bird said that she has not seen data supporting an inference that being sexually abused increases the incidence of suicide. Committee members asked if there is legislation that Dr. Adelsheim and his colleagues need to make it easier to gather data to compile suicide statistics.

Ms. Spruce-Bly requested \$450,000 for implementation of SB 417 for Native American suicide prevention, which is an unfunded bill. Dr. Adelsheim stated that SB 417 is intended to provide technical assistance and culturally appropriate support for suicide prevention among Native Americans. Harrison Kinney, executive director of the Behavioral Health Services Division (BHSD) of the HSD, stated that he applied for federal funds to support the mandates of SB 417, but such funding is a year away. Dr. Adelsheim's group, which includes the DOH and Ms. Spruce-Bly, has started to examine ways to implement SB 417, in addition to seeking private foundation funds. According to Ms. Bird, the group has:

1. developed a process to inform tribal members;
2. delegated data collection to a working group;
3. expanded outreach to Native Americans; and

4. engaged stakeholders such as the Pueblos of Zuni, San Felipe, Acoma and Sandia, Kewa Pueblo and the Mescalero Apache Tribe, as well as the Navajo Nation and off-reservation Native Americans living in Albuquerque.

### **Substance Abuse and Mental Health Services Administration Grants for Behavioral Services in Tribal Communities**

Mr. Kinney stated that the BHSD funds Native American health consortiums, including the five pueblos located in Sandoval County and the Eight Northern Indian Pueblos. Mr. Kinney emphasized the importance of peer-to-peer relations in achieving positive outcomes. Two programs that provide peer-to-peer relations are the Shiprock Healing Circle and the Healthy Homes Project serving Navajos in the Farmington area.

Randall Berner stated that his organization, the Five Sandoval Indian Pueblos, provides behavioral health and other treatment services to the Native Americans and non-Native Americans in the community through independently licensed counselors and UNM psychiatric services videoconferencing.

Esther Tenorio, director of the Circles of Care, stated that the biggest problem in the Pueblo of San Felipe is alcohol abuse and the second biggest problem is domestic violence. The Pueblo of San Felipe was awarded a three-year federal Substance Abuse and Mental Health Services Administration grant, which is being used to develop pueblo-based services for behavioral health, including children's behavioral health, in a culturally competent way that combines both traditional support and western behavioral health services such as psychotherapy.

Bernie Teba stated that his employer, the Children, Youth and Families Department, mandated that he work collectively with the tribes.

Dr. Adelsheim stated that Maria Yellow Horse Braveheart, Ph.D., associate professor for the CRCBH at the Department of Psychiatry at UNM, has been working on obtaining a federal grant to support her work on transgenerational trauma, which particularly affects tribal communities.

Kathy Sanchez, program manager of Tewa Women United (TWU), explained that her center offers integrated traditional and western support services in the areas of: (1) sexual assault; (2) environmental health and justice; and (3) birthing. In addition, TWU offers a support network called the Circle of Grandmas. Ms. Sanchez explained that tribal members have suffered discrimination and shame over their traditional clothes, traditional language and substance abuse. She asserted that tribal members' pain and shame affects not only themselves, but also their descendants, through a pattern of exponential harm. Deep shame can lead to suicide, Ms. Sanchez stated.

The committee asked if there is legislation that Dr. Adelsheim and his colleagues need to create residential treatment centers for Native Americans.

### **Public Comments**

Rick Vigil, former governor of the Pueblo of Tesuque, stated that he has been involved in the managed care industry since 1999. He believes that tribes should avail themselves of the opportunity presented by the PPACA's insurance exchange provisions to take ownership of their insurance. Mr. Vigil wondered about what he described as the governor's opposition to the PPACA. Mr. Vigil emphasized the importance of positive government-to-government relations between tribal and state and federal governments and the need to communicate, collaborate and coordinate.

Pat Romero, who was born at the Pueblo of Taos, described his work for Taos Men, an organization committed to providing mentorship, support and advocacy services to tribal members who have committed acts of domestic violence.

The meeting recessed at 6:00 p.m.

### **Thursday, July 7**

The meeting reconvened at 9:14 a.m. Catherine O'Neill, Ed.D., executive campus director of UNM-Taos, greeted the committee.

### **PPACA and Health Insurance Legislation and Regulation**

#### **PPACA Insurance Mandates; Alignment of State Laws and Regulations**

John Franchini, superintendent of insurance, Public Regulation Commission (PRC), stated that the PPACA requires that there be more sharing of medical records and industry cost-cutting measures. He added that American health care is famous for being crisis-driven, which is expensive. He suggested that the better, less costly approach is for patients to use primary care from the beginning to avert crisis. He stated that everyone, including insurers, medical providers and individual insureds, must help keep health care costs, and thus insurance rates, down.

Craig Dunbar, chief deputy superintendent, PRC, discussed the federal ombudsman grant and the federal consumer assistance grant. He stated that for years, the PRC has had a Managed Health Care Bureau working with consumers and fielding consumer complaints.

### **Rate Review: Implementation of SB 208**

Superintendent Franchini stated that the rate review process now includes more procedures that allow rate increases to be approved with more diligence and care. Under current state law, federal guidelines must be used for determining insurers' claim payment obligations as follows: 80% of revenues must be used to pay insurance claims, and 20% of revenues may be used for administrative costs and profit. In addition, SB 208 (2011 regular session) requires the PRC's Insurance Division to present proposed rate reviews to the public. SB 208 also provides the opportunity to appeal a rate increase approval. Superintendent Franchini anticipates some rate increases this year and said that the federal government requires any single rate increase over 10% to be subject to federal review. Superintendent Franchini stated that consumers cannot afford a 15% rate increase each year.

### **SB 89: Private Health Insurance Purchasing Co-Op**

Superintendent Franchini stated that his office ran a model on insurance purchasing groups as described in SB 89.

### **Consumer Advocacy; Status of Development of the Office of Ombudsman**

Mr. Dunbar stated that the PRC has had a Managed Health Care Bureau for years. The bureau works with consumers and responds to their complaints. The federal consumer assistance grant will help the bureau to expand its automated system and enhance its web site by adding languages other than English and Spanish. Committee members suggested that the web site be linked to the state's sunshine portal. Committee members also stated that the purpose of the web site is to educate people who need information, which necessitates a tutorial that provides information through audio, visual and print. Mr. Dunbar was advised by committee members to keep Senator Rue and Senator Feldman informed about the web site.

Mr. Dunbar reported that the federal ombudsman grant will fund the position of ombudsman for the bureau. Mr. Dunbar stated that the bureau needs an ombudsman, regardless of whether health insurance exchanges are initiated by the state. The ombudsman could help both consumers and providers.

Mr. Dunbar stated that the federal rate review grant will enable the PRC to hire four extra people for the following positions already advertised: (1) information technology (IT) analyst;

(2) financial analyst/actuary; (3) consumer analyst; and (4) hearing officer. Committee members are concerned about what would happen to these positions after the one-year funding from the grant lapses, but Mr. Dunbar said he is applying to the federal Department of Health and Human Services (DHHS) for three additional years of federal funding for these positions.

Superintendent Franchini stated that all of these new legal requirements will increase access to care. Marla Shoats, lobbyist for BlueCross BlueShield of New Mexico, stated that the new legal requirements will slow down the rate increase process. She added that it is counterintuitive that rate increases would be disapproved while medical costs are not being held down. Bruce Butler, lobbyist for Presbyterian Healthcare Services (PHS), stated that the rate review bill would add a very slight cost increase to insurers, but it would not add costs to any other things. For example, Mr. Butler said that there already has been a very active appeals process at the Insurance Division of the PRC. Committee members suggested that having an ombudsman to ease and assist with consumer and provider concerns could lower health care costs.

In response to a committee question about what percentage of the state's population is privately insured, Christine Baca, bureau chief of the Managed Health Care Bureau of the Insurance Division of the PRC, stated that she would get back to the committee with that figure. Superintendent Franchini stated that he would provide the committee with copies of the annual reports submitted by the companies that provide private health insurance in the state. Committee members brought up a concern about the fact that PHS and Lovelace Health System are both providers and insurers. Superintendent Franchini said that there is some competition in the private health insurance market but not as much as he would like.

### **Health Care Reform and Hospitals**

Jeff Dye, president of the New Mexico Hospital Association, stated that he believes that universal health coverage is best for consumers, hospitals and providers alike. Mr. Dye believes that \$765 million will have to be cut from Medicare over the next decade. Mr. Dye mentioned that the governor vetoed a bill that would have formed a task force to study the creation of accountable care organizations (ACOs). The ACOs would be given a global budget and be responsible for the health outcomes of populations of patients. Setting up an ACO will require a lot of infrastructure, according to Mr. Dye, as the proposed Medicare ACO rules put too much burden on providers. There is a need for more balance in the rules, he said. He urged that Medicaid redesign not copy the Medicare model.

Committee members stated that a January 24, 2011 *New Yorker* article by Atul Gawande, "Hot Spotters", said that focusing on the 5% most expensive patients and getting non-medical personnel to work with them achieved cost containment, yet hospitals and doctors complained about a loss in revenues.

Mr. Dye discussed other Medicare-related health reform factors that are affecting or may affect hospitals, including value-based purchasing, bundled payments, health-care-acquired

infection penalties and health information exchanges. He voiced his regret that "tort reform" was not included in the PPACA, and he urged state-level tort reform.

Committee members inquired about the rise in urgent care facilities. Mr. Dye attributed that to patients' preference of 30-minute visits to urgent care over a three-hour to four-hour hospital emergency room visits. Committee members asked why urgent care services could not be made available as part of hospital care, to which Mr. Dye responded that the Emergency Medical Services Act requires hospitals to perform minimum screenings of all patients, which contribute to the cost of the visit, whereas stand-alone urgent care facilities do not need to do so.

In response to a committee question, Mr. Dye stated that the member hospitals were split in half on whether behavioral health care and physical health care services should be integrated. In general, his association supports the idea of coordinated care and also support the HSD's reduction of managed care organizations in the state from seven to three or four.

Committee members stated that hospital-acquired infections are the third- or second-leading cause of death and that either the University of Chicago or the University of Michigan has a program in which it admits the mistake and accepts blame, which are important keys to starting resolution and containing costs. Mr. Dye agreed that communication is key.

### **Health Care Reform and Business**

Gary Oppedahl, chair of the Health Committee of the state Association of Commerce and Industry, stated that his organization's recommendations on the health insurance exchange are generally those expressed in SB 38 (2011 regular session), which the governor vetoed. Mr. Oppedahl stated that businesses do not want to prevent reform and implementation of the PPACA, but they do want to participate in the implementation. He added that most small businesses do not have large human resources departments to read the PPACA and explain it. Committee members gave him the web address, [www.healthcare.com](http://www.healthcare.com), to access a web calculator.

### **HSD IT and the State's Response to the PPACA**

Brian Pietrewicz, chief information officer of the HSD, discussed the replacement of the current IT system, ISD2, that is used to determine Medicaid eligibility. The committee cautioned the HSD about the transition to a new IT system since the state has been burned on that before with the SHARE system. Mr. Pietrewicz stated that four companies bid to replace ISD2; the HSD visited the other states that have implemented the new IT system; the HSD brought in a project management officer; and the HSD has been working on the transition for two years. He asserted that the HSD cannot continue with ISD2, which is inflexible and cannot be adjusted to any Medicaid redesign. The HSD so far has invested \$20 million in the new IT system. The HSD could not postpone this process, he said, due to the PPACA deadlines. He said that the HSD can get reimbursement from the federal government after the state opts in to the health insurance exchange.

Ms. Caverly discussed the IT systems gap analysis, which is necessary to assess the state's readiness to implement key PPACA provisions, including the establishment of a health insurance exchange. Ms. Caverly stated that the gap analysis is a prerequisite to applying for federal establishment grants under the PPACA. There is no director of the OHCR.

### **New Mexico Medical Insurance Pool and Federal High-Risk Pool Update**

DeAnza Sapien, policy director of the New Mexico Medical Insurance Pool, stated that her organization insures otherwise "uninsurable" individuals and, for individuals with low incomes, helps to pay insurance premiums. Ms. Sapien stated that the state pool is at a 105% standard risk rate. She stated that there also is a federal medical insurance pool, begun shortly after enactment of the PPACA, to care for the sickest people first.

### **Health Care Work Force Programs at UNM-Taos**

UNM-Taos faculty Jim Gilroy, dean of instruction, Dr. O'Neill, Marty Hewlett, Ph.D., area coordinator for health sciences, and Kathy Falkenhagen, M.S.N., R.N., director of nursing programs, spoke to the committee about the health sciences programs at UNM-Taos. Ms. Falkenhagen stated that a Higher Education Department grant enabled the construction of a state-of-the-art simulation laboratory with a mannequin for the UNM-Taos nursing program. She stated that in 2010, 14 nursing students graduated from the two-year registered nurse (RN) associates degree program and passed their licensure examinations. Eleven of those students stayed in Taos to begin their nursing careers. Ms. Falkenhagen reported that students range from the ages of 22 to 62.

Ms. Falkenhagen hopes that the state's enhancement funding will continue to support the nursing program, which will alleviate the severe nursing shortage. Mr. Gilroy stated that the initial enhancement fund of \$250,000 was cut to \$125,000 and then cut to \$90,000. Mr. Gilroy stated that there are \$300,000 in expenses for the nursing program, and the only way to keep the nursing program alive would be to lower enrollment or to add a tuition surcharge. Committee members informed Mr. Gilroy that he could ask the legislature for additional funding.

Committee members asked if nursing students at UNM-Taos could seamlessly transition to the four-year bachelor of science in nursing (BSN) program at the main campus. Dr. O'Neill responded that students could remain in Taos and take satellite BSN courses being offered live in Albuquerque. Dr. O'Neill stated that the UNM-Taos nursing program is identical to other nursing programs offered throughout the state and that there is a consortium that meets eight times per year in accordance with a bill that passed requiring uniformity in the nursing programs.

Dr. O'Neill stated that nursing students also could obtain to a masters of science in nursing (MSN). After that, nurses could continue with their education to earn a Ph.D. The committee stated that in Taos County, the largest employer is Holy Cross Hospital. UNM-Taos faculty members provided handouts indicating that in Taos County, seven out of 10 jobs are in health care. Dr. O'Neill stated that the average annual starting salary for nurses is \$55,000, with full benefits.

Committee members asked about a job saturation level for nursing students, and Mr. Gilroy responded that graduating 16 nursing students per year would fulfill local staffing needs. It was observed that a cohort cannot be based solely on anticipated saturation. Based on anecdotal information, there is a very high demand for nurses due to high turnover, higher anticipated nursing needs under the PPACA when it is implemented in 2014 and the fact that most of the MSNs in the state are close to the age of 60 and may wish to transition to teaching or administrative duties due to the heavy physical demands of nursing.

The committee meeting recessed at 6:30 p.m.

### **Friday, July 8**

The committee meeting reconvened at 9:02 a.m.

### **DOH Oversight; Public Health Funding; Health Wellness and Prevention; Information Technology**

#### **Physical and Mental Health**

Secretary of Health Catherine Torres stated that physical health and mental health go hand-in-hand.

#### **IT at DOH**

DOH Acting Chief Information Officer Sean Pearson stated that the federal Health Information Technology for Economic and Clinical Health Act (HITECH) requires each state to have a health technology information coordinator, a function that he serves. He stated that there are federal requirements mandating the meaningful use of records. In his office, the meaningful use of electronic health records involves three stages: (1) the current stage — collecting data; (2) the second stage — reporting the data in 2013; and (3) the third stage — analyzing how health outcomes are being improved.

#### **DOH-Tribal Communication and Consultation**

Committee members mentioned that the Pueblo of Taos leadership expressed concern about the lack of openness on the part of the executive. Secretary Torres stated that she has attended two tribal consultations, has been active in planning a tribal summit to take place at the end of July or early August and has worked closely with IAD Secretary-Designate Allison.

Secretary Torres stated that the DOH tribal liaison is Dr. Ron Green from the Pueblo of Laguna. She admitted that she probably needs another liaison. Secretary Torres stated that the Epidemiology Division of the DOH works closely with the tribes to share data. Committee members asked about the impact of the DOH's modernization on tribal health care and asked Secretary Torres to provide the committee with a list of DOH funding and support of tribal health care programs.

#### **Prenatal and Postnatal Care**

Committee members inquired about cuts to WIC, which Secretary Torres heard would be significant. The committee members asked if Secretary Torres had contacted Congress about the proposed cuts to WIC. Secretary Torres responded that she did speak to U.S. Senator Tom Udall, U.S. Representative Ben R. Lujan and U.S. Representative Martin T. Heinrich. The committee moved to act on the proposed WIC cuts by: (1) immediately sending a letter to the congressional delegation urging that WIC cuts either not be made or be kept to a minimum; and (2) assessing the cuts when they are made, then writing a follow-up letter discussing whether WIC implementation procedures address recipient accountability.

Jane Peacock, a nutritionist with WIC, stated that funds used for WIC are the best possible use of money for target populations of women, infants and children. She stated that WIC screens women for drug, alcohol and tobacco use and acts as a referral source to get pregnant women the medical care they need. She asserted that the purpose of WIC is to promote optimal birth outcomes, and 70 studies show that WIC works. In response to a committee concern, Ms. Peacock stated that 95% of women on WIC are not on drugs.

### **Funding Cuts Affecting DOH**

Committee members stated that the legislature did a disservice by cutting funding to health councils. Secretary Torres agreed that health councils are very beneficial, and she wants to see the legislature return and find out how to address the funding of such councils.

Secretary Torres addressed other funding cuts. She told the committee that prenatal care clinic funding was cut on the grounds that such services are available elsewhere, but she is dubious about where and whether it is available to all women who need prenatal care. She also said that the legislature asked that the DOH not duplicate services, yet it is a hardship to transfer providers from location to location. Dr. Maggi Gallaher of the DOH's Infectious Disease Bureau stated that a DOH provider would have to drive several hours to see a patient in a remote location when that provider could be in the provider's office seeing several patients in the same amount of time.

### **Medical Marijuana**

Secretary Torres has visited three of the 25 producers of medical marijuana in the state. She stated that the DOH is in the first year of collecting licensing fees from them. She told the committee that close to 4,000 people in the state are approved to use medical marijuana, and they must carry state-issued cards to avoid arrest. She added that many cancer patients who are in remission turn in their cards. To obtain a card, any licensed physician practicing in the state must write a prescription for medical marijuana to treat one of the diagnosed listed illnesses. The patient would then submit the prescription with an application to the Cannabis Division of the DOH. Committee members expressed concerns about the burden on law enforcement to verify patient participation in the program when the cards do not show a picture of the patient.

### **Tobacco Settlement Funds**

The committee discussed the state's use of \$38 million to \$40 million in tobacco settlement funds for health care. Committee members asked whether the attorney general (AG)

or the executive had informed the DOH about legal challenges to the tobacco settlement that, if successful, could require the state to repay money already received and expended. Secretary Torres indicated that she is unaware of such legal challenges. Committee members urged the DOH to discuss the matter with the AG's Office. Committee members stated that an LFC report indicates that the legal challenges are based on tribal tobacco sales in 2003 and 2006. Committee members also stated that Senator Lynda M. Lovejoy sponsored a bill that would have fixed a glitch in a tobacco tax law, passed in 2010, about participating and non-participating producers, but the governor vetoed Senator Lovejoy's bill. Secretary Torres stated that she would meet with the governor the following week and inform the committee about how to fix the glitch.

#### **New Mexico Health Policy Commission Data**

Committee members stated that the New Mexico Health Policy Commission was successful, yet funding and staff were cut. Committee members asked who would be taking charge of the health care data that the commission had compiled. Secretary Torres indicated that the Epidemiology Division would take custody of it. Committee members and Ms. Esquibel stated that the enabling language and confidentiality provisions in the law that created the commission could prevent that data transfer. Committee members suggested working with Secretary Torres to amend the law to allow the data to be maintained by the DOH.

#### **Health Care Reform and PPACA Update; Status of Grant Tracking and Applications**

Vickie Howell, Ph.D., director of the Office of Performance at the DOH, said that last year her office started tracking grant announcements and awards. She said that half of the PPACA grants have been awarded to state agencies and the rest to other entities. Her office searches the DHHS and federal health care reform web sites to search for award notices by state. Committee members were concerned that the DOH is not getting that information any sooner than when it is posted on the web site.

Dr. Howell stated that her office tracks grants so that no more than one state agency applies for the same grant. Committee members also expressed concern that her office had to track information, indicating a lack of willingness to share information on the part of agencies. Committee members suggested that there should be a central clearinghouse for the grant information. Committee members also mentioned that SJM 1 should be resuscitated and that a director should be appointed to the OHCR.

In response to the committee's question about whether, since January 1, 2011, the DOH has applied for any federal funds for accountable care, Secretary Torres responded that she would give the committee a list of the federal grants that are available to the DOH. The committee expanded the request to a list of all grants available under the PPACA, which Secretary Torres agreed to provide.

Jane Wishner, founder and executive director of the Southwest Women's Law Center, stated that her organization has applied for the community transformation grant under the PPACA.

## **Public Comment**

Gladys Cosal, a Pueblo of Taos member, is concerned about inadequate health care for Native Americans due to cultural and geographic barriers between providers and patients. She also is concerned about inadequate allocations of food stamps to Taos food stamp applicants.

Dick Mason of Health Action New Mexico supports legislative health councils.

Joan Stafford of the New Mexico Coalition for Reproductive Health urged the legislature to caution the DOH regarding WIC cuts, as infant and mother mortality rates are still alarming.

## **OHCR Stakeholder Panel: Consumer, Provider and Insurer Stakeholders**

### **Consumer Stakeholders Group**

Ms. Wishner is also the chair of the Consumer Stakeholders Group. She stated that her organization's mission is to increase opportunities for women and girls, many of whom are unaware of the multitude of opportunities available to them. She stated that part of SJM 1 (2011 regular session) would have established a working group to promote consumer education and protection. She stated that stakeholders have had no guidance from the Governor's Office on how it wants stakeholders to participate in the discussion on health care reform. Her stakeholder group understands that no state can apply for stage two grants without setting up an exchange office, but stage one grants are available for IT needs. She believes that stage one grants also are available for staffing and planning purposes. Her group asked Superintendent Franchini to apply for a consumer assistance grant, which he agreed to do. She urged the state to apply for all available PPACA grants. Finally, she added that her group asked the OHCR to post online all subcontractor contracts.

### **Insurance Stakeholders Group**

Mike Wallace of Delta Dental, co-chair of the Insurance Stakeholders Group, said that his group seeks innovation and competition in an insurance exchange. Milton Sanchez of BlueCross BlueShield of New Mexico, co-chair of the Insurance Stakeholders Group, said that his group supported the health insurance exchange but wanted insurance stakeholder representatives included on the board (Ms. Wishner disagreed with that). He also said that his group wanted legislation to allow the board to determine how many and which health plans would be part of the exchange. His group looks at medical loss ratios and tries to determine what needs to be done to keep the private insurers that are in the state as well as to bring in more competition. Mr. Wallace agreed with committee members that in the future, healthy behavior should be incentivized.

### **Medicaid Stakeholders Group**

Craig Acorn, managing attorney at the New Mexico Center on Law and Poverty, spoke on behalf of the Medicaid Stakeholders Group. His group believes that all New Mexicans will gain from a health insurance exchange, which will close the gap in coverage for the uninsured who are impoverished yet do not qualify for Medicaid. His group also believes that closing the gap will save health care costs by reducing the amount of emergency care received. His group

believes that, in addition to establishing a health insurance exchange, the gap in coverage also can be remedied by: (1) streamlining the Medicaid application process; (2) having the state use the poverty data from users of the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families Program and Head Start to enroll Medicaid-eligible persons; and (3) presuming Medicaid eligibility for families going to the emergency room without health insurance and extending Medicaid coverage for that visit and health care for the next several months. Mr. Acorn stated that Medicaid has to be coordinated with the health insurance exchange since many income-volatile people will be on the cusp of Medicaid eligibility and could fall through the cracks.

Mr. Acorn cited 2010 data from the HSD indicating that 62,000 children are eligible for Medicaid or the Children's Health Insurance Program, yet only 5,500 of those kids were enrolled as of March 2011. Committee members had concerns that when there was a Medicaid fund shortfall, the HSD decreased efforts to enroll people. Committee members also discussed with Mr. Acorn, as well as Ellen Pinnes of the Disability Coalition, data from a UNM Bureau of Business and Economic Research study that predicted growth in health care jobs due to the additional health care services to be provided post-health care reform. Committee members asked Ms. Esquibel to provide the number of people employed by the health care industry.

#### **Comments on Stakeholder Input**

Enrique Romero, OHCR, thanked the committee for giving the stakeholders, who are part of the Governor's Advisory Group, a chance to speak. Committee members stated that every New Mexican should have the same access to quality health care. Committee members stated that the Provider Stakeholders Group was invited but did not attend the meeting and apparently has not met at all since the fall. Mr. Romero also said that the Small Business Stakeholders Group kind of dissolved. He said that he would try to get it going, upon the committee's urging, but with only Ms. Caverly and himself staffing the OHCR, it would be difficult.

Buffie Saavedra, United Health Care, also has considered the gaps in coverage for low-income populations. Her organization wants the HSD to keep it informed about Medicaid redesign, including how it will affect people on the waiting list for Medicaid long-term service. Her organization wants to make sure that all available PPACA funds are applied for and used.

Ms. Saavedra stated that many impoverished people are on waiver wait lists and receive limited services. Her organization hopes that a health insurance exchange will save money. She believes that the Medicaid system is severely broken because it does not serve everyone in need.

Mr. Acorn stated that his group does not necessarily disagree that the Medicaid system is broken, but his group is concerned about the blade being used to make cuts and the opacity of the process. He asserted that changes to the program should not be implemented in a way that devastates the people who need the program.

Committee members requested independent analysis of the following programs proposed by Secretary of Human Services Sidonie Squier in her Medicaid reform campaign: (1) enhanced

benefit program or medical savings accounts; (2) pay for performance activities in Medicaid implemented in such states as Maine, Massachusetts, Arizona, California, Oklahoma, Pennsylvania, Michigan, Rhode Island and Florida; and (3) federal Section 1115 waivers.

### **Further Stakeholder Input Solicited**

To gain information that could be useful for setting up a health insurance exchange, Mr. Romero stated that a phone survey of 750 uninsured or underinsured people was conducted to learn about the impediments to health insurance coverage that people face.

### **Health Insurance Exchange Deadlines**

Committee members discussed the provisions under the PPACA whereby the state must have a health insurance exchange starting up by January 2013 and fully operational by January 2014. Committee members added that if the state were to start a health insurance exchange, then an appropriate bill would need to be ready for the next regular session or for a special session in 2012. Committee members also pointed out that some legislators have concerns about the previous health insurance exchange bill and prefer that the federal government run and fund the exchange. Committee members expressed concern that the legislature be included in the Medicaid redesign and health insurance exchange efforts.

### **Health Care Reform in the Taos Community**

Michael Kaufman, M.D., a Taosño provider and member of the New Mexico Medical Society, stated that his group is designing an integrated system for health care delivery. He stated that there is evidence that medical home care models are the superior health care model for efficacy and economy, yet that model is not funded. Instead, doctors are paid to see people a few times a year. Based on the current fee-for-service model, Dr. Kaufman said, it is difficult to get patients to modify their behavior to control their obesity or diabetes. Dr. Kaufman stated that the medical home model saved millions on Medicaid costs in North Carolina, and in Denmark, the medical home model reduced readmission to hospitals by 30%. He also said that Oregon has passed a bill allowing communities to provide medical homes. Dr. Kaufman cited a Virginia study showing that 68% of Medicare money was spent on the 5% most expensive patients.

Jemery Kaufman, M.D., stated that under the current fee-for-service model, doctors are paid to keep patients sick, which results in a low-value health care system. However, if providers are organized under an ACO that is responsible for good outcomes, then there would be more healthy patients, lower health care costs and a high-value health care system. She stated that doctors would have to be organized and maintain good data. The Kaufmans also said that even the electronic billing codes would have to be changed to reflect a holistic, not fee-for-service, system of care. In addition, she stated that there would have to be financial incentives to reward doctors for saving the system money. Dr. Jemery Kaufman stated that there is a model in Grand Junction, Colorado, that can be looked at, but while its patients are well-managed, BlueCross BlueShield of New Mexico takes the savings and profits out of the community and redistributes them to out-of-state locations or shareholders. She stated that providers could form their own insurance company if they are organized enough, although they could run into problems with the Federal Trade Commission.

Dr. Jemery Kaufman stated that her group is designing a medical home model for all of Taos County, and it wants participation from the Pueblo of Taos, which has not bought into it yet. She stated that her group plans to provide medical services based on each patient's needs, not by rationing, and at lower costs than the current model. Committee members asked how such a model would be administered in a larger area. Dr. Michael Kaufman stated that a medical director would be needed to coordinate efforts and negotiate with insurers, and electronic records would be required. He said that the average primary care physician spends \$70,000 per year filling out referral forms. That inefficiency could be eliminated under the medical home model. He did say that barriers would include whether providers could share money and trust insurers.

Committee members asked what the committee could do for the group. Dr. Michael Kaufman stated that adapting the Oregon bill to a New Mexico version would help. He added that Holy Cross Hospital supports the group. The patients at Holy Cross Hospital are divided somewhat evenly among the following groups: (1) Medicaid recipients; (2) uninsured patients; (3) Medicare recipients; and (4) private insurance patients.

Dr. Jemery Kaufman stated that if and when the PPACA goes fully into effect, then the business model for insurers will change dramatically and insurers will no longer be able to cherry pick the healthiest, lowest cost patients to insure. When insurers can no longer deny coverage to keep profits high, they will be very interested in cost savings that can be achieved through the medical home model.

The committee adjourned the meeting at 4:11 p.m.

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

**August 17-18, 2011  
Western New Mexico University, Silver City**

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, at 9:10 a.m. on Wednesday, August 17, 2011, at Western New Mexico University (WNMU) in Silver City.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Nora Espinoza  
Rep. Dennis J. Kintigh  
Rep. Antonio Lujan

**Absent**

Sen. Gay G. Kernan  
Sen. Linda M. Lopez  
Sen. Gerald Ortiz y Pino

**Advisory Members**

Rep. Ray Begaye (8/18)  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia  
Sen. Cisco McSorley  
Sen. Sander Rue

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Rep. Eleanor Chavez  
Rep. James Roger Madalena  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez  
Sen. John C. Ryan  
Sen. Bernadette M. Sanchez  
Rep. James E. Smith  
Rep. Mimi Stewart

**Guest Legislators**

Rep. Rodolpho "Rudy" S. Martinez  
Sen. Howie C. Morales

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

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Abenicio Baldonado, Intern, LCS  
Greg Geisler, Analyst, Legislative Finance Committee (LFC)

RubyAnn Esquibel, Principal Analyst, LFC

**Wednesday, August 17**

At Senator Feldman's request, Senator Morales welcomed the committee, speakers and audience to Silver City and thanked them for coming.

Tony Trujillo, president of the Grant County Prospectors Civil Organization, welcomed the committee.

Joseph Shepard, Ph.D., president of WNMU, welcomed committee members and informed them that there are 3,600 students attending WNMU, where the schools of nursing and occupational therapy are vital to meeting the health care work force needs of southwestern New Mexico.

James Marshall, mayor of Silver City, also welcomed the committee to Silver City.

Representative Martinez welcomed the committee and stated that it is necessary to recognize the needs of rural communities and the huge needs of the health care system and to figure out what it will take to provide health care services to those with the greatest need, including the underprivileged. He added that the Department of Health (DOH) is running a 200-bed long-term nursing facility that will need financial support as the population of Grant County ages.

Committee members asked Dr. Shepard how many WNMU graduates are residents of Silver City and how many received jobs in Silver City upon graduation. Dr. Shepard indicated that he would get back to the committee with that information. Dr. Shepard said that WNMU wishes to expand its health care program, as the many aging baby boomers will be living far longer than previous generations and will need many health care services.

**Reinventing Medicaid Through the Medical Home**

Mary Takach, M.P.H., R.N., program director of the National Academy for State Health Policy, presented on the medical home model as applied to Medicaid. She distributed a handout titled "Reinventing Medicaid Through Medical Homes". She told the committee that the United States has the best health care system to care for the sick yet the worst system to keep people from getting sick. She stated that the decades-old research on primary care indicates that resources must be shifted to primary care. Ms. Takach stated that the U.S. rates low on primary care infrastructure and the ability to provide primary care yet rates high on health care spending.

Ms. Takach stated that medical homes are a way to integrate care and improve communication among providers. Committee members asked Ms. Takach to distinguish between the medical home model and health care homes. She referred the committee to page 14 of her handout, and stated that sometimes the terms are used interchangeably.

Ms. Takach said that several states tie Medicaid payments to objective medical home evaluation criteria. States such as Iowa, Maine, Maryland, Massachusetts, Michigan, New York, North Carolina, Pennsylvania, Rhode Island, Vermont and West Virginia have adopted National Committee for Quality Assurance (NCQA) medical home standards, which broadly include:

1. enhanced access to and continuity of care;
2. identifying and managing patient populations;
3. planning and managing care;
4. providing self-care support and community resources;
5. tracking and coordinating care; and
6. measuring and improving performance.

Ms. Takach stated that seven other states have developed their own standards for tying Medicaid payments to objective medical home criteria outside of the NCQA criteria, which include Colorado, Minnesota, Nebraska, Oklahoma, Oregon and Washington. She stated that bringing the care coordinator to the patient produces better outcomes.

Ms. Takach reported that the average age of these programs is two years, but some states' Medicaid surveys show that modest bumps in fee payments to primary care providers pursuant to the medical home model have resulted in dramatic reductions in overall health care costs that derive from emergency room visits and other high-need services. In most states, these programs are implemented on a budget-neutral basis. For example, Oklahoma saw a decline in per-member, per-month costs of Medicaid even though the medical home model was implemented on a budget-neutral basis. In addition, Oklahoma had a drop in patient complaints about same-day/next-day appointment availability from 1,670 to 13 in one year.

In response to committee members' inquiries, Ms. Takach stated that she could not serve as a consultant for the state or the committee, as her organization does not give feedback about whether a state's policy is good or bad. Her organization simply gathers and compares states' data, and she stated that she would be happy to be a resource to the committee.

Ms. Takach suggested that the medical home model should be much more cost-effective because many of the primary health care services would be delivered by non-physicians such as nurses and behavioral health care specialists. In response to committee members' questions, Ms. Takach stated that medical home models will require primary care providers to: (1) provide patient-centered care and inquire about whether patients' needs are being met; (2) follow whether patients' health outcomes are being improved; (3) determine if patients' behavioral health needs also are being met; and (4) have strong relationships with other care providers to provide auxiliary medical services so that patients receive complete medical services. If providers lack such relationships, Ms. Takach continued, then it would be hard to provide continuous care for patients. She emphasized that strong relationships in the medical community must be established before the medical home model can be attempted. The provider groups must be sufficiently high functioning and organized before becoming accountable care organizations (ACOs) with integrated delivery systems, she insisted.

Committee members asked whether a bureaucracy will have to be in place to monitor outcome-based care. Ms. Takach stated that she has observed a continuum of monitoring in the various states. Some states, such as many following the NCQA standards, have no bureaucracy or oversight and use the NCQA's judgment as to the quality of a medical home program. Other states not following NCQA standards, such as Minnesota, or those with standards above and beyond the NCQA standards, such as Vermont, employ more oversight and even perform Medicaid audits. Ms. Takach stated that some states such as Vermont and Minnesota do not use managed care to manage Medicaid.

Committee members suggested that Ms. Takach's data indicate that most providers are not following evidence-based guidelines for the practice of medicine and outcomes. Ms. Takach said that some states require providers to use a guidelines checklist to make sure that appropriate screenings and effective alternative health care options are considered.

Committee members pointed out that the Kaiser Family Foundation data show that the costs of Medicaid, listed on page 11 of her handout, are rising more slowly than health care costs in the non-Medicaid arena. The committee asked Mr. Geisler to find out the per-person cost for Medicaid patients versus non-Medicaid patients in the state.

### **Groundbreaking for the Integrated Primary Care Clinic at Hidalgo Medical Services (HMS) and Tour**

At the groundbreaking, Charlie Alfero, chief executive officer of HMS, distributed a brochure describing the new HMS facilities. Mr. Alfero and other members of the HMS staff and community, including legislators and representatives from Congress, spoke at the groundbreaking.

### **HMS: Community Health Teams and Community Health Workers**

Mr. Alfero distributed handouts and spoke about the populations that HMS serves. He contrasted the current vertical system of health care with the new model he advocates, which will be horizontal and will improve health outcomes and reduce costs. In one example of a vertical system of health care, he found 62% savings over a typical horizontal health care system.

Mr. Alfero stated that HMS's system of health care delivery includes the provision of behavioral health, dental health and health-related services, including nutrition and diet, to focus on the delivery of care and meaningful health outcomes. Mr. Alfero stated that at HMS, community health workers work one-on-one with patients to improve health outcomes. HMS budgets two to two-and-a-half patients per hour.

Carmen Maynes, director of community organization development at HMS, said that HMS's community health workers work with patients and their families, often in their homes, and help with the process of obtaining medication, food stamps and Human Services Department (HSD) services. Ms. Maynes illustrated the necessity of providing such services with the example that patients will not address their diabetes conditions if they cannot afford electric or gas utilities.

Mr. Alfero stated that community health workers advocate for their patients' improved health outcomes by helping them receive, to the extent possible, education about health and healthy food, housing and job search assistance and family support. He said that HMS has experienced statistically significant drops in blood sugar levels of diabetics who are seen by just one community health worker.

Ms. Maynes stated that staff at HMS know of one patient who went to the emergency room of the hospital 40 times in one year because that patient was homeless and needed food and a place to sleep. Mr. Alfero said that this individual inappropriately used the health care system to get a bed and food. Ms. Maynes stated that an HMS community health care worker found a bed at a residential facility while Molina provided transportation to the facility for the patient. Committee members asked why the emergency room staff did not flag this individual before the number of visits reached 40. Ms. Maynes responded that now that HMS has contracted with Molina, HMS hopes that such inappropriate use of emergency room services will not occur.

Mr. Alfero emphasized the importance of community self-determination. Mr. Alfero believes that state agencies and state-funded agencies and organizations have a duty to work with HMS and the HMS model to improve community health outcomes and to work on more demonstration projects to create a more credible health care delivery system. As an example, he stated that HMS engages in community outreach by working with teen moms. He said that HMS was able to help 90% of teen moms in the HMS program graduate from high school, a much higher rate of graduation than the overall 60% graduation rate in the state. Mr. Alfero stated that one of the greatest indicators of future health and use of Medicaid is high school graduation. Mr. Alfero asserted that when high school graduation rates increase, there will be health care savings from improved health and reduced enrollment in Medicaid.

Committee members asked whether some of the data Mr. Alfero presented will be reported in a formal study. Mr. Alfero said it will come out in the Annals of Managed Care, which staff was asked to provide to the committee.

Mr. Alfero said that the standardization of private medical practice is good to a certain point, but the ability of providers to make independent decisions is also important. Mr. Alfero stated that current care is based on following the dollars and driven by volume and concentration of siloed care. He stated that currently, providers do not track an individual's treatment by other medical providers, resulting in both the possible duplication of and inadequate provision of medical services.

Mr. Alfero believes that spending a set amount per Medicaid patient to manage the patient's care will save thousands or hundreds of thousands of dollars. Committee members asked if the HMS model can be scaled to different environments, both urban and more rural. Mr. Alfero answered in the affirmative. Committee members pointed out that HMS provides all services under one roof and wanted to know if HMS's model could be utilized successfully and cost-effectively by a currently operating, spread-out facility in a place like Albuquerque. Mr. Alfero said that there is Commonwealth Foundation data and HMS internal data showing that

immediate cost savings will result from implementing the medical home model in just about any community. A committee member stated that just because the federal government said that the medical home model will work does not guarantee cost savings or avoidance of another huge bureaucracy. Ms. Maynes said that HMS has implemented four community health centers in other communities and that the model is scalable. According to Ms. Maynes and Mr. Alfero, the initial up-front investment will turn into long-term savings. Mr. Alfero said that if financial incentives are put into outcomes and overall health care costs are lowered, then that is what people will do.

Committee members stated that the role of state government is to provide services to people with needs. Committee members said that it appears that HMS starts with the patient, then looks at the providers who can be coordinated to serve the patient. Committee members suggested that the DOH, the HSD, and the Public Education Department try, in a similar vein, to coordinate the provision of services by starting with an assessment of the stakeholder's needs, then coordinating services to increase efficiency and effectiveness and reduce duplication.

Mr. Alfero and Ms. Maynes said that HMS helps its patients coordinate applications for services from various state agencies. Such help navigating the state system is necessary, as each patient could be required to fill out 33 different applications for such services as food stamps, housing, Head Start and Medicaid enrollment, according to Mr. Alfero and Ms. Maynes. Mr. Alfero stated that HMS uses a software program called Chassis to auto-fill such applications for patients and is trying to integrate such software with its medical records database.

In response to committee members' questions, Mr. Alfero stated that he has not supported the certification of community health workers because then they become fee-for-service community health workers.

Mr. Alfero stated that he supports bulk payments for outcomes. For example, he said, there is a model where providers get a bulk payment with an instruction that patients be kept out of nursing homes. He added that there is more than enough money being spent on health care to support an outcome-based health care model.

### **Forward New Mexico: Work Force Development**

Darrick Nelson, M.D., chief medical officer at HMS, discussed provider supply and work force retention issues. He mentioned that House Memorial 2 (2011 regular session) created a task force to study work force development of health care providers, including not only physicians but also nurses, midwives and other health care providers. He stated that recently it was determined that there is a need in this state for 168 physicians, 34 nurse practitioners, 16 physician assistants, 20 registered nurses, two licensed practical nurses, one certified nurse midwife, 46 dentists and seven dental hygienists, and that the greatest need is likely in rural areas.

Dr. Nelson said that promoting work force development should start within the state and must start in the primary schools. He stated that the University of New Mexico's (UNM's) BA-MD program searches for program candidates from the state's high schools.

Tamera Ahner, work force development coordinator at HMS, spoke about the current year work plan. By providing volunteer programs for high school students seeking immersion in health clinics, health career clubs for middle and high school students, mentoring and shadowing opportunities and communication through online social media and more traditional means, HMS gives students opportunities to discover which health fields they may be interested in joining. She added that HMS wants to increase the number of students coming into New Mexico to study and to join the health care field.

Committee members asked how to get more health care professionals in the areas where they are needed. Dr. Nelson firmly believes that it starts in the primary school level. There are curricula that can be offered in schools, and school counselors can be educated on how to inform students about their options pursuing health care careers.

Dr. Nelson stated that half of the students from the state who are in the UNM BA-MD program are from rural areas. Mr. Alfero said that students from rural areas are more likely to become primary care providers and more likely to practice medicine close to home.

Brian Bentley, chief executive officer of the Gila Regional Medical Center, discussed an impediment to physician recruitment in the state. He said that he had to pay the salary of a physician who agreed to work for the center yet could not start his job and practice in the state for six months due to credentialing delays, and such delays cost the center \$100,000. Committee members asked how they could help. Dr. Nelson advised the committee to stay on the same course, continue to support loan repayment options and continue to be innovative about recruiting students to the state.

### **Panel Discussion: ACO Models**

Mr. Hely distributed a handout and gave an overview of ACOs. Mr. Hely stated that initial presentations about ACOs were based on the Academy of Health version, but now there are numerous possible versions of ACOs. Mr. Hely stated that the National Conference of State Legislatures describes ACOs as a structure that combines new medical service delivery forms with new forms of provider payments and that is designed to save costs. Under the ACO model, the payer negotiates risks and cost savings with providers and apportions payments accordingly. Mr. Hely added that the idea of care coordination and information sharing through information technology is critical to ACOs. Many ACOs are based on capitated systems (per member, per month), such as those systems used by managed care organizations. In contrast, some use partial capitation, so that part of care may be carved out. The Academy of Health model requires all payers to discuss how the cost of care and payment for care will be apportioned between providers, according to Mr. Hely. Moreover, ACOs can be established for Medicaid, Medicare or in the private insurance realm. The federal Patient Protection and Affordable Care Act of 2010 (ACA) provides for the establishment of Medicare ACOs.

Lisa Farrell, vice president of integrated care solutions at Presbyterian Healthcare Services, elaborated on the establishment of Medicare ACOs. She reported that her office would be filing its ACO application in two days. She informed the committee that Kaiser Medical in California has been operating an ACO for a long time. She stated that the ACO model requires accountability, responsibility to patients and management of costs. There is a significant amount of care management necessary in an ACO, according to Ms. Farrell. She stated that the proper infrastructure must be built and care must be given to patients in their homes through telemonitoring and home visits by case managers in order to prevent readmission to hospitals. The challenge in the current system is that such follow-up and preventative care is not paid for. The ACO model provides for higher simultaneous profit-sharing and risk-sharing based on an actuarial model. Ms. Farrell stated that her organization has a lot of experience in the risk-based reimbursement capitation model.

Mr. Alfero reminded the committee of House Bill 35, which the legislature passed during the 2011 regular session. It would have created an ACO task force in Hidalgo County, but Governor Martinez vetoed the bill. Mr. Alfero stated that he knows of no current plans to create an ACO model in Hidalgo or Grant County and that HMS has no plans to apply to be a Medicare ACO.

#### **Public Comment**

Reza Ghadimi, P.A., taught a physician assistant's course at UNM that was popular but it was cut due to budget constraints. He emphasized the need for physician assistants in the state and the need to preserve programs to produce them.

#### **Recess**

The meeting recessed at 5:31 p.m.

#### **Thursday, August 18**

The meeting reconvened at 9:15 a.m.

#### **Update and Panel Discussion on Medicaid Redesign**

Julie Weinberg, director of the Medical Assistance Division of the HSD, distributed a handout about Medicaid redesign, which she said will focus on administrative streamlining, payment reforms, aligning incentives across the program, better quality health care and improved health outcomes. She stated that one of the benefits of obtaining a "1115 waiver" from the federal Centers for Medicare and Medicaid Services (CMS) will be to give the HSD time to redesign Medicaid to provide better quality for less money. Listed on pages 5 and 6 of her handout are the key concerns expressed at the eight public meetings that the HSD held in July and August of 2011 to solicit public input on Medicaid modernization.

Ms. Weinberg reported that the HSD solicited input about Medicaid modernization from tribal leaders at the single tribal consultation, as listed on page 7 of her handout. Ms. Weinberg said that she expects there to be more tribal consultations on Medicaid redesign.

She also reported that the HSD met with smaller stakeholder groups such as the New Mexico Hospital Association, Salud!, the Coordination of Long-Term Services Program, the New Mexico Health Care Association, the New Mexico Association for Home and Hospice Care, representatives from advocacy groups for women, children, the physically and developmentally disabled and the poor, the New Mexico Primary Care Association and the Medicaid Coalition.

Ms. Weinberg thinks that the HSD can provide better health care and contain costs under its Medicaid modernization. The HSD's four principles of Medicaid modernization, according to Ms. Weinberg, are to: (1) develop and implement a comprehensive, coordinated service delivery system (explained more fully on page 16 of her handout); (2) pay for performance and require provider and health plan responsibility (explained more fully on page 15 of her handout); (3) require personal responsibility on the part of patients (explained more fully on page 14 of her handout); and (4) gain administrative simplicity (explained more fully on page 13 of her handout). The HSD has not decided yet whether to include the developmental disability waiver in the 1115 waiver and whether to carve in or carve out behavioral health.

Ms. Weinberg said that the development of health information technology is critical to Medicaid modernization.

Ms. Weinberg stated that Medicaid currently takes up 16% of the state budget, and that the CMS projects a 5.8% per year increase in health costs, which is faster than the economy is projected to grow.

Gwen Cassel, program director for the Department of Allied Health at WNMU, brought her first-year occupational assistants class to observe the meeting. Committee members suggested that copies of Ms. Weinberg's handout be distributed to these students.

Alicia Smith, president of Alicia Smith and Associates, contributed to Ms. Weinberg's handout and was present during Ms. Weinberg's presentation.

Mr. Bentley said that the center worked with four different Medicaid managed-care Salud! contractors, one of which arbitrarily stopped paying on the contract. He believes that the non-paying Salud! contractor owes the center \$1 million. Mr. Bentley agrees with the concept of personal responsibility for an individual's health. He also believes that pay for performance is already happening in the health industry and that his center can demonstrate it. Mr. Bentley said that the center's expenses have increased, yet its revenues have not increased. He believes that the 40 or so additional performance measures to be imposed by Medicare will require the incursion of additional costs, as the center will have to hire employees to review and submit the proper documentation to comply with the additional performance measures. Mr. Bentley

indicated that administrative rule simplification and flexibility to allow the center to provide care inexpensively would be ideal. He said that in contrast to HMS, private doctors receive no payment to provide longer visits and follow-up care. Mr. Bentley anticipates a huge increase in enrollment in Medicaid. Mr. Bentley urged the committee to support and encourage health care provider educational programs at state higher educational institutions to reduce the constant recruitment from other states.

Karen Carson, M.D., president of the New Mexico Pediatric Society and chief of pediatrics at BCA Medical Associates, distributed handouts and testified as a private physician in Roswell. She supports the concept of requiring personal responsibility and co-payments from Medicaid patients. In her observation, 25% to 30% of the Medicaid patients at her office do not need medical services. For example, she stated, runny noses can be taken care of by a grandmother or an aunt. In another example, she stated that patients will use an office visit to obtain a prescription for over-the-counter medications such as analgesics so that Medicaid will cover the cost because Medicaid will not cover the same medication as a non-prescription drug.

On the issue of co-payments, Dr. Carson believes that Medicaid patients should be charged for sick visits, visits to the emergency room and missed appointments but not for well visits. She also believes that there should be a sliding scale, since for the truly destitute, a \$1.00 co-payment means no milk for the day. However, for those at 200% of the federal poverty level, a \$1.00, \$2.00 or even a \$5.00 dollar co-payment is reasonable, she believes. She reported that people at the top of the Medicaid income level come in to her office with their nails done, drive beautiful cars and play on Nintendo Game Boys.

Dr. Carson indicated that reimbursement for Medicaid can be problematic. She lamented that when the Salud! contractors delay or wrongfully deny Medicaid reimbursement, they do not have to pay interest. Because one of the Salud! contractors failed to update immunization codes in January, as it should have, \$4,000 worth of immunizations administered in the spring went unpaid until just before this committee meeting. She reported to the committee that a physician in Las Cruces had to take out a loan to pay for office operating expenses and go unpaid for a couple of months when a Salud! contractor delayed reimbursements. Committee members suggested that Ms. Weinberg and the HSD should investigate the Salud! contractors' lack of accountability.

Dr. Carson agrees with pay-for-performance measures for providers. However, she does not want to see a reduction in the amounts of Medicaid reimbursements, which she believes would result in a reduction in the number of providers willing to see Medicaid patients.

Quela Robinson, staff attorney for the New Mexico Center on Law and Poverty, distributed a handout and said that her center represents low-income people in the state. She said that her center is glad that the HSD solicited public comment and has refrained from committing to charging Medicaid patients co-payments and integrating the developmental disabilities waiver into the global waiver. Ms. Robinson reported that 25% of the population, which amounts to 550,000 people, in the state are on Medicaid. She clarified that to qualify for Medicaid, patients

must be not only impoverished but also, in most cases, disabled, elderly, pregnant or a minor child. Sixty percent of Medicaid enrollees are children, she stated. She added that the next largest group of Medicaid recipients is seniors. She asserted that Medicaid is not a charity.

Ms. Robinson stated that the HSD's Medicaid redesign should start with the concerns repetitively expressed at the public hearings by stakeholders, instead of with the HSD's four principles of Medicaid redesign.

Ms. Robinson disagreed with charging Medicaid recipients co-payments, as 20% of New Mexicans cannot pay for food. In addition, she said that for the vast majority of people, it is in their best interests to see medical providers and that missed appointments are often the result of unreliable transportation or the inability to get time off from an hourly wage job. Moreover, she asserted that fees and co-payments will not save money for the state because when people cannot afford co-payments, they will avoid seeking medical care until the crisis stage. This ultimately would result in greater costs, she stated.

Ms. Robinson suggested that before the state seeks to expand the managed care system, the system should be scrutinized to determine how and whether it is working. Ms. Robinson stated that the Center on Law and Poverty is concerned that an expansion of managed care would result in difficulties receiving services, as has occurred in Florida and Tennessee.

As for the HSD's proposed pay-for-performance measure, Ms. Robinson stated that she has seen no evidence that pay for performance would result in the improvement of health outcomes rather than just an increase in administrative costs for oversight and monitoring.

Ms. Robinson reported that her center is concerned about a global waiver that would include home, community and developmental disability waivers. She stated that the 1115 waiver sought by the HSD would give the state the discretion to waive any aspects of Medicaid.

Bill Jordan, policy director of New Mexico Voices for Children, distributed two handouts, one titled "The Economic Benefits of Health Care Reform in New Mexico" and the second describing the tax revenue impact of the ACA. He expressed appreciation for the HSD's and Ms. Smith's engagement of the advocates in the Medicaid redesign process. A redesign that does not result in a reduction of eligibility, benefits or access to care would be great, he said. However, Mr. Jordan warned, the last time Medicaid was described as "unsustainable", during the early part of the Richardson administration, 30,000 children lost their Medicaid coverage. The state has the second highest rate of uninsured kids in the nation, and many children who are eligible for Medicaid are not enrolled. This is due to a lack of political will to ensure coverage for eligible children, according to Mr. Jordan. He believes that the ACA could help remedy that situation.

Mr. Jordan directed the committee to his first handout, "The Economic Benefits of Health Care Reform in New Mexico", which contains projections for Medicaid enrollment for 2012 and 2014 and projections for the amount of federal dollars that could flow to the state under the

ACA. According to this handout, between 2014 and 2020, the state should receive between \$10.5 billion and \$13.3 billion, by a "very conservative estimate". Furthermore, Medicaid expansion will bring in a great deal of money that will offset any expense the state can expect to incur.

In response to committee concerns, Ms. Weinberg said that even if the developmental disability waiver is incorporated into the 1115 waiver, the state cannot do whatever it wants; a change in Medicaid benefits would require a formal request to the federal government and solicitation of public input. Committee members advised Ms. Weinberg that the HSD should demonstrate that a 1115 waiver would save money rather than cause the state to lose out on federal funding. Committee members suggested that, rather than making cuts to Medicaid, the state should raise taxes or agree to the ACA.

As for whether behavioral health care should be included or carved out of a global waiver, Ms. Weinberg stated that she has always been opposed to "silo"-ing mental health from physical health care, as the brain is part of the body.

Committee members asked the HSD what role the legislature will have in this process. Ms. Weinberg agreed to give committee members a copy of the 1115 waiver application with an attached summary. Ms. Weinberg asserted that there is no guarantee that the HSD will solicit the committee's input before submitting the 1115 waiver application. However, there will be a long process of dialogue with the federal government during the 1115 approval process, she said. Committee members suggested that the HSD give them an outline of the proposed application sooner rather than later. Committee members mentioned that staff will have to get started on any legislation that may need to be prepared for the 2012 regular session to implement a 1115 waiver. Ms. Weinberg agreed to present the committee with a concept paper before the application is completed.

Mr. Hely stated that Cindy Mann, director of the Center for Medicaid and State Operations at CMS, said that states that have zero cost sharing would have their federal match payment — known as the federal matching assistance percentage (FMAP) — increased by 1%. Ms. Weinberg had not heard of that, nor had Ms. Smith, although she did not deny that could be true. The committee chair expressed the expectation that the HSD would verify that information and report back.

### **Minutes Approved**

The minutes from the July 2011 committee meeting were approved.

### **Public Comment**

Kathleen Hunt, the executive director of Border Area Mental Health Services, stated that her clinic serves people from a broad, rural, frontier area, regardless of their ability to pay and on a sliding-scale or no-fee basis. She described co-payments as a collection nightmare and an unbearable administrative burden. Her clinic supports the carving out of mental health services from the global waiver to avoid a dilution of services.

Sylvia Sapien, director of the promatora program at Dona Ana County's La Clinica de Familia, stated that her program focuses on parenting. La Clinica de Familia, Ms. Sapien explained, is one of the first clinics of its type in the state. She stated that there are a few adult patients on Medicaid in her clinic who drive fancy new cars (in response to Dr. Carson's comment), but there are many more who have to wash their dishes with bar soap because they lack the money for dishwashing liquid.

Doris Husted of the Arc of New Mexico said that promotoras are critical in New Mexico, since there many families lack the ability to negotiate the medical system. Ms. Husted asked that incentives such as Medicaid debit cards not be used to discriminate against people with developmental disabilities; that practitioners not be punished under a pay-for-performance system; and that practitioners not be given incentives to select only those patients who can get better quickly. She stated that the most severely mentally ill are long-term patients who will not improve quickly.

Jim Jackson, executive director of Disability Rights New Mexico, stated that he will join with other members of the disability coalition to meet with the HSD to discuss the impact that co-payments will have on individuals with developmental disabilities. Mr. Jackson asked that the HSD focus on how to improve health services to Medicaid recipients and not drive the system based on the fear that it will go broke. Mr. Jackson added that his group believes there is room for cost savings in the developmental disability waiver program without cutting services to those in the program. Cost-saving measures would allow people to be added to the developmental disability waiver program from the wait list.

Barbara Webber of Health Action New Mexico stated that the redesign of Medicaid and Medicare presents an opportunity to change the health care system to a preventative care model. She pointed out that in all other industrialized countries, the proportion of doctors is 70% primary care doctors to 30% specialists. In the U.S., it is the reverse, she said.

Evangeline Zamora of Life Quest, Inc., asked that the Medicaid redesign spare emergency room services, the family, infant, toddler program and the developmental disability waiver from cost-cutting measures.

Anna Otero Hatanaka of the Association of Developmental Disabilities Community Providers said that there already are changes happening now to the developmental disability waiver that she hopes will produce benefits for the medically fragile and most disabled.

Sandra Adondakis, New Mexico government relations director of the American Cancer Society Action Network, spoke about the hardship that co-payments would impose on cancer patients, who go through periods when they see doctors numerous times each week. Even a small co-payment such as \$4.00 per provider over the course of a month could render treatments unaffordable, she said. She stated that patients who forgo medical care due to financial impediments could delay seeking treatment, resulting in later stage diagnosis and treatment and ultimately higher health care costs.

### **New Mexico Health Policy Commission: Health Care Work Force Data Collection**

Jerry Harrison, Ph.D., acting director of the New Mexico Health Policy Commission (HPC) and executive director of New Mexico Health Resources, distributed a handout about HPC data records. As the HPC is unfunded, Dr. Harrison asked the committee to resuscitate the provisions of a 2009 bill so that all functions of the HPC may be transferred to the DOH, to which Secretary of Health Catherine Torres agrees. Specifically, Dr. Harrison recommends that:

1. the HPC functions be transferred to the DOH;
2. the DOH continue to have access to the hospital inpatient discharge data system, which is at least 30 years old;
3. the UNM Health Sciences Center and the DOH work around the geographic access data system;
4. the legislature fund the HPC for the period when such functions are transferred; and
5. there be a public advisory committee to oversee the data records formerly maintained by the HPC.

In addition, Dr. Harrison lamented the lack of analysis since the defunding of the analyst position in 2009 of the hospital inpatient discharge data system data submitted under statutory mandate by hospitals and the Regulation and Licensing Department. The committee chair agreed to take on the legislation suggested by Dr. Harrison and wondered about whether it could be put on the governor's proclamation for the upcoming special session.

### **Status of DOH Program Contracts; Disabled Children Services; Prenatal Services; Immunizations; Tuberculosis Treatment; and Buprenorphine Treatment for Incarcerated Individuals**

Secretary Torres distributed handouts titled "Status of Prenatal Care", "Brain Development in Children", "Health Care Work Force Data Collection" and a handout outlining DOH contract processes and record-keeping processes.

Secretary Torres also distributed handouts showing fiscal year 2011 tribal memoranda of understanding, fiscal year 2012 tribal professional service contracts and fiscal year 2012 tribal provider agreements.

The committee chair asked Secretary Torres to ask the governor about the process of transferring all of the HPC data to the DOH, which initially will require a bill. The committee chair suggested that such a bill be placed on the proclamation for the special session.

Secretary Torres referred the committee to the handout containing updates on DOH contract processes and record-keeping processes. That handout included a flow chart showing the state's use of the procurement process; the professional service contract provider agreement process; contracts funded in fiscal year 2011 and contracts not funded in fiscal year 2012; discussion of the federal Family Educational Rights and Privacy Act of 1974; discussion of the federal Health Insurance Portability and Accountability Act of 1996; a list of goals for the provision of children's medical services and children's medical services provider agreements; a

list of immunization programs and contracts and tuberculosis programs and contracts; and a discussion of the suboxone (buprenorphine) treatment program with a list of contracts and agreements. Secretary Torres contrasted the daily \$12.00 per-patient cost of suboxone treatment, which adds up to \$10,920 per year, with the \$30,000 annual cost of incarceration.

Jim Green, deputy secretary of the Department of Finance and Administration, spoke about the New Mexico Abilities process. For more information about New Mexico Abilities, a central nonprofit agency that provides comprehensive statewide support to foster development of contracts for New Mexico people with disabilities, community rehabilitation programs and public bodies, see [www.newmexicoabilities.org](http://www.newmexicoabilities.org).

Gayle Kenny, bureau chief of the Infectious Disease Bureau of the DOH, referred to the DOH's handout and discussed the DOH's actions in treating hepatitis in the state.

Secretary Torres informed the committee that Dr. Dan Derksen was appointed as the director of the executive's Office of Health Care Reform and started working in that capacity two weeks ago. Prior to the committee meeting, Dr. Derksen reported to the committee chair that he would work on applying for an ACA grant for the health insurance exchange. The committee chair wants Dr. Derksen to speak at the committee meeting in October.

Committee members asked whether the DOH has a general counsel. Secretary Torres said that she is still searching for a general counsel, but that the DOH employs six attorneys, including Ramona Schmidt, who reviews all DOH contracts. By July 29, 2011, Secretary Torres had signed at least 1,000 provider contracts, most involving CMS, thus meeting the retro-payment requirement.

Committee members were concerned that people released from jail would not have access to suboxone opioid addiction therapy due to lack of payment means. Dr. Maggi Gallaher, medical director of the Family Health Bureau of the DOH, discussed vendor issues that affected the suboxone program. She stated that those issues apparently have been addressed and resolved.

Committee members inquired about school-based health center contracts. Secretary Torres stated that the contracts allow the provision of health care services on September 1. Committee members were concerned about the gap in services, given that this school year started on August 15, 2011 in most districts.

In response to a committee member's inquiry about the DOH's most important unfunded or inadequately funded need, Secretary Torres responded that school-based health clinics and the protection of minors are her biggest concerns, in addition to the continued provision of hepatitis, tuberculosis and addiction treatment services.

Committee members inquired whether the director position at the Fort Bayard treatment facility is being filled. Secretary Torres responded that Fort Bayard has the most difficult

director position to fill due to the location and the requirement that the director be hospital-certified. A handout about the Fort Bayard treatment facility was distributed by a member of the public who did not submit her name.

Cathy Stevenson, deputy director of the Developmental Disabilities Supports Division of the DOH, spoke about the developmental disabilities waiver. Committee members asked whether the DOH spoke to the HSD about not compromising the current waiver programs. Secretary Torres stated that the DOH is using its assessment tools to get to the point where people can be taken off the waiting list.

### **ACA: Federal Fund and Grant Opportunities**

Ms. Esquibel distributed two handouts prepared by the Federal Funds Information for States (FFIS) and State Policy Reports: "Health Care Reform Grant Allocations Per State" and "Status of Funding Opportunities in Health Care Reform Law". Ms. Esquibel reported that New Mexico received the first \$1 million for planning the health insurance exchange and may apply for two subsequent tiers of funding for implementation. The amounts of subsequent funding will depend on the application, including how the scope of work is described.

Ms. Esquibel stated that the state should be strategic in how it applies for and uses federal funds. She said that the federal congressional "super committee" could decide on funding cuts to state programs but that ACA funds could replace the state funds that are cut.

Ms. Esquibel explained that some of the grants for which the state could apply include exchange innovation grants, which have been awarded to seven other states in the amount of \$50 million; grants for professional health care recruitment, some of which UNM has sought. Some grants have deadlines and other grants provide rolling opportunities for application, according to Ms. Esquibel.

Committee members asked whether grants are available to fund capital outlay for community health centers. Ms. Esquibel stated that she believes that there are grants to fund the operational budgets of, but not the capital outlay for, community health centers. Committee members asked whether community health centers have received information about grant opportunities under the ACA. Ms. Esquibel suggested that the question be submitted to Dr. Derksen now that he has become the director of the Office of Health Care Reform.

Committee members also asked Ms. Esquibel how many ACA funds were applied for by this administration as opposed to the last administration. Ms. Esquibel did not know the answer to that but said that the DOH under Secretary Torres is applying for a community transformation grant under the ACA. The DOH seeks community transformation grants to create spaces based on Las Cruces revitalization areas that feature schools, walkable spaces, nutritional programs, gardens and community health centers, according to Mr. Hely. Ms. Esquibel added that the community transformation grants are not capped and the amount will depend on how the application is structured.

Ms. Esquibel promised to provide LCS staff with FFIS updates on ACA grant opportunities as they are posted every three months.

The meeting adjourned at 2:15 p.m.

**MINUTES  
of the  
FIRST MEETING  
of the  
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE OF THE  
LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**

**August 19, 2011  
Mesilla Valley Hospital, Las Cruces**

The first meeting of the Behavioral Health Services Subcommittee (BHSS) of the Legislative Health and Human Services Committee was called to order on August 19, 2011 at 10:07 a.m. at the Mesilla Valley Hospital in Las Cruces.

**Present**

Sen. Mary Kay Papen, Chair  
Rep. Ray Begaye, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Bernadette M. Sanchez

**Absent**

**Advisory Members**

Sen. Sue Wilson Beffort  
Sen. Dede Feldman  
Rep. Miguel P. Garcia  
Rep. Antonio Lujan

**Guest Legislators**

Rep. Zachary J. Cook  
Sen. Howie C. Morales

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Abenicio Baldonado, Intern, LCS  
Greg Geisler, Legislative Finance Committee

**Minutes Approval**

These minutes have not been approved by the Behavioral Health Services Subcommittee as subcommittee members were not available for approval before the subcommittee finished its work for the interim.

**Friday, August 19**

**Welcome**

Brian Hemmart, chief executive officer, Mesilla Valley Hospital, welcomed the subcommittee and led a tour of the hospital.

**Interagency Behavioral Health Purchasing Collaborative (IBHPC) Update: OptumHealth Contract Report**

IBHPC director Linda Roebuck Homer introduced the IBHPC's new deputy director, Diana McWilliams, and informed the subcommittee that Ms. McWilliams has also taken on the role of monitor with respect to the ongoing corrective action plan (CAP) under which OptumHealth of New Mexico (OptumHealth) is operating. Alicia Smith and Associates, a contracting agency, used to be the state's monitor, but when it was hired for the Medicaid redesign project, it resigned as CAP monitor.

Ms. McWilliams greeted subcommittee members and informed them that she was a former legislator from the State of Delaware. She distributed a handout entitled "Presentation to the LHHS, Behavioral Health Services Subcommittee Behavioral Health Purchasing Collaborative Update" (Human Services Department (HSD) handout). Ms. McWilliams covered pages 1-18 of the handout. Ms. McWilliams agreed to provide to the subcommittee the tables of data in the handout in larger print.

Subcommittee members inquired about the data on page 10 of the HSD handout regarding turnaround time for claims payment and including information about claim denials. Since the HSD issued the CAP, OptumHealth has been playing 99% of its claims within 30 days to 60 days, according to Michael Evans, chief executive officer of OptumHealth. Mr. Evans stated that he did not know the rate and number of denial of claims, but he agreed to provide that information to the subcommittee later in the day. Subcommittee members also asked for the criteria for the denial of claims. Mr. Evans said the criteria include those "basic to the industry", "national standards" and "local standards". Mr. Evans further explained that there are clinical practice guidelines and medical necessity guidelines that cover OptumHealth's claims processing. The subcommittee requested information regarding the populations — gender, race, class, age — on which guidelines are based.

Subcommittee members asked the total dollar amount that OptumHealth receives in its role as the statewide behavioral health entity. The annual contract is for \$370 million to \$380 million, depending on Medicaid rolls. OptumHealth paid for the monitoring when Alicia Smith and Associates performed the monitor role, and it continues to do so now that Ms. McWilliams, a classified state employee, has assumed that role. A subcommittee member raised a concern regarding the independence of the monitor when OptumHealth was actually paying for her services.

Ms. Homer stated that OptumHealth spent \$330 million in fiscal year 2010 on direct services.

Harrison Kinney, director of the HSD's Behavioral Health Services Division, told the subcommittee that the HSD funds the Turquoise Lodge, a substance abuse treatment facility.

Subcommittee members asked why the state cannot get Medicaid funding for residential inpatient treatment at such places as Turquoise Lodge, Yucca Lodge and Mesilla Valley Hospital. Ms. Homer explained that states have been fighting the Centers for Medicare and Medicaid Services' institutional mental disease (IMD) exclusion rule since its inception 20 years ago. The IMD rule states that adults cannot be covered by Medicaid in an institution unless the majority of the care they receive is not behavioral health-related. Ms. Homer promised the subcommittee a brief describing the IMD issue.

Subcommittee members reviewed the HSD handout, which describes the number of claim denials over time. Upon request, Ms. McWilliams told the subcommittee members that she would send staff for the subcommittee a spreadsheet in color showing the dip in accurate claims for July 2011.

Mr. Evans said that the statewide entity contract requires OptumHealth to maintain a 3% or lower inaccurate or inappropriate denial rate under an audit. Marilyn Van Horn, chief operations officer of OptumHealth, stated that OptumHealth is contractually limited to no higher than 10% denials overall. Inappropriate denials must make up 3% or lower of these denials, she explained. "Inappropriate denial" means a provider submitted a claim accurately and OptumHealth inappropriately denied it. The percentage is not 10% of contract dollars; it means 10% of the total number of claims. Subcommittee members wondered what dollar amount was being denied. Subcommittee members wanted to know dollar amounts on services already provided but that the payer is denying, voicing concerns that behavioral health providers are losing money due to these denials.

Mr. Evans did not know how much it would cost a provider to appeal an OptumHealth denial. An appeal entails a peer-review process to get more information to see whether medical necessity criteria are met. OptumHealth has to issue its determination within two days of its receipt, Mr. Evans believes. The costs likely vary according to whether the provider is small or large. Subcommittee members asked Mr. Evans to provide data on the cost of appeals for providers. Subcommittee members stated that too many denials for small providers could put those providers out of business. Mr. Evans said OptumHealth wants to keep providers in business.

Subcommittee members wanted data on the claims appeals process as well as on administrative denials — how many per year, what kind of denials, dollar amount and actual denials, how many, what kind and whether providers whose claims are denied are small providers or large providers. A subcommittee member stated that OptumHealth should have that data or it would be neglecting its job. Ms. Van Horn stated that OptumHealth's estimate of the cost of processing a claim is \$25.00. Ms. Homer informed the subcommittee that the IBHPC has a lot of this information but has not yet compiled it. Ms. Homer said that the HSD and OptumHealth would provide all of that information that same day.

Ms. Homer provided an overview of the claims appeals process: a claim is made, and, if denied, OptumHealth requests more information. After receiving that information, OptumHealth has three days in which to issue a determination. A request for reconsideration may thereafter be filed with OptumHealth. Upon an unfavorable redetermination, the matter may then go before Ms. Homer at the IBHPC. Thereafter, it may go to the New Mexico Medical Review Association (NMMRA).

When asked about CAP sanctions against OptumHealth for its violations of the contract, Ms. Homer stated that no monetary fine had been assessed upon OptumHealth but that OptumHealth was required to pay 60% of denied claims. Forty percent of the claims were classified as "egregious" denials, requiring the NMMRA to do independent reviews of these. The authorization rate of reconsiderations is 20%. Subcommittee members asked whether interest was being paid on denials, and Mr. Evans said there was no interest paid.

Ms. Homer informed the subcommittee that in its first year as the statewide entity, OptumHealth was sanctioned \$1 million. When the IBHPC amended its contract with OptumHealth, OptumHealth volunteered to fund \$2 million in substance abuse treatment and suicide prevention in Native American and rural communities. Hence, OptumHealth paid out \$3 million at that time, plus the cost of the monitor and its information technology system reconfiguration.

Subcommittee members inquired whether smaller providers and rural providers with fewer administrative staff tend to experience a higher rate of denials, and they requested that the IBHPC provide that data.

Ms. Homer brought to the subcommittee's attention the information on pages 19 through 26 of the HSD handout about: (1) quality improvement goals; (2) performance measures; and (3) health homes.

Mr. Evans next gave his presentation. He distributed a handout entitled "An Overview Presentation" and presented information about OptumHealth's: (1) investment in Native American communities as well as telehealth; (2) value-added services; (3) community reinvestment; and (4) core service agencies.

A subcommittee member asked whether value-added services came out of OptumHealth's administrative losses or medical losses. Mr. Evans replied that value-added services are counted as administrative losses. In response to a question regarding the need for value-added services when core service agencies are supposed to provide comprehensive services, Mr. Evans stated that he thinks that the need for additional services may be attributed to geography.

Jim Ogle of the National Alliance for the Mentally Ill-New Mexico (NAMI) distributed two handouts as follows: (1) a list of concerns from the NAMI to the BHSS about OptumHealth's management of the statewide entity contract; and (2) a copy of a February 21, 2011 letter from the NAMI to Secretary of Human Services Sidonie Squier. Mr. Ogle addressed

the subcommittee about the information in the NAMI handouts. The subcommittee asked OptumHealth to provide within 10 days a written response to the NAMI's concerns as listed in the first NAMI handout.

Subcommittee members expressed the concern that OptumHealth should pay providers interest on reversals of denials of claims. They referred to paragraph 3 of the NAMI's February 2011 letter to Secretary Squier saying that denial of claims results in an extensive loss of revenue to providers, causing many to begin the process of laying off employees and reducing services. The subcommittee discussed writing a letter to request from the HSD's counsel an opinion on whether OptumHealth could be forced to pay interest on denied claims and through adjudication found to have been wrongly denied. Ms. Homer stated that she would request from the HSD's general counsel an opinion in this regard.

Subcommittee members also brought up the statement in the NAMI's list of concerns that OptumHealth had failed to execute its promise in the request for proposals (RFP) to implement crisis response teams throughout the state. These teams are instrumental in protecting individuals living with mental illness from inappropriately entering the criminal justice system. Mr. Evans said he would respond to each of the NAMI's points.

The subcommittee considered the question as to how widespread it is that people living with mental illness get taken to jail inappropriately. Ron Gurley, executive director of the Doña Ana County Forensic Intervention Consortium, a jail diversion program for mentally ill individuals, addressed the subcommittee and stated that the lack of inpatient beds for mental health patients means that mentally ill people often go to jail as an alternative when behavioral health facilities have reached their very limited capacities. Mr. Gurley articulated a need for more mental health courts, pretrial services and diversion to mental health facilities. He stated that Doña Ana County has about 300 beds. Bernalillo County Jail has more than 700 inmates on anti-psychotic drugs. The average stay for individuals living with mental illness in jail is more than 300 days. Mr. Gurley stated that there should be crisis response teams in emergency rooms to divert the people who are there because of mental illness episodes to mental illness treatment facilities.

A motion was made, which was seconded and which the subcommittee then approved. As first stated, the motion was to request that Mr. Evans respond regarding his opinion on OptumHealth's contractual obligations to fund a crisis response team and a request that the IBHPC meet as soon as possible with Mr. Evans to resolve issues from the past and establish what future actions can occur. Mr. Hely requested clarification as to the motion's content. The subcommittee members clarified that the motion was for Mr. Hely to write to the IBHPC and the HSD's general counsel on behalf of the subcommittee and request issue of a legal opinion as to whether:

- interest is due to the providers whose claims were the subject of a recent settlement between OptumHealth and the IBHPC;

- monetary sanctions should be imposed upon OptumHealth for its improperly denied claims; and
- the IBHPC may be required to fund a crisis response team to assist law enforcement in properly working with individuals living with mental illness who are having symptomatic episodes.

Another motion was made, seconded and approved by the subcommittee to direct Mr. Hely to draft a letter on behalf of the subcommittee to Secretary Squier requesting that she respond to each point in the February 21, 2011 NAMI letter.

Becky Beckett, advocate and family member of a behavioral health services recipient, stated that there is more to mental health services than giving medications, and services cannot be cut. Upon request, Ms. Beckett provided the subcommittee with copies of 15 letters from behavioral health services consumers addressing their concerns with OptumHealth and cuts to behavioral health services. In some ways, Ms. Beckett explained, OptumHealth was helpful in that it was quick to help get her daughter's new prescription filled. On the other hand, the paperwork burdens imposed by OptumHealth have not been helpful. Her daughter's providers insisted that she use the time set aside for her therapy session to fill out paperwork for OptumHealth reimbursement, and Ms. Beckett's daughter had to leave without receiving therapy services.

A subcommittee member asked how widespread it is for mentally ill people to be jailed for behavioral health-related incidents. Mr. Ogle responded that 5% to 6% of incarcerated individuals have a mental illness; in Albuquerque, it is closer to 30% of prisoners. Roswell has a new mentally ill prisoner incarcerated each day.

Mr. Gurley stated that the problem of inadequate behavioral health service availability in the state is "compounding itself". There is a drastic shortage of beds for residential or inpatient treatment. He suggested that the federal government may end up running the state's behavioral health system if things do not improve.

Ms. Beckett informed the subcommittee of her opinion that there are not enough core service agencies to serve the state's population of people living with serious mental illness. She explained that, when it is not convenient — *i.e.*, patients are geographically dispersed — individuals will not seek out the core service agencies; they will just go without the services they need.

Ms. Beckett produced a packet of letters to Governor Martinez. The subcommittee passed a motion to make the letters part of the minutes. (See attached.)

### **RFP for Statewide Behavioral Health Entity; IBHPC Pilot Project**

Roque Garcia distributed a handout that included HB 432 (2011 regular session), an article abstract entitled "U.S. Physician Practices Versus Canadians: Spending Nearly Four

Times as Much Money Interacting With Payer", a flow chart of funding for behavioral health and a flow chart of regionalization.

David Hedgcock, executive director of Providence of Arizona, Inc., stated that his entity is based on prevention and its fiscal setup provides incentives to keep people out of the "system". Subcommittee members questioned the value of returning some children to harmful home environments where they will not get the same quality of care as in a residential treatment facility. Mr. Hedgcock stated that the pilot project model promotes regional community solutions. Ms. Beckett stated that she agrees with the regional community approach.

Ms. Homer distributed a handout entitled "RFP for the Statewide Entity", which lists time lines for the statewide behavioral health entity contract. She also distributed a handout from the New Mexico Behavioral Health Expert Panel, dated August 15, 2011, entitled "White Paper Draft". Ms. Homer told the subcommittee that in a few weeks, she would be able to provide an update to the subcommittee about the RFP for a behavioral health statewide entity and Medicaid modernization.

A subcommittee member inquired whether the RFP would include the sharing of risk between providers and a managed care entity. Ms. Homer stated that it could.

A question was asked of Mr. Hedgcock as to whether Providence of Arizona's operations were certified by the National Committee on Quality Assurance as an accountable care organization. He informed the subcommittee that they were not.

A subcommittee member asked whether the behavioral health pilot project would use quality measures to assess the project. Mr. Garcia responded that it would. He went on to explain that administration and profit should be capped at 10%. Providence of Arizona's operations in Tuscon have a ratio of administration and profit to medical loss of 10.5% to 89.5%.

Mr. Garcia stated that the pilot project could be operated statewide, but he believes that the state should have regionalized care.

When asked whether small providers would be part of the pilot project, Mr. Hedgcock responded that Providence of Arizona subcontracts with small providers in the amount of \$180 million per year.

### **Opioid Addiction Treatment and Payment**

Eugene Marciniak, M.D., Region 5 health officer of the Department of Health (DOH), distributed the following handouts: (1) "Medication Assisted Therapy (MAT) for Opiate Addicted Persons at Public Health in New Mexico"; and (2) "Behavioral Health Services Subcommittee 08.19.11: Opioid Addiction Treatment in Public Health". At the DOH, the attitude is to treat opioid addiction as a chronic physical health condition.

### **Opioid Addiction and Drug Policy**

William Wiese, M.D., M.P.H., director of the Institute of Public Health at the University of New Mexico Health Sciences Center, distributed two handouts as follows: (1) "SM 18 New Mexico Drug Policy Task Force Report to Behavioral Health Services Subcommittee"; and (2) the "Fall, 2010 Interim Report on Senate Memorial 33 by the Drug Policy Task Force".

Dr. Wiese presented on the drug policy task force that was continued under SM 18 (2011 regular session), which was an extension of SM 33 (2010 regular session). He introduced Harrison Silver, M.D., with whom he has been working.

Dr. Wiese informed the subcommittee that Jennifer Weiss, a member of the task force, lost her son last weekend from a heroin addiction. She had access to early intervention measures, but there were impediments to insurance coverage. In addition, private insurance does not cover residential substance abuse treatment facilities.

According to Dr. Wiese, approximately 3.2% of New Mexican high schoolers use heroin, which Dr. Wiese characterized as an "epidemic". Eighty-five percent of prisoners in the state have a substance abuse problem, yet the ratio is one substance abuse treatment professional to every 113 prisoners. It is estimated that 5% of the high school students in Bernalillo County alone have used heroin in the last 30 days.

Dr. Wiese said that the risk of relapse continues after recovery. Most people with an addiction do not get treated as though they have a disease, they get treated as though they exhibit bad behavior. Current treatment approach is misdirected, according to Dr. Wiese. A large proportion has a concurrent medical condition that underlies the addiction and probably contributes to the addiction. People with addictions are punished and stigmatized, which exacerbates their avoidance of measures to treat the addiction. In addition, society has an enabling culture that glamorizes substance abuse.

Last year in the state, more people died of unintentional prescription drug overdoses than heroin overdoses. Dr. Wiese suggested that legislation may be in order to address this problem. All harm reduction programs need to be funded. It is critical that primary care be a critical part of providing substance abuse treatment needs, since the state has a dearth of behavioral health care providers and an uneven distribution of them across the state.

Dr. Wiese stated that incarceration exacerbates addiction problems. The cost-benefit ratio for prevention or treatment is huge with school-based and community-based prevention programs: for every dollar, the "payback" is \$25.00 to \$30.00. According to data from the federal Substance Abuse and Mental Health Services Administration, the payback for substance abuse treatment is \$7.00 to \$8.00.

In general, private insurance will not pay for residential substance abuse treatment, also known as "rehab", which takes about 20 to 30 days. Inpatient coverage for a three- or four-day stay in the hospital or outpatient treatment is usually all that is covered.

A subcommittee member stated that she would like to see the DOH educate the public on heroin addiction.

Dr. Wiese emphasized to the subcommittee that early school-based interventions are helpful and cost-effective.

The need for Project ECHO to be used in substance abuse treatment was emphasized by a subcommittee member, who pointed out that it was "short-sighted" to cut Project ECHO funds and try to handle its needs solely through grants.

A subcommittee member reminded the subcommittee and audience that Medicaid is an entitlement program, and prisoners should get fee-for-service substance abuse treatment services.

Other subcommittee members pointed out:

- the need for a comprehensive database to track substance abuse statistics;
- the need for post-prison, reintegration substance abuse treatment supports;
- the role that individual choice plays in substance abuse; and
- that people do not go to prison for simple possession of illegal substances; that parole violations, multiple offenses and psychological evaluations are usually co-occurring.

### **Public Comment**

Rachel Madewell identified herself as a "small provider" and thanked the subcommittee for asking "hard questions". She stated that it is difficult to survive in the current climate and that small providers such as she are being "pushed out".

Maggie McGowan spoke about IMD hospitals, which cannot get reimbursement for adult Medicaid recipients. She hopes that the state can show the impact of this, considering how few adults are on Medicaid.

Mr. Gurley stated that a "tremendous number" of people end up in jail because of substance addiction, and this is costly for communities. The new RFP for the statewide behavioral health entity should consider "all options" for addressing this issue.

Mila Mansaram, the vocational program director for the Community Outreach Program for the Deaf, wants OptumHealth to be reappointed as the statewide entity after the reissuance of the RFP. OptumHealth, she explained, has been good at providing services to deaf, hard-of-hearing and deaf and blind individuals who had been long awaiting appropriate services. These populations are "seriously at risk" because of inadequate services.

Linda Mondy stated that she is afraid there will no longer be behavioral health services available in many places because of inadequate reimbursement to providers. Due to time constraints, Ms. Mondy stated that she would follow up with written comments that she will direct to the subcommittee.

The meeting adjourned at 6:00 p.m.

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

**October 5-6, 2011  
South Valley Health Commons  
Albuquerque**

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, on October 5, 2011 at 9:36 a.m. at the South Valley Health Commons in Albuquerque.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan

**Absent**

Rep. Nora Espinoza  
Sen. Gay G. Kernan  
Sen. Gerald Ortiz y Pino

**Advisory Members**

Sen. Sue Wilson Beffort (10/5)  
Rep. Ray Begaye (10/5)  
Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena (10/5)  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen (10/5)  
Sen. Nancy Rodriguez (10/5)  
Sen. Sander Rue

Sen. Rod Adair  
Sen. John C. Ryan  
Sen. Bernadette M. Sanchez  
Rep. James E. Smith  
Rep. Mimi Stewart

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

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Abenicio Baldonado, Intern, LCS  
Ruby Ann Esquibel, Principal Analyst, Legislative Finance Committee (LFC)

**Wednesday, October 5**

**Welcome to South Valley Family Health Commons**

Robert DeFelice, chief executive officer, and Paul Luna, president of the board of directors, First Choice Community Healthcare, welcomed the committee to the facility, located at the South Valley Health Commons. Mr. DeFelice thanked the committee for its good work promoting health care in the state. Senator Feldman informed the committee that First Choice Community Healthcare is a model that other health care facilities could emulate. At the end of the meeting, she thanked the staff at First Choice Community Healthcare, especially Michelle Melendez, patient services director, for hosting the committee and helping the meeting run smoothly.

**Update from the New Mexico Office of Health Care Reform; Options for a State Health Insurance Exchange**

Daniel Derksen, M.D., appointed in August as the director of the New Mexico Office of Health Care Reform in the Human Services Department (HSD), along with Priscilla Caverly and Jonnie Lus, represented the New Mexico Office of Health Care Reform before the committee. Dr. Derksen distributed a handout setting forth:

- (1) the priorities of his office (slide 2 of the handout);
- (2) an overview of the payer sources of health insurance in the state (slide 3 of the handout);
- (3) a projection of New Mexicans who will gain health insurance coverage starting in 2014, then in 2020 (slide 4 of the handout);
- (4) a chart showing current New Mexico health insurance coverage numbers in 2011 versus 2014 health care insurance coverage projections, which chart was used to apply for federal grants (slide 5 of the handout);
- (5) a list of future New Mexico health insurance exchange (HIX) time lines, which shows very tight time lines (slide 6 of the handout);
- (6) a summary of the federal Patient Protection and Affordable Care Act of 2010 (ACA) HIX requirements (slide 7 of the handout), which require the state to create its own exchange, which Dr. Derksen's office would prefer; in the event of the state's failure to do so, the state is required to use a federal government-established HIX;
- (7) a description of the need to integrate the screening, eligibility and enrollment of New Mexicans in one of the following coverage programs (slide 8 of the handout):
  - (a) Medicaid's Children's Health Insurance Program;
  - (b) the state basic health plan;
  - (c) an individual HIX on either a subsidized or unsubsidized basis; or
  - (d) a Small Business Health Options Program exchange;
- (8) a description of some of the information technology (IT) interfaces for a future HIX, Medicaid and federal data hub (slide 9 of the handout), including:
  - (a) eligibility screening, including income data;
  - (b) eligibility determination;
  - (c) eligibility results;

- (d) plan selection; and
- (e) enrollment confirmation;
- (9) an illustration of the Integrated Service Delivery System 2 Replacement (ISD2R) Project and HIX parallel track approach, including a plan to submit a level 1 and a level 2 grant on a tight schedule (slide 10 of the handout);
- (10) a chart showing the HIX business functions (slide 11 of the handout) that had to be described for the grant application, as referred to in the previous numbered paragraph;
- (11) a list of the state's primary care shortage numbers and distribution problems (slide 12 of the handout), including a determination that the state currently lacks 400 primary care physicians (anticipated to expand to 500 when more residents are covered by a HIX or Medicaid);
- (12) a description of SB 14 (Laws 2011, Chapter 152), sponsored by Senator Feldman, about maintenance of health care data and signed by the governor on April 8, 2011 (slide 13 of the handout);
- (13) a mention of HB 710, sponsored by Representative Picraux during the 2009 regular session, for the promotion of patient-centered medical homes (slide 14 of the handout);
- (14) a chart showing a comprehensive primary care initiative that the federal Centers for Medicaid and Medicare Services (CMS) released, which presents an opportunity to taper off from a fee-for-service system to a payment system to keep people healthy and to team-manage chronic conditions such as diabetes (slide 15 of the handout);
- (15) a brief description of ACA funding sources for 2014 (slide 16 of the handout);
- (16) a *Wall Street Journal* headline about a lawsuit filed by the U.S. Department of Justice in the U.S. Supreme Court to review the health care overhaul (slide 17 of the handout); and
- (17) Dr. Derksen's contact information (slide 18 of the handout).

Dr. Derksen asserted that the HIX must mesh seamlessly with the Medicaid program.

The committee members expressed concern about confidentiality of medical conditions and data security with regard to the IT interfaces for a future HIX, Medicaid and federal data hub. Dr. Derksen directed the committee to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides protections. Senator Feldman pointed out the hefty civil penalties that could be imposed for HIPAA violations.

Dr. Derksen commended the committee for endorsing legislation several years ago requiring a call center, which has given the state a jump on this federal requirement for the HIX.

Dr. Derksen said that there are many New Mexicans who are eligible for Medicaid but are not enrolled. With the ACA and HIX requirements, many more residents will have insurance coverage either through Medicaid or the HIX. In addition, there are special provisions in the ACA that allow Native Americans a number of options for setting up their own HIXs.

In response to a committee member's query, Dr. Derksen stated that his office would be happy to provide the number of Native Americans covered by Medicaid. Committee members asked Dr. Derksen to repeat his presentation to the five Sandoval County pueblos.

In response to committee member concerns, Dr. Derksen stated that, even with the institution of the HIX, there will still be an estimated 100,000 to 250,000 uninsured individuals in 2020. It is anticipated that there will be a number of individuals who will opt out and accept the tax penalty or who will move from program to program and be exposed to potential gaps in coverage.

In response to a committee member pointing out that behavioral health was omitted from his presentation, Dr. Derksen stated that it is currently unknown whether behavioral health will be carved into or carved out of Medicaid. The state has the ability to include behavioral health treatment in the HIX plans. Dr. Derksen mentioned that there is a work force shortage in the field of behavioral health care, which means limitations on access to care. However, a committee member pointed out that the state does allow treatment to be provided by psychiatric nurses.

Committee members discussed with Dr. Derksen the problem with health care work force shortages in the state. The primary health care worker shortage and the multi-hour wait for emergency room services and infrastructure deficiencies are a problem, Dr. Derksen said.

Dr. Derksen asserted that the state needs to make sure work force needs are met to fully effectuate coverage under the HIX. Committee members noted that it will take longer to train workers to fill the current need than it will take to implement the ACA. Committee members also suggested that instituting a team-based approach to care, such as that provided by First Choice Community Healthcare, could be part of the solution. Dr. Derksen added that it is also necessary to change the way payments for health care services are structured, regardless of whether a recipient is insured under the HIX or Medicaid. Moreover, he asserted, the HIX must mesh seamlessly with the Medicaid program.

Dr. Derksen discussed the 70-page grant application, titled "New Mexico Level 1 Health Insurance Exchange Establishment Grant", which was submitted by his office on September 29, 2011 and has been posted on its web site. He did not provide the committee with a copy of the application. He reported that the application requested \$33.4 million, an amount in line with other states' requests. Of that amount, 60% to 70% was requested for IT purposes. Dr. Derksen hopes that his office will receive the level 1 grant in November. He anticipates submitting a level 2 grant application in March 2012.

A committee member suggested that Dr. Derksen explore the possibility of postponing a HIX in the state until after 2014 so that the state can observe how well other states' HIXs and the federal data hub work. A committee member also expressed concern that the state not become insolvent by adding people to Medicaid if the federal government becomes unable to adequately fund Medicaid. A committee member also asked whether undocumented non-citizens will be part of the HIX.

Committee members also inquired about the HIX plans for children, which is a concern because there are 60,000 uninsured children in the state.

Dr. Derksen distributed a second handout, titled "NM's Health Extension (HERO) Program: Enhancing Community Infrastructure, Supporting Health Reform". Dr. Derksen was asked by the committee members whether he was asked for his input regarding a Medicaid redesign, to which he replied that he expects to be asked. A committee member said he would be more inclined to support the HSD's Medicaid redesign if Dr. Derksen were part of it.

Senator Feldman asked what Dr. Derksen envisioned would be the legislature's role, if any, in a HIX. Dr. Derksen said he hesitates to ask for a legislative fix when the federal rules are still in a proposed state. He believes that the final federal rules will look different from the proposed rules currently posted online. He believes that an award of federal grant money could allow his office to consult with legislatively authorized work groups, including representatives from the Insurance Division of the Public Regulation Commission, to discuss policy. Senator Feldman indicated that the legislature has a constitutional obligation to be partners with his office.

Senator Feldman also asked about the State Coverage Insurance (SCI) program, whose participants want to know whether they will continue to receive insurance through SCI or the HIX. Dr. Derksen responded that it would depend on their eligibility factors. Some individuals who are up to 138% of the federal poverty level may be newly eligible for Medicaid, while others may be covered by a basic health plan established pursuant to the ACA or by private insurance with a tax subsidy.

Senator Feldman also asked about payment aggregation and risk adjustment plans, to be answered by Dr. Derksen in the future.

## **Minutes**

The minutes from the LHHS meeting in August were approved.

## **Proposed Federal Rules and Developments on the HIX**

Marge Petty, regional director, Region VI, U.S. Department of Health and Human Services (HHS), introduced Jay Angoff, senior advisor to U.S. Secretary of Health and Human Services Kathleen Sebelius. Mr. Angoff stated that insurance is a dysfunctional market because there is no industry competition based on price and quality. Instead, consumers compete based on industry assessments of their risk factors. However, because not everybody is insured, the risk cannot be spread across all populations of patients. After the implementation of the ACA in 2014, insurance companies no longer will be able to exclude or disproportionately charge people with preexisting conditions. The insurance industry agreed to this requirement of the ACA because it will have many more insureds and will be able to spread the risk and insure people at a standard rate. There also must be a risk adjustment system to take risks away from companies with low-risk consumers and spread it to companies with more high-risk consumers.

Mr. Angoff stated that the most meaningful part of the HIX is a web site on which consumers can compare programs by services, price and quality, which may spur competition in the market. The insurer also benefits by cutting sales and advertising costs, as more consumers than ever before can have access to information about the insurance policies through the HIX web site.

Mr. Angoff stated that the federal government hub would be interconnected with various agencies that could verify the input data that HIX applicants enter. He stated that the functions of the HIX should include:

- (1) certifying, decertifying and recertifying plans;
- (2) establishing ratings based on relative quality and price;
- (3) providing consumer information in a standard format;
- (4) providing electronic calculations of performance indicators after input of income data;
- (5) comparative information viewed on the web site;
- (6) determining eligibility for the HIX and facilitating enrollment;
- (7) establishing exemptions and granting approvals based on exemptions; and
- (8) establishing a navigator program.

Mr. Angoff listed the multiple areas in which the federal government has indicated that states have the flexibility to tailor the HIX to their needs, such as:

- (1) where the information is housed and whether the HIX will be a nonprofit entity, an independent agency or housed within an existing state entity;
- (2) what the exchange's jurisdiction is: most states will opt for a single state exchange, but the states with large populations may have regional exchanges;
- (3) what type of conflict-of-interest standards will the HIX adhere to: in the proposed rule, parties with an economic interest, such as insurers, can be on the board of the exchange;
- (4) how active or weak will the HIX be: how much bargaining power on behalf of consumers should the state exercise through the HIX;
- (5) network adequacy standards: how many providers will compete in a market and how near must the providers be to the insureds;
- (6) marketing standards: by what consumer protection laws must insurers abide;
- (7) risk adjustment: balancing risk among qualified health plans;
- (8) small business participation in the HIX: whether the ceiling should be 50 employees or 100 employees; whether the employer or each employee should choose the plan; and whether a small business exchange should merge with the individual exchange;
- (9) discretion over whether the state will run the HIX or allow the federal government to run the HIX or whether the state will run the exchange in partnership with the federal government;
- (10) whether to use a single application the HIX develops or to use one developed by the federal government; and
- (11) if states can decide whether to use the navigator program.

Mr. Angoff stated that there are five primary functions of a HIX:

- (1) consumer assistance;
- (2) plan management;
- (3) eligibility determination;
- (4) enrollment; and
- (5) financial management.

Mr. Angoff asserted that the HHS supports states by:

- (1) providing exchange grants;
- (2) managing a data services hub on behalf of the state; and
- (3) providing financial management assistance services (including running risk-adjustment and risk-carvers programs).

Mr. Angoff listed a number of HHS resources, particularly for IT support, including that:

- (1) New Mexico applied for and received a planning grant;
- (2) the HHS offers an establishment grant; and
- (3) the HHS offers an innovator grant.

In a federal-state partnership model, the HHS would primarily be responsible and accountable for establishing the HIX, while the state would be responsible for running the HIX. The federal government so far has identified the following partnership model options:

- (1) the state will engage in plan management through plan selection by rating and doing quality analysis of each insurer's plan and providing data management;
- (2) the state will provide consumer assistance, including in-person assistance, navigator management, outreach and education; and/or
- (3) the federal government will manage the remaining functions.

Mr. Angoff reminded the committee that if the state HIX were certified under the ACA, federal grant funding would be available on January 1, 2013 and January 1, 2014 for all functions. If the state is performing limited functions to effectuate the HIX, then grant funding would be available for the functions actually performed. If the state decides not to participate, no additional funding would be available in 2013 or 2014.

Mr. Angoff commended the committee for being "visionary" in introducing insurance exchange bills and a patient protection bill before the ACA was passed.

Committee members asked how the HIX would be implemented in the state, given that the state has multiple areas with no broadband and populations with no computers. Ms. Petty remembered that Dr. Derksen said that 30% of the state's residents lack web access, and he emphasized the utility for the state to be involved in establishing the HIX to accommodate the

populations without internet access. Also, Ms. Petty stated that the New Mexico State University agricultural extensions serve as models for community access and outreach.

Mr. Angoff stated that the small business tax credit under the ACA will give small businesses through 2014 an estimated \$40 billion in benefits. Committee members mentioned the small business help option and were concerned about seasonal and temporary employees and their impact on small business administration of a highly fluctuating employee pool. Mr. Angoff stated that there is no requirement for small businesses with fewer than 25 workers to buy insurance for their workers. In response to committee concerns, Mr. Angoff stated that the rules concerning businesses located in multiple states have not yet been written. In response to committee questions about nonprofit businesses, Mr. Angoff stated that they also would be entitled to a tax credit, although the credit would be smaller than what other small businesses would receive.

Committee members asked if there is any way to postpone the January 1, 2014 deadline, to which Mr. Angoff answered no, unless the ACA is amended. In contrast, the January 1, 2013 certification deadline in the regulations is flexible.

Committee members asked if the federal match for Medicaid is "in concrete" such that, as the state experiences higher Medicaid enrollment, it will be reimbursed at 100%. Mr. Angoff stated that Senator Feldman and Mr. Hely would know and that it is in regulations, not in statute. For the federal pool, patients must have been uninsured for six months to qualify, unlike in New Mexico. Mr. Angoff stated that the young and healthy could be covered at lower risk and less expense under catastrophic policies. Ms. Petty stated that premiums are scaled by age, even if they have preexisting conditions. Committee members added that there is a need for personal responsibility and personal habits that are voluntary, and there is a desire for private industry to flourish. Committee members asked whether the state may take advantage of the federal HHS data hub yet opt out of establishing a HIX pursuant to the ACA, to which Mr. Angoff answered in the affirmative.

Committee members made several inquiries, to which Mr. Angoff responded by promising to follow up with staff with answers to the following:

- Can a state hold money that is granted in, e.g., 2012, for use to implement at a date beyond the January 1, 2013 readiness review — say, in 2014 or 2015?
- What happens if a state receives implementation grant money and later decides not to implement the exchange?
- The final rule on the exchange is not yet out, but is any further definition available for what is meant by a federal exchange or a state-federal partnership for exchange operation and financing?

### **Colorado Health Benefit Exchange Development**

Shawn Raintree, operations manager of the Colorado Health Benefit Exchange (COHBE), has been working for six months on the exchange with Joan Henneberry, the planning

director. Mr. Raintree distributed a handout titled "Colorado Health Benefit Exchange Overview, October, 2011". He described Colorado's exchange development, which started with a statewide dialogue in 2010 followed by: a planning grant to the Colorado Health Institute; broad-based work groups; support from foundations; dialogue with technology and service firms; bipartisan legislation last spring; the appointment of an unpaid board of directors; and the submission of a level 1 grant application. Mr. Raintree stated that the core principle is consumer engagement, but having a healthy insurance market is also important.

Mr. Raintree informed the committee that no state general funds have been used for establishing the COHBE. Committee members asked how the COHBE will pay for operating funds after the federal grant money is gone, to which Mr. Raintree responded that it would be funded by insurers as a cost of their participation in the exchange. In response to a committee question about why insurers would willingly do that, Mr. Raintree responded that the insurers would be motivated by the size of the marketplace that would be opened to them by the exchange. Mr. Raintree stated that from a business point of view, anyone should be able to make an exchange work and that the proposed federal regulations offer an extraordinary degree of flexibility. When asked by the committee whether he saw any problems in the proposed federal regulations, Mr. Raintree said not really, although the procedures in the proposed regulations could have been simpler. For example, giving tax credits involves complications. Mr. Raintree reported that in Colorado, the view is that even a conservative role is to just jump into the ACA — there is no downside. As Mr. Angoff said, the state can pull out at any time.

### **Public Comment**

Gail Evans, legal director of the New Mexico Center on Law and Poverty, reviewed the 70-page grant application, titled "New Mexico Level 1 Health Insurance Exchange Establishment Grant", recently submitted by the New Mexico Office of Health Care Reform. Ms. Evans discussed several problems with proposals in the application, including the following:

- (1) the HIX will be "housed" at the New Mexico Health Insurance Alliance, which includes up to nine governor appointees, as well as insurance industry appointees;
- (2) there was no notice to ACA supporters that the HIX would be housed in the alliance;
- (3) no advocate input was solicited; and
- (4) the board of the alliance will become the board of the HIX.

Ms. Evans informed the committee that the center would inform the federal government that it opposes the HIX as described in the level 1 grant application, and she asked the committee to send a similar letter. Ms. Evans asked the committee to allow the New Mexico Center on Law and Poverty to make a presentation to the committee about its concerns after the committee has a chance to review the grant application.

Dick Mason of Health Action New Mexico said he agrees with Ms. Evans' analysis and opinions.

### **Tour of South Valley Health Commons**

Melissa Manlove, chief operations officer for First Choice Community Healthcare, and William Burns, D.D.S., dental director for First Choice Community Healthcare, gave a tour of the facility.

### **Thursday, October 6**

The meeting reconvened at 9:18 a.m.

#### **Early Childhood Services Data**

Peter Winograd, Ph.D., director of the Center for Education Policy Research at the University of New Mexico (UNM) College of Education, distributed a handout titled "Early Childhood Services: How Data Can Help Us Understand What We Have and What We Need", which covers:

- (1) the importance of a common agenda for collective impact;
- (2) the present need for effective data systems;
- (3) the goal that every child be prepared for school;
- (4) gathering, organizing and presenting data to enable the exploration of fundamental policy issues affecting children in the health and human services and education realms; and
- (5) 22 pages of data and graphics illustrating the measures of risks for children and the existence of and the need for additional early childhood programs in the state.

Dr. Winograd congratulated the legislature on passing SB 120 (Laws 2011, Chapter 123) and advised the committee to prioritize legislation based on where children are most at risk, where existing early childhood programs are, where the gaps are and how such gaps might be filled.

Mimi Aledo-Sandoval, senior fiscal analyst for the LFC, agreed that SB 120 demonstrates the legislature's commitment to a robust early childhood system. She distributed a handout titled "Early Childhood Services CYFD, DOH, PED". Ms. Sandoval stated that 80% of brain development occurs before a child reaches three years of age, and there is a 10% return of investment for early childhood programs. According to Ms. Sandoval, the LFC supports the alignment of service delivery programs delivered by the Children, Youth and Families Department (CYFD), Department of Health and Public Education Department (PED), which does not occur currently. Consequently, there may be both overlap and gaps in services.

Committee members inquired about data on babies born to unwed mothers and noted that it was not in Dr. Winograd's handout. Dr. Winograd said he has that data, but he could not include everything in his handout. A committee member suggested focusing on the individual families posing the greatest risk to their own children. Dr. Winograd noted that the CYFD does a great job at trying to make appropriate choices in the best interests of children on a case-by-case basis.

Committee members discussed data indicating that Head Start's benefits fade by third grade. Dr. Winograd countered by saying that there is tremendously well-documented evidence on how the return on investment in early childhood programs provides benefits to the children that last well into adulthood.

Committee members suggested that the data presented in Dr. Winograd's handout could have been manipulated by programs seeking funding and could ignore the family support systems that help babies and children in their communities. Dr. Winograd said that it can be challenging to develop an early childhood program that respects families and communities and to pinpoint where there is good family support and where there is not. Dr. Winograd said he agrees with the need to respect traditional values and the strength of traditional New Mexico families.

Committee members suggested that there could be a problem with using percentages rather than absolute numbers because the percentages of children who cannot read are higher in rural, low-population-density counties than in Bernalillo County, yet there would be a higher absolute number of children who cannot read in Bernalillo County than in more rural counties, as the population is much higher in Bernalillo County. Dr. Winograd said that the maps he presented are rough guides and would have to be accompanied by tables showing total numbers of children (not percentages) and discussions by experts to present as much information as possible to support policy discussions.

In response to committee members' queries, Diana Martinez Gonzales, division director, Early Childhood Services, CYFD, said that the pre-kindergarten program is in the sixth year. An external evaluator from UNM examined the effectiveness of program, and the results showed that children who come to pre-kindergarten straight out of the home require more assistance than those who come from a quality preschool experience. Ms. Gonzales hoped that the federal Race To The Top funding and implementation of SB 120 would allow the CYFD to collect longitudinal data on the effectiveness of the pre-kindergarten program.

Dr. Winograd stated that the PED has the data on children who entered pre-kindergarten six years ago and are now in third grade and he hopes that the PED starts analyzing that data.

Committee members asked how PED-taught pre-kindergarten and CYFD-contracted private pre-kindergarten results differ. Ms. Gonzales responded that the results appear identical.

Committee members looked at the LFC's data and asked whether there are early childhood care and education needs that have yet to be met. Ms. Gonzales stated that some charts may show areas of unmet needs due to a lack of community infrastructure to provide early childhood services, and in those cases, there are no programs to fund. Committee members also asked whether there is any failure to apply for all possible federal matching funds for early childhood care and education. In response to committee members' queries, Ms. Gonzales stated that all funding for pre-kindergarten programs comes from the state's general fund, while all funding for early childhood home visits comes from federal funding. Committee members asked about whether there are unmet early childhood care and education needs and how much more

general fund dollars would be needed to cover the early childhood care and education needs of children whose households live at 150% of the poverty line and 200% of poverty line. Dr. Winograd stated that he would provide those figures by the 2012 regular session.

### **Child Protective Services Investigation and Report; Formal Action Plan**

Michael Weinberg, program evaluation manager with the LFC, distributed a handout titled "Report to the Legislative Finance Committee" and reported on the LFC's evaluation of the Protective Services Division of the CYFD. Mr. Weinberg stated that over the last five years, the legislature has minimized fund reductions to the CYFD in recognition of the incredibly important services that the CYFD renders. Pages 12 through 15 of Mr. Weinberg's handout list the findings and recommendations showing performance data for the CYFD, areas of progress and opportunities for improvement in safety outcomes for children.

Mr. Weinberg stated that one of the challenges that the CYFD has faced is high caseloads. Jared Rounsville, director of the Protective Services Division, CYFD, stated that when the economy tanked, the CYFD saw more instances of abuse. He assumes that greater unemployment creates more stress on families, which sometimes results in increased instances of substance abuse, which in turn creates the circumstances for higher rates of abuse.

Mr. Weinberg added that the executive hiring freeze reduced the number of caseworkers available to handle a greater number of cases. In addition, an 18% employee turnover rate contributed to inefficiencies, according to Mr. Weinberg. Such systemic turnover cost the CYFD \$1 million to \$2 million to train new people and get them up to speed.

Mr. Weinberg described some of the LFC's recommendations listed in his report, including: (1) training caseworkers to use technology to reduce the amount of paperwork they need to do; (2) increasing the caseworker-to-supervisor ratio; (3) differentiating between the amount of training new employees receive based on their experience, education and qualifications; (4) differentiating between investigations based on levels of risk presented after an initial assessment of risk; (5) placing children in foster care only as a last resort; (6) reallocating appropriations for back-end services, such as foster care, to front-end services, such as home services, to teach families appropriate care; and (7) maximizing federal dollars.

Mr. Rounsville stated that his division agrees with many of the LFC's recommendations, such as maximizing federal dollars, which the division will be better able to do since it had an audit in July containing helpful suggestions. However, Mr. Rounsville said that his office disagrees with increasing the caseworker-to-supervisor ratio. He stated that the CYFD currently has one supervisor for every 3.8 caseworkers, and if the CYFD were fully staffed, it would have one supervisor for every 4.5 caseworkers, which is close to the standard recommended by the National Association of Social Workers, which the CYFD prefers to follow. Mr. Rounsville's division also disagrees with shifting funding from back-end services to front-end services because there is still a dire need for back-end services.

Mr. Rounsville's division also disagreed with the LFC's suggestion of a differentiated response and investigation system because the state has the lowest rating for service array, according to federal data, which means that there would not be the infrastructure to deliver a differentiated response.

Mr. Rounsville disputed the LFC's characterization of a significant waiting list for in-home services. As a result of a recent federal audit, the CYFD continues to improve the in-home services program, according to Mr. Rounsville. The in-home services program helps to prevent the removal of children from their homes by providing instruction so that parents can safely care for their children. As a result, there has been a dramatic reduction in the number of children in foster care.

A committee member expressed concern about the information that Mr. Weinberg provided indicating that, nationally, the incidence of child-on-child violence is four times higher in foster homes than in the general community. In addition, a committee member asked about the CYFD's data on treatment foster care in the state compared to the nation, which Mr. Rounsville said he could provide.

In response to a committee member's query, Mr. Rounsville said that there are multiple programs that provide some funds for former foster children once they are age-ineligible for foster home services. Such funds may provide financial assistance for utilities, furniture, post-secondary education and training.

Committee members asked whether the CYFD collaborates with law enforcement to increase agency efficiency and reduce costs. Yolanda Berumen-Deines, secretary of children, youth and families, responded that such collaboration is done to the extent possible, but the CYFD still needs caseworkers in the numbers presented.

### **CYFD: Update on Programs and Priorities**

Secretary Berumen-Deines, Edna Reyes-Wilson, deputy secretary of children, youth and families, and Bob Tafoya, chief of staff, CYFD, addressed the committee and distributed a handout. They spoke about the CYFD's:

- (1) strategic focus;
- (2) early childhood services initiatives;
- (3) child protective services initiatives;
- (4) juvenile justice services initiatives;
- (5) behavioral health services initiatives;
- (6) department-wide initiatives; and
- (7) performance measures.

A committee member expressed concerns about a policy of favoring family reunification, even in some cases of serious abuse and when reunification may not be in the child's best interests. The committee member opposed the tendency to preserve the family instead of preserving the child. The committee member also requested data on how many reunified children were subsequently abused in their family households.

### **Family-Friendly Workplace Task Force (HM 1 — Regular Session, 2011)**

Giovanna Rossi Pressley, president of Collective Action Strategies, LLC, Jessica Aranda, program director of Southwest Creations Collaborative, and Lee Reynis, Ph.D., director of the Bureau of Business and Economic Research at UNM and chair of the HM 1 task force, were joined by Representative Picraux in addressing the committee. They distributed a handout titled "Taskforce on Work-Life Balance". Ms. Rossi Pressley reported that the task force has been studying the economic security of working mothers. Dr. Reynis stated that 60% of children under six had both parents in the work force, yet employers generally have not been accommodating. The only federal law that supports workers with families, the federal Family and Medical Leave Act of 1993, allows unpaid leave for no more than 12 weeks to be taken when a baby is about to be born or after the baby is born.

The presenters asserted that there can be a net bottom-line benefit to employers from passing family-friendly policies.

A committee member suggested that men and members of the business community be asked to collaborate with the task force.

### **Casa de Salud — Justice, Access, Support and Solutions for Health**

Zane Maroney, clinic administrator of Casa de Salud, appeared with Andru Zeller, M.D. and Jesse Barnes, M.D. They reported that Casa de Salud was founded in 2004 in the South Valley of Albuquerque by clinicians who wanted to provide high-quality, low-hassle health care services delivered through traditional and alternative methods. They serve Albuquerque's uninsured, underinsured and immigrant populations. They stated that the goals of the clinic are to deliver: (1) same-day services, including evening and weekend hours; and (2) value-based and holistic health care, while the clinicians enjoy the freedom to focus on diagnosing the patient based on the whole person.

Mr. Maroney reported that Casa de Salud employs four physicians, two nurse practitioners, two physicians assistants, a doctor of oriental medicine, a licensed massage therapist and a technician who specializes in the removal of tattoos, scars and hair. Casa de Salud is planning an expansion to double the current 2,400-square-foot facility.

Casa de Salud saw 11,000 visits during the preceding year, of which 85% to 95% were uninsured. Though the majority of clients have low incomes, 90% pay the \$30.00 per-visit fees. The average cost is \$39.00 per patient, per visit. Casa de Salud has no on-call system. The clinic sees patients for extended hours and on weekends. Patients are referred to Presbyterian hospitals if needing hospitalization, thus lessening some of the burden on the UNM system. Not

taking insurance decreases much of the administrative burden. However, next year, Dr. Zeller explained, the clinic will pilot a project to accept reimbursement from one insurer.

Dr. Zeller explained that Casa de Salud uses pre-med, pre-nursing and other students planning to enter medical training programs to do a lot of the medical assistant work. They are an affordable work force that learns cultural competence in a number of areas at the clinic, including the culture of health care delivery, working with clinicians, etc. Many of these individuals are from the local community and are bilingual in Spanish and English.

Mr. Maroney drew the committee's attention to JAZZ for Health's legislative proposal (see handout) to average at least three insurers' rates to set a maximum rate that providers may charge uninsured individuals. JAZZ for Health administrators have put together a patient-friendly billing project that should lead to fair pricing and billing policies. Representative Chavez stated her wish to reintroduce this legislation, informing the committee that other states have passed this legislation. New Jersey and California, she reported, base their maximum rates on those rates that Medicaid pays providers. Though the ACA contains such a provision, it applies only to nonprofit hospitals. This bill would "level the playing field; she said."

Upon a motion to endorse a duplicate of the 2011 regular legislative session's House Bill 223 (Representative Chavez), the committee voted to endorse it.

Nandini Pillai Kuehn, Ph.D., M.H.A., president of the board of directors of New Mexico Health Connections, a nonprofit 501(c)(29) corporation, and Rick Thaler, a member of the board of directors of New Mexico Health Connections, gave a presentation. Mr. Thaler owns a woodworking company, OGB Architectural Millwork, that employs 80 people. He provides his employees with health insurance. He said that having a work force whose health needs are taken care of well means a good work force. However, since his health care insurance costs have risen 14% to 18% each year, that jeopardizes his ability to provide health insurance. He and other members of New Mexico Health Connections founded the organization as a nonprofit health insurance cooperative that will make insurance plans available at a reasonable rate for small businesses and individuals. New Mexico Health Connections is considering developing its own network across the state, contracting with community clinics and becoming its own insurance company. Milton Sanchez, BlueCross BlueShield of New Mexico, stated that his company is a member-owned, not-for-profit insurance company.

### **Public Comment**

Dick Mason said he opposes appointments of insurance company representatives to the New Mexico Health Insurance Alliance. He said he comes out of the corporate world, and, in his years of corporate work, has never encountered putting a distributor on an oversight committee. Mr. Mason distributed a one-page handout titled "Testimony to the Legislative Health and Human Services Committee", dated October 6, 2011, summarizing his viewpoints on the exchange.

Shari Gonzales, a private citizen who grew up in the South Valley, testified that not only is the care at Casa de Salud far superior to other facilities' health care services, but it is also delivered at a very reasonable rate. She feels that because of her connection to the health care workers at Casa de Salud, the compassionate way in which she is treated there and the reasonable prices, she is compelled to volunteer there. By giving her time to Casa de Salud, she helps the clinic extend care to others.

### **Adjournment**

Senator Feldman thanked the South Valley Health Commons and Ms. Melendez, who helped ensure that the meeting ran smoothly. There being no further business before the committee, the fourth meeting of the LHHS for the 2011 interim adjourned at 4:05 p.m.

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

**October 7, 2011  
Albuquerque Convention Center**

The second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee for the 2011 interim was called to order by Representative Antonio Lujan, chair, on Friday, October 7, 2011, at 9:18 a.m. at the Albuquerque Convention Center.

**Present**

Rep. Antonio Lujan, Chair  
Sen. Nancy Rodriguez, Vice Chair  
Sen. Rod Adair

**Absent**

Rep. Nora Espinoza  
Sen. Mary Kay Papen  
Rep. Danice Picraux

**Temporarily Appointed Members**

Sen. Dede Feldman for Sen. Mary Kay Papen  
Rep. Miguel P. Garcia for Rep. Nora Espinoza

**Guest Legislator**

Sen. Cisco McSorley

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Lisa Sullivan, Staff Attorney, LCS  
Rebecca Griego, Records Officer, LCS  
Abenicio Baldonado, Intern, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Copies of all handouts and written testimony are in the meeting file.

## **Friday, October 7**

### **Call to Order**

Representative Lujan welcomed presenters, members of the subcommittee and the public to the second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee for the 2011 interim.

### **Long-Term Services: Status of Coordinated Long-Term Services; Hilltop Institute Report**

Julie Weinberg, director of the Medical Assistance Division of the Human Services Department (HSD), began her presentation by distributing a handout titled "Coordination of Long Term Services Program Fall 2011". Ms. Weinberg referred subcommittee members to the statistics in her handout about the Coordination of Long-Term Services (CoLTS) program. Ms. Weinberg also discussed the CoLTS program fact sheet prepared by the Hilltop Institute (Hilltop Survey). (See handout.) Subcommittee members asked her whether the Hilltop Survey addressed payments. She was asked how many claims were rejected as "clean" claims (submitted without errors by providers) and what are the time frames for paying formerly rejected, but successfully appealed, claims. Another subcommittee member asked whether those percentages were unique to New Mexico and how these figures compare to other states. Ms. Weinberg agreed to get that information to the subcommittee.

Subcommittee members stated that they are frequently contacted by providers who are not promptly paid, particularly in the Native American community. Ms. Weinberg stated that the latter problem stems from confusion in managed-care organizations' (MCOs) claims processing systems. These problems tend to be technical issues that take a while to work out. The HSD worked on it for a year to fix it. Both CoLTS MCOs over the summer finally figured out how to get those payments out.

Subcommittee members asked how CoLTS will fit into the HSD's proposed Medicaid modernization. Ms. Weinberg said that MCOs are siloed under the current system. Modernization aims to reduce the number of silos, so it is anticipated that fewer MCOs will be selected as "health plans", as these fewer MCOs will be charged with taking care of the various programs such as CoLTS and the other waiver and non-waiver programs, including behavioral health. She stated that the separation of behavioral health from other CoLTS services was a "big issue" for CoLTS participants. Ms. Weinberg stated that the secretary of human services has said that services might be reduced, but not as a result of modernization; any cuts would be the result of mounting health care costs. Subcommittee members mentioned that providers need continued funding to continue providing necessary services.

Subcommittee members reiterated the request that the legislature review the HSD's Medicaid redesign concept paper before the 1115 waiver application is submitted. Ms. Weinberg stated that the legislature would be provided an opportunity to see the concept paper.

Gil Yildiz, executive director of the Independent Living Resource Center (ILRC), told the subcommittee that the ILRC has been providing services and advocacy for people with disabilities in 10 counties for 20 years. From an independent living perspective on the Hilltop Survey report, the ILRC believes that there are strategies in the report that can improve independent living services and encourage the state to investigate implementing those strategies, particularly the money follows the person concept. The ILRC advocates for full implementation of money follows the person. Community reintegration is not money follows the person. It is more costly to put someone in a nursing home than to allow the individual to live in the community. New Mexico has a history with this: in 2006, a money follows the person statute was passed, but the prior administration never fully implemented this state law.

Ms. Yildiz stated that the ILRC supports the Community First Choice Option set forth in the federal Patient Protection and Affordable Care Act of 2010 (ACA) to replace the Personal Care Option (PCO) program and thereby reduce disparity in income eligibility. She pointed out that this strategy is recommended in the Hilltop Survey report.

Jimmy Maldonado testified before the subcommittee about his receipt of services. He has been in a wheelchair for 27 years. The PCO program started somewhere around the year 2000, he stated. Before that, it was difficult to get help. The PCO program's appearance in 2000 changed his life. Before that, he had his large extended family help him to avoid getting bedsores. Every year for the last 10 years, he has had to fight for maintenance of the PCO hours he gets. He emphasized that he is not asking for more. He has to go in front of a hearing officer to fight to get the same number of hours. It is scary for him to think that he could end up in a nursing home. This program gives him the opportunity to be independent and be cared for out in the community. He told the subcommittee about a friend who was forced to enter a nursing facility after her PCO hours were cut from 40 hours per week to 20 hours per week. Going to a nursing home is a heartbreaking experience. Mr. Maldonado stated that he has been able to keep up his health because of the PCO and contributions to his community by coaching YAFL (Young America Football League) football.

Subcommittee members commented that if the state keeps reducing PCO hours, the medical costs (e.g., for bedsores) will be higher than just paying for PCO hours. Agreement was expressed with Mr. Maldonado's contention that putting him into a nursing home is not as beneficial as keeping him in the community in the PCO program. Subcommittee members stated that community reintegration gives first priority for already funded slots. When someone moves from a nursing home into the community, that person displaces another person on the waiver waiting list by taking up a waiver slot. The money follows the person concept is where Medicaid dollars flow to the community on PCO hours rather than using waiver dollars. One subcommittee member stated that this concept is really hard to understand. Ms. Yildiz stated that there are members of the disability community who would be happy to meet with members of the subcommittee to explain the concept.

Subcommittee members asked for more explanation about Medicaid rules that require participants to "lose everything" if they go into a nursing home. Mr. Maldonado stated that he lives in an "accessible" apartment in which, for example, the light switches are low and everything is wheelchair accessible. If he had to go into a nursing home, he would have to give up the apartment and might not have accessible housing to go back to.

His mother's house is difficult to be in, he said. Mr. Maldonado told the subcommittee that he prefers to be able to come and go as he pleases as opposed to being in a nursing home with restricted hours and restrictions on coming and going. Being in your own home and the little bit of independence that disabled individuals have would be lost, according to Mr. Maldonado. Without PCO services, people with disabilities feel that they are imposing on their friends and family when they have to ask for help. A paid PCO attendant is seen as being there for the individual and is not being imposed on; this gives the individual more control over that individual's life. He stated that he did not know where he would go if he lost those services.

### **Public Comment**

Ellen Pinnes, consultant for the Disability Coalition, explained the money follows the person concept and the difference between it and community reintegration. In community reintegration, any slots that open up in the home- and community-based CoLTS-C (formerly disabled and elderly) waiver are reserved for people leaving nursing homes to return to the community. Only individuals leaving nursing homes can get a waiver slot, which means no one from the waiver waiting list is ever taken off the list to receive services, and the total number of people receiving waiver services does not go up. In money follows the person, a new waiver slot is created for the person leaving the nursing home, using the money that Medicaid has been paying for nursing facility care to pay for community services instead. Because any vacancies that arise in existing slots do not have to be saved for people leaving nursing homes, those vacancies can be given to people on the waiting list. By filling vacancies in this manner while adding new slots through money follows the person, the total number of people served on the waiver goes up. Ms. Pinnes stressed that the state's policy has been that ONLY individuals leaving nursing homes can get waiver slots, so the time spent on the waiting list before receiving services has essentially become infinite, as no one is ever taken off the list to receive services. She also noted that the total number of people served on the waiver has been falling because not all vacant slots have been filled.

Subcommittee members asked whether it would take more money to add people to money follows the person. Ms. Pinnes stated that it would not take any more money; the idea of money follows the person is that money the Medicaid program is already paying for nursing home care is used instead to pay for services in the community. Ms. Weinberg said that it is the HSD's position that the way integration works is not fair for individuals awaiting placement on the CoLTS-C waiver. The HSD did apply for money follows the person under the ACA, but Ms. Weinberg's office is short-staffed. The federal government says it will allow the state to implement money follows the person in addition to the waiver. Ms. Pinnes informed the subcommittee that there is an increased federal match for people who move from a nursing home

to the community through money follows the person. Ms. Weinberg also said that the grant pays for planning.

Lisa Schatz-Vance, executive director for the Senior Citizens' Law Office in Albuquerque, encouraged stakeholder participation in the money follows the person discussion. The perception in the community is that people who fall off the CoLTS-C waiver, due to death or improper transfer of a family home, are not having their vacancies filled.

Jim Jackson, Disability Rights New Mexico, stated that the policy that only people coming out of nursing homes get the slots is a state policy, not a federal policy. Therefore, the legislature has some control over that. Ms. Schatz-Vance stated that the total number of people served has dropped significantly. Mr. Jackson also addressed the design of the CoLTS program. There are still silos among the component services. Also, the eligibility requirements have not changed. He stated that many participants would lose Medicaid eligibility if they leave the nursing home to return to the community. Thus, the state has to keep people in more expensive care, i.e., nursing homes, so that people do not lose coverage because there is no mechanism to fund them for community services other than through the waiver program. This is because income eligibility is much higher for nursing home or waiver services than it is for other Medicaid programs such as the PCO. He stated his concern about Medicaid modernization because the state intends to have all Medicaid MCOs handle the full range of services for all populations, which means that MCOs with no experience working with the disabled community would manage long-term services.

### **Long-Term Services: Status of the Medicaid PCO**

Charles Sallee, deputy director of the Legislative Finance Committee (LFC), addressed the subcommittee regarding the PCO program. He distributed LFC Report #11-04. He discussed the CoLTS program's goals (see handout). He endorsed the concept of a bill introduced in 2011 that would have required that any changes to the state's Medicaid plan, or any waiver changes, be accompanied by a fiscal impact report. The bill was passed by the legislature and pocket-vetoed by the governor. The costs of CoLTS have exploded. He explained that the state is paying a lot of money to MCOs to manage a continuum of care, but state policies do not allow an actual continuum of care. Now, there is an incentive to use lower-cost community services versus nursing homes. Many CoLTS enrollees start out not using many services as "healthy dual eligibles" (individuals enrolled in both Medicaid and Medicare). Yet, they usually graduate to using more services. Once they use even five hours of state waiver services, costs to the state balloon. Before the transition to CoLTS, the state created the PCO entitlement program. Full implementation of CoLTS has meant that in fiscal year 2010, \$800 million went to CoLTS, which is \$235.5 million, or a 40% increase, over fiscal year 2007. The HSD built in 10.5% in administrative costs for management by MCOs, assuming that would keep costs down.

The Hilltop Survey reported that community reintegration that keeps people in the community will save money, but community-based services that do not prevent eventual nursing home enrollment will not save money.

Projections from the HSD to fund the CoLTS program fluctuated wildly. For example, healthy dual eligible participants cost the state \$180 per month per individual. Meanwhile, nursing home client projections were too low, resulting in an unanticipated \$14.5 million cost.

Ms. Weinberg distributed a handout titled "The Personal Care Option Program Update" and directed the subcommittee to slide 7. She said it was the federal government that was at fault; most CoLTS-C services used are the homemaker services. Skilled workers are not used as much as the PCO-style (homemaker) services. She stated that the HSD agrees with the LFC in that the PCO program is driving a lot of the costs in CoLTS. Last year, the HSD started identifying natural supports when assessing PCO participants to try to save money when multiple PCO participants live together because chores such as cooking and laundry could be done at the same time. New budgeting does not allow for duplicative services when individuals are already receiving services from other places, such as family. They talked about efforts to reduce the number of fair hearings and thus reduce costs and the burden on members. The HSD has seen some reductions in PCO hours, mostly based on determinations of natural supports, such as when a member lives in a family where there is an able-bodied parent making meals. However, for the services that a household member would not otherwise be doing, they should be assessed as not a natural support. Ms. Weinberg stated that the HSD has no plans for regulation changes. She reported that she heard that the number of activities of daily living (ADLs) with which the average nursing home resident requires assistance is now four. The threshold to become nursing home-eligible is two ADLs. She told the subcommittee that she had heard that the nursing home occupancy rate has not changed. To her, it seems that the community is well-balanced in terms of people with long-term support needs in the community because those in nursing homes are clearly those who need more assistance than those in the community.

Ms. Pinnes distributed a handout titled "The Personal Care Option: A Vital Part of New Mexico's Long-Term Services System". In order to receive PCO services, one must be assessed as needing a nursing home level of care and be covered by Medicaid. The PCO allows people to receive services at home. It is cheaper than institutional care and improves recipients' quality of life. For those who qualify, the PCO, as an entitled program, is available without a waiting list — unlike the disabled and elderly (now CoLTS-C) waiver, whose waiting list is infinite because, pursuant to state policy, no one is taken off the waiting list to receive services. Ms. Pinnes reviewed the history of the PCO program to show that the program is not "out of control" as is often claimed. She stated that the program was poorly designed and administered in its early days. However, since changes were made in 2004, the rate of growth to the PCO program (52%) has been considerably lower than that of the Medicaid program overall (65%). Payment rates and the average cost per person have dropped dramatically. The HSD has continued to make regulatory changes that reduce the numbers of hours of PCO services received by individuals. Ms. Pinnes noted that the latest revision changes the assessment instrument in a way that reduces the number of hours of service by 30% to 40%.

Significant reductions to PCOs may run afoul of the federal Americans with Disabilities Act of 1990 (ADA), which is about allowing people with disabilities to live, as much as possible,

like people without disabilities. The Disability Coalition does not object to relying on natural supports when they are available. However, Ms. Pinnes told the subcommittee that caution is needed to ensure that the state is not pushing family members into things that they are not willing and able to perform, as that can lead to abuse and/or neglect of the person who needs services. She pointed out that families already bear a significant portion of the burden of providing long-term services, both paid and unpaid, and that this imposes financial, emotional and physical stresses that usually fall disproportionately on women.

Ms. Pinnes also distributed a handout on the Community First Choice option that she and Ms. Yildiz encourage the state to consider. This option would help to equalize income eligibility for long-term services programs. Also, because there would be an enhanced federal match, the state could serve more people in the community without increasing state expenditures. Finally, she distributed the Disability Coalition's recommendations for Medicaid redesign, which have been provided to the state's contractor, Alicia Smith.

In response to subcommittee members' questions, Ms. Weinberg said that she does not necessarily agree that the regulations will reduce PCO hours by 30% to 40%, and not everyone will suffer a reduction. She stated that the HSD is looking at household services that can be done simultaneously. She believes that pre-hearing conferences will help PCO recipients before a hearing on the reduction in hours. Ms. Weinberg stated that she does not know how people who cannot advocate on their own behalf and have no one to do it for them can do an appeal.

### **Public Comment**

Venita Goor, peer support mentor with the San Juan Center for Independence in San Juan County, inquired why PCO hours are being decreased. When someone transitions from a nursing home to that person's own home, that person is given 38 hours, then MCOs do an assessment and decrease the hours to seven. These people will wind up back in hospitals and back in the nursing home as a result of reduction in PCO hours.

Sarah Grace, advocate and co-chair of the legislative action team for the New Vistas Independent Living Center informed the subcommittee that her group had met with Secretary of Human Services Sidonie Squier and Governor Susana Martinez. She expressed her wish that the HSD continue to support the Disability Coalition's recommendations for redesign and to continue to solicit stakeholder input throughout the process and not just at public hearings.

Yvonne Hart stated that she has helped a few people with disability fair hearings. She reported that she has a "real problem" with the assessment instrument; that it misses the mark. The level of care assessment by social workers and caregivers is a one-hour assessment not involving observation of functioning — only involving questions. Many people are unable to communicate their needs. She stated that she has a lot of experience regarding natural supports, which provides a shifting of resources, not "free" services, by family members. It is not realistic to consider them otherwise.

Penny McMallon identified herself as living with autism. She stated that when people usually think of accessibility, they think about physical impairment. As a person living with autism, she told the subcommittee that she has seizures from flickering fluorescent lights; ceiling fans, especially if they have lights, too; perfumed soap in restrooms; and screeching brakes by public buses. If employers speak too fast, she cannot understand.

Independent advocate Nat Dean stated that she had been on a waiver waiting list for seven years to receive services for traumatic brain injury. As a brain injury survivor, she really appreciates the subcommittee's hard work and the formation of the subcommittee as well as the members' willingness to serve on it.

Diane Lucero told the subcommittee that she is the mother of a disabled quadriplegic son. He has had three brain strokes and lost his vision. He has been told that he does not qualify for Medicaid because he receives Social Security Disability Insurance (SSDI), which was not his choice. He cannot receive the PCO seven days a week. He receives help three days a week through Medicare. There are people who are not getting the care they need. For the last two years, the person giving his care seven days a week has been his girlfriend. He will not go to a nursing home to qualify for the waiver. His girlfriend hurt her back last spring. He cannot get out of bed himself. He still needs help even though he gets \$708 a month through SSDI, which makes him ineligible on the basis of income for the PCO.

Lisa Rossignol, a graduate student at the University of New Mexico (UNM), identified herself as the mother of a four-year-old girl living with epilepsy. She wants her daughter to be on the developmental disabilities waiver. She was put on the CoLTS medically fragile waiver waiting list. When her daughter got to the top of the list in September 2008, the funds were then frozen. Ms. Rossignol explained that she had to walk away from a career with \$1,000 copayments a month on private insurance so that she could qualify on the basis of income for Medicaid. She asked the subcommittee to consider what would it look like to extend the Medicaid waiver portion to people on a wait list just to help with private insurance copayments.

### **Business Opportunities for Individuals Living with Developmental Disabilities**

Nannie Sanchez stated that she wants the disabled population to be empowered and self-sufficient through creative employment opportunities. She has had her own business, assisting the movie industry, for the last three years. A subcommittee member credited Ms. Sanchez with creating the subcommittee. Rosemarie Sanchez, Nannie's mother and herself an advocate, reiterated what her daughter said about people with cognitive disabilities being the real minority. Rosemarie's and Nannie's group wants to see more people with cognitive disabilities own their own businesses. The Sanchez's are requesting legislation to serve as an incubator to five businesses, providing each with \$25,000 with a five-year loan. "There are no jobs for people with developmental disabilities", Rosemarie Sanchez stated. If they have access to the means to earn a living, these individuals will be removed from dependence.

Ruthie Marie Beckwith, Tennessee Microboards Association, Inc., has been appointed by the courts to look for employment opportunities for people coming out of the state facilities at

Los Lunas and Fort Stanton. Ms. Beckwith discussed the benefits of, and impediments to, furthering the employment opportunities of the cognitively disabled. Her favorite example of a job that can be carved out is at the airport, grabbing gray bins from the conveyor belt to free up Transportation Security Administration officers. The purpose of incubating corporations is to nurture businesses owned by people with developmental disabilities. She distributed a proposal for incubating small businesses owned by the cognitively disabled titled "New Employment Options for Individuals with Developmental Disabilities".

The subcommittee then made and passed a motion that it endorse in concept the Sanchez-Beckwith proposal.

### **Developmental Disabilities Self-Advocacy**

James Maes, parent of a 14-year-old son living with Down syndrome, wanted to bring the subcommittee up to date. As a parent of a child with developmental disabilities, one of his greatest concerns is what will happen to children when their parents are gone and how will they be received in the community. He stated that the New Mexico Center for Self-Advocacy (CSA) at the Developmental Disabilities Planning Council provides training to individuals for coping and self-advocacy and to schools to make others more aware and tolerant of people with disabilities. It also does training modules to prevent bullying and on how to be treated as an adult and not as a child. It has been working with UNM and New Mexico Highlands University (NMHU) students, who work alongside the CSA as participants or "members".

Connie DeHerrera, director of the CSA, distributed a handout about what the CSA does. The mission of the CSA, she stated, is to support people to advocate for themselves and to create awareness in the community. She reported that CSA participants' opinions are very important. They develop the training modules and they learn from each other as they learn new skills. UNM graduate students are studying special education. They work with the members to develop PowerPoint presentations. The UNM students learn the importance of student-driven teaching. NMHU students also are learning to be special education teachers. CSA members also work with dental students, behavioral health students and insurance agents. The U.S. Army Corps of Engineers just hired someone with autism. The center will do sensitivity training. The CSA recognizes and celebrates the dignity and struggles of people with developmental disabilities. This year, the CSA conducted 168 trainings and trained 3,524 people. The CSA was invited to do training in the Northern Mariana Islands because people there with developmental disabilities were not out in the community, and they got to see the CSA's self-advocates out in the community, speaking at conferences. The CSA made a big difference. The CSA also has a sign language class and a computer literacy class. Some members have moved from group homes into the community. Many have the confidence to start post-secondary education. Some have sought employment.

Daniel Ekman identified himself as being personally and professionally involved at the CSA. He is living with autism. He began his work with the CSA as a graduate student. He stated that he had not known that advocacy was an option for anybody, including himself. He had few role models. He graduated with honors as an undergraduate and with a 4.0 grade point

average from graduate school; but he always felt like a failure, was depressed and had low self-esteem. At the CSA, he was working with people who saw his disability as part of the whole picture, not as faults to be criticized. The CSA gave everyone a support network. Mr. Ekman saw many people facing the same challenges who were successful. He has seen self-advocates improve their confidence, social skills and sense of self-worth. They experience an improvement in the opportunities they encounter.

### **Minutes**

Minutes for the June 24 Disabilities Concerns Subcommittee meeting were approved.

### **Disabilities Services and the Disability Trust Fund**

Jim Parker, director of the Governor's Commission on Disability, told the subcommittee that his office registered more than 1,000 people at the Southwest Conference on Disabilities at the Albuquerque Convention Center going on today. Last year, the subcommittee endorsed SB 65, sponsored by Senator Phil A. Griego, to assist in funding disabilities programs. During the 2011 regular session, the bill was tabled in the Senate Finance Committee. It would have called for a \$5.00 per vehicle add-on fee at registration. The goals of the bill would have assisted organizations throughout the state in such endeavors as the one just discussed by people from the CSA. Subcommittee members urged Mr. Parker to not give up. Subcommittee members also acknowledged John Block for his work. Mr. Parker said there are a lot of other organizations and advocates in the state for the disabled who help make a difference in how the disabled are seen as people and how legislation is pursued to help break barriers to bring that community into the greater community.

### **Public Comment**

Liz Thompson, who is involved with the New Mexico Autism Society, thanked the subcommittee for its work.

Rachel Riboni is a stakeholder in the Mi Via self-directed waiver program. She said that HSD regulations need to be changed to ensure adequate care. She said that the UNM Hospital does not accept Evercare Health Plans and that the other medical centers from which she sought wound care similarly refused to treat her. Senator Rodriguez said she would talk to the director of Evercare.

Nancy Bearce of New Mexico Abilities just completed her second week as its chief operating officer. She said her organization is trying to employ the disabled under state contracts.

Sally Fox, who calls her organization "Equality for New Mexicans with Service Dogs/People on Medicaid", advocates equality for Medicaid recipients with service dogs. Since 2008, state regulations will not permit veterinary or grooming services for therapeutic assistance animals. She won a human rights hearing, but she has been discriminated against based on that ruling. The regulation violates the ADA, which requires equal services for disabled and

nondisabled individuals. Enrolling in the Mi Via program was a blessing. She wants an executive order or a memorial saying that the ADA must be followed in this respect.

**Adjournment**

There being no further business before the subcommittee, the second meeting of the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee for the 2011 interim adjourned at 3:25 p.m.

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

**November 2-4, 2011  
Room 307, 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, on November 2, 2011 at 9:40 a.m. in Room 307, State Capitol.

**Present**

Sen. Dede Feldman, Chair  
Rep. Danice Picraux, Vice Chair  
Rep. Nora Espinoza (11/3)  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino (11/2)

**Absent**

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye (11/3, 11/4)  
Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill (11/3, 11/4)  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez (11/4)  
Sen. Sander Rue  
Sen. John C. Ryan (11/2)  
Sen. Bernadette M. Sanchez (11/2)  
Rep. Mimi Stewart (11/3, 11/4)

Sen. Rod Adair  
Rep. James Roger Madalena  
Rep. James E. Smith

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

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Rebecca Griego, Records Officer, LCS  
Leslie Porter, Research Assistant, LCS

Kathleen Dexter, Researcher, LCS  
Abenicio Baldonado, Intern, LCS

## **Wednesday, November 2**

### **Welcome and Introductions**

Senator Feldman welcomed the committee members and guests and invited the members to introduce themselves.

### **Using the Basic Health Plan to Make Coverage More Affordable to Low-Income Households**

Stan Dorn, J.D., senior fellow at the Urban Institute Health Policy Center (Urban Institute), appeared via webcast and discussed the Basic Health Plan (BHP) option provided to states pursuant to the federal Patient Protection and Affordable Care Act of 2010 (ACA). Mr. Dorn stated that the goal of the BHP option is to ensure that low-income children receive health coverage when their families do not qualify for Medicaid. His handout set forth:

- (1) health care affordability data (pages 5 through 7 of the handout):
  - (a) the premiums and actuarial value of coverage for a single, uninsured adult at various income levels qualifying for subsidies under the ACA;
  - (b) examples of health plans at various actuarial value levels; and
  - (c) perspectives on consumer costs;
- (2) federal law on the BHP (pages 10 through 12 of the handout);
- (3) health care options for New Mexico (pages 14 through 16 of the handout):
  - (a) building on existing plans to make coverage more affordable;
  - (b) subsidy eligibility in New Mexico under the ACA without the BHP; and
  - (c) subsidy eligibility in New Mexico, under one possible approach to the BHP;
- (4) modeling methodology (pages 18 and 19 of the handout);
- (5) charts and explanations illustrating the modeling results (pages 21 through 28 of the handout);
- (6) policy implications (pages 30 through 40 of the handout); and
- (7) conclusion of the presentation (page 41 of the handout):
  - (a) the BHP could improve affordability for low-income consumers, including some Medicaid adults who might otherwise be moved to the exchange;
  - (b) the BHP allows state Medicaid savings without imposing major cost increases on Medicaid beneficiaries;
  - (c) the trade-off for consumers being smaller provider networks;
  - (d) the trade-off for the exchange being fewer covered lives and higher individual market premiums;
  - (e) the trade-off for the providers being fewer financial gains from the ACA; and
  - (f) the key obstacle being waiting for guidance from the federal Centers for Medicare and Medicaid Services (CMS).

Mr. Dorn explained that the Urban Institute is a nonprofit located in Washington, D.C., that was established in the 1960s. He said that the institute is well-respected and that the staff works very hard to provide balanced perspectives.

The committee inquired whether the plan outlined is a program that will allow New Mexico to utilize federal funding to develop a more affordable health plan for low-income individuals who can join the exchange, thereby reducing state costs. Committee members asked if those patients will have a smaller provider network, which will result in the exchange having fewer people from which to draw.

Matthew Buettgens, senior research fellow at the Urban Institute, stated that without the ACA, 500,000 people would be uninsured in New Mexico, and with the ACA, there would be 23,100 uninsured individuals. He said that the difference is the result of the people who would be included in the exchange and in Medicaid.

Addressing committee concerns regarding employers offering consistent health plans to all employees, Dr. Buettgens explained that the ACA states that if employees cannot afford a health plan offered by an employer, those employees are allowed to move to the exchange and purchase a plan with the tax credit that is subsidized with their purchase. He further explained that in this scenario, the ACA requires the employer to pay a penalty for this. However, if the employee were enrolled in the BHP, the employer would not have to pay a penalty.

Dr. Buettgens stated that health care providers will be better off because they will have more paying customers.

In response to questions, Mr. Dorn said that the use of public funds is being expanded to provide health care for more people.

Senator Feldman thanked the presenters for studying this topic specifically for New Mexico's situation. She urged committee members to keep in mind that New Mexico was the first state to extend Medicaid to children in poverty to 185% of the federal poverty level. Representative Picraux added that reform should be viewed through a bottom-up lens.

### **Public Comment**

Kelsy Heilman, New Mexico Center on Law and Poverty, said that the BHP holds promise. It is critical that, at the state level, there is clear agreement about affordability on cost-sharing to make sure it results in better coverage. The BHP presents a great opportunity, she stated, but the state needs to make sure the BHP will actually be better than the protections afforded through a health insurance exchange. State law will have to close any gaps in protections in federal law.

Mary Feldblum, executive director of the Health Security for New Mexicans Campaign, stated that the BHP would increase the number of people insured while decreasing the number of people in the exchange. She questioned the number of people who will enroll in an exchange.

She stated that an exchange must have substantial numbers to attract insurers for better plans to be provided, creating competition for affordable premiums. She offered a brief cost analysis of exchanges, participation rates and market share projections for New Mexico. She provided a handout from the Washington State Health Care Authority, dated November 24, 2010. Her handout is available in the meeting file. She drew the committee's attention to a quote in her handout from researchers David Reimer and Alain Enthoven, who stated that an exchange would need a "critical mass" of covered individuals — "at least 20 percent of the insured population that does not already receive Medicaid or Medicare.". *Id.* at 1. "Only a pool of this size could attract serious bids from insurers," according to Mr. Reimer and Mr. Enthoven.

Marco Gonzales, lobbyist for Molina Healthcare, extended the organization's support of the BHP and said that it agrees with what has been said about additional coverage without additional cost. He said Molina Healthcare will provide a detailed briefing if it is the desire of the committee.

### **Minutes**

The minutes from the LHHS meeting in October were approved.

### **Bachelor's to D.D.S. Degree Report**

Gary Cuttrell, D.D.S., J.D., chair, Department of Dental Medicine, University of New Mexico School of Medicine (UNM SOM), and Peter Jensen, D.D.S., M.S., M.P.H., director, Residency Program, Department of Dental Medicine, UNM SOM, provided information on the bachelor of arts degree program to a dental school to obtain a doctor of dental science or doctor of dental surgery degree (BA/DDS). A handout was provided setting forth:

- (1) residency success (page 2 of the handout);
- (2) UNM Hospital statistics and outreach efforts (pages 3 and 4 of the handout);
- (3) the legislation creating the BA/DDS program, Senate Bill 133 and other dental feasibility studies (pages 5 and 6 of the handout);
- (4) the costs of a dental school in New Mexico (pages 7 and 8 of the handout);
- (5) specifics of the BA/DDS program:
  - (a) to alleviate the dentist shortage in New Mexico;
  - (b) to recruit talented high school students to UNM and the program;
  - (c) 10 years of incremental and permanent funding commitment; and
  - (d) a three-phase program with an affiliation agreement with a regional dental school as long as New Mexico does not have a dental school;
- (6) student and background information (pages 9 and 10 of the handout):
  - (a) planning is for 20 students with an affiliated dental school; and
  - (b) the Western Interstate Commission for Higher Education funds 10 spots annually;
- (7) legislative funding requests and requirements (pages 10 and 11 of the handout), include:
  - (a) a new program development request of \$400,000;
  - (b) pre-dental undergraduate costs of \$2 million;

- (c) dental school costs of \$6 million; and
- (d) residency costs of \$8 million; and
- (8) New Mexico's unique dental challenges include:
  - (a) .6 dentists per 1,000 persons compared to a national average of .8 dentists per 1,000 persons;
  - (b) a bottom quartile ranking in the number of dentists per 1,000 persons;
  - (c) 70% of dentists practice within the four-county Rio Grande urban corridor; and
  - (d) 25 of 33 counties are health professional shortage areas that comprise 42% of the population.

In response to inquiries from the committee, Mark Saavedra, lobbyist for UNM, said that the BA/MD program is in its second year. He said he would provide the committee with the dropout rate of the cohort group.

Committee members engaged in conversation with Dr. Jensen about the undergraduate degree structure, inquiring about why the degree is a bachelor of arts versus a bachelor of science.

Committee members inquired about the residency aspect of the program and the need for residents in rural New Mexico. Dr. Jensen explained that residents currently practice in rural New Mexico. He added that there is not enough clinic space for the cohort group, so the program must go beyond Albuquerque. He said the program has established relationships with alternate clinical sites in order to rotate residents, and as the faculty is established, more students can transition to the rural areas. Conversation ensued regarding these regional agreements.

The topic of a dental school in New Mexico arose. Dr. Cuttrell emphasized that this is not something he is advocating. Members requested that a copy of the study concerning this be distributed to the interested members.

In response to a query, Dr. Cuttrell said that a benefit of the program is that students know that they have a guaranteed spot in a dental school. Students are allowed to leave the program if they decide that they no longer wish to continue to dental school once they have earned their bachelor of arts degrees.

### **Health Insurance Rate Review, Grievance Procedures and Ombudsman Programs**

Christine Baca, bureau chief, Life and Health Rate and Form Filing Bureau and Managed Health Care Bureau (MHCB), Insurance Division (ID), Public Regulation Commission (PRC), discussed the functions of the bureau. She said the MHCB requires insurance companies to provide grievance procedures in a culturally linguistic manner. Ms. Baca provided a handout explaining the Annual Health Plan Grievance Report setting forth:

- (1) the total number of grievances reported by insurance companies subject to the MHCB grievance procedure (page 2 of the handout);

- (2) health insurance complaints by type and determinations (pages 3 through 8 of the handout); and
- (3) dollars saved to the consumer by insurance carrier (page 9 of the handout).

Craig Dunbar, deputy superintendent of insurance, ID, PRC, explained the time lines for the rate request, the general hearing request and the hearing appeals and provided charts. Regarding the rate requests, he said that there is a 60-day rate review process: 12 days for the rate increase request to be posted on the web site; 30 days for a comment period on the web site; and 18 days for actuaries to review the information. Concerning the general hearing requests, Mr. Dunbar said that a hearing must be held within 90 days, and the hearing officer must make a recommendation to the superintendent of insurance, who will issue a final order within 60 days of the hearing. He said that from this issuance, an appeal to the PRC can take place. Finally, he explained the hearing appeals process, which requires a hearing to be held within 40 days and 90 days for the PRC to make a decision.

Mr. Dunbar also discussed web site enhancements to be made to the search/display rate filings; consumer notifications; interactive services; and calendar. He said the upgrades should be completed between December 1, 2011 and January 1, 2012. He said these modifications are to make the web site consumer-friendly. In addition, he briefly discussed the budget narrative and said he is looking forward to collaborating with the federal government to secure funding.

Mr. Dunbar introduced Ashley Purdy, who has recently been hired as the ombudsman in the consumer assistance program. Ms. Purdy stated that she is familiar with the grant process and insurance procedures. She informed the committee that she plans to assist consumers with the filing complaints and appeals processes as well as collecting data, tracking inquiries and educating consumers on their rights.

Committee members inquired about ACA insurance mandates, such as no cost for preventative care. Some members supposed that these mandates would result in increased insurance rates due to the provider cost reimbursements. They inquired whether insurance companies have the ability to opt out of the insurance requirements by withdrawing from the state insurance market. Ms. Baca confirmed this analysis and said that if a company chooses to withdraw, it must notify its policyholders 180 days prior to doing so, and it is prohibited from conducting that service in the area for five years. Further discussion took place regarding insurance company bankruptcy and whether there is a mechanism in place for policyholders to migrate to other companies. Ms. Baca replied that this occurs through reinsurance. She said changes to this need to be made through the legislature, and committee members requested that she analyze the proposed changes and provide language to the committee. Ms. Baca clarified that the MHCB has an examination team that can investigate the matter if there is reason to believe that an insurance company is becoming insolvent.

Responding to an inquiry, Ms. Baca explained that when an insured individual is denied a service, that person has the opportunity to appeal that denial internally within the insurance

company. If the insurance company upholds the denial, the individual may then contact the MHCBC, where the external reviews are conducted.

A request was made for Ms. Baca to submit information to the committee pertaining to the number of cases in which a consumer was determined to be correct and those in which the insurance company was determined to be correct.

A brief discussion took place about the most common types of consumer complaints received, how the calls are handled and the amount of staff available to take the calls. A suggestion was made that the hiring of additional staff for this purpose may fall within the purview of grant funding. Further discussion took place about the number of grants applied for and the number received.

A request was made for the MHCBC to provide the committee with data on the insurance budgets for all 50 states.

Members of the committee asked how New Mexico rates in relation to other states. Ms. Baca responded that the MHCBC is working to update the consistent changes to interim final rule and to the federal regulations. Mr. Dunbar stated that New Mexico is average in updating and negotiating these new regulations. Concern was expressed about the need for state money and new statutes to be enacted prior to 2014, when all federal regulations go into effect. Ms. Baca said a financial crisis is rapidly approaching because the internal claims process and external review procedure will apply to comprehensive plans that are traditional fee-for-service plans and are not typical HMO or PPO plans. She said those plans are also subject to the grievance procedure. She said solutions to this are included in the proposed regulation, and she said the MHCBC will be the single point of contact for all grievances. Discussion took place about giving the insurance companies the option to submit their grievance data to the ID to ease the strain on the ID.

A request was made for the MHCBC to provide data concerning how New Mexico's rate of claims to grievances compares to that of other states.

Senator Feldman brought forth the issue that the ID was placed on probation due to the lack of actuarial analysis on rate reviews. Mr. Dunbar informed the committee that a meeting is taking place on the day of this meeting and that he does not know the decision as to whether or not to take the ID off probation. He clarified that this probation is due to actions of the previous administration. Senator Feldman said the ID has failed to update the ability to look up the actual files or for an individual to sign up to be ratified if an insurance carrier is asking for a rate review. Senator Feldman and Mr. Dunbar discussed staffing needs.

### **Thursday, November 3**

The meeting reconvened at 9:40 a.m.

Upon the request of Senator Feldman, Mr. Hely brought an email message from Mr. Dorn to the committee's attention, illustrating the ratio for Medicaid provider rates. These figures showed New Mexico Medicaid provider rates to be among the higher, but not the highest, provider rates. Mr. Hely said the email provides information on the BHP and clarifies several points raised on November 2 during Mr. Dorn's presentation. Mr. Hely noted an article included in the committee materials titled the *Quiet Health-Care Revolution*, by Adrain Slywotzky and Tom Main, which is a counterpoint to the Urban Institute's data.

### **Anti-Cancer Drug Pricing Parity (SB 385, 2011 Regular Session)**

Barbara McAneny, M.D., chief executive officer, New Mexico Oncology Hematology Consultants, Ltd., presented on the implementation of a bill passed in the 2011 regular session, sponsored by Senate President Pro Tempore Timothy Z. Jennings, that requires parity in pricing between intravenous and oral anti-cancer drugs. Previously, oral therapies for these anti-cancer medications were not covered by insurance plans, as oral therapies do not involve treatment in the medical office, unlike intravenous treatments. Dr. McAneny explained that these oral therapies are included among pharmacy benefits, which have tiered coverage. Intravenous drugs are considered to be inpatient treatments and are not tiered. Everyone is one chronic disease away from devastation, she reminded the committee, and she discussed how most people are unable to pay for these treatments at \$5,000 to \$1 million a bottle. Dr. McAneny said that insurance companies claim they cannot afford to offer better rates and that these insurers included anti-cancer oral therapy in the same coverage tiers as cosmetic or discretionary treatments, such as Botox. She stated that health insurance is supposed to protect individuals against the high costs incurred when they are sick, yet most bankruptcies are due to medical situations. She extended her appreciation for the legislation.

Sandra Adondakis, New Mexico government relations director, American Cancer Society (ACS) Cancer Action Network, said this law is a recent example of how the legislature is considering proven strategies that prevent and treat cancer. She offered further examples that set New Mexico apart from other states, including tobacco funding and the breast cancer license plate. She said that despite these efforts, cancer remains a significant problem. She provided a handout that offered data on:

- (1) cancer facts (page 2 of the handout);
  - (2) estimated new cancer cases for select sites in New Mexico (page 3 of the handout);
  - (3) estimated cancer deaths for select sites in New Mexico (page 4 of the handout);
  - (4) anti-cancer drug pricing (page 5 of the handout):
    - (a) the ACS works to eliminate cost barriers to patient access to cancer treatment;
- and
- (b) New Mexico joins 13 states in passing anti-cancer drug pricing parity laws; and
  - (5) a chart setting forth cancer incidence rates in the United States from 2003 through 2007 (page 7 of the handout).

Members of the committee inquired about co-pays and tiering and asked if the fault lies with the link between the insurance companies and pharmaceutical companies. Dr. McAneny

replied that the drugs are incredibly expensive, and there are no apologies from the pharmaceutical industry. She said that in an ideal world, there would be cost control, which may require research and development subsidies, as determined by Congress. Co-pays should be determined by medical necessity and effectiveness, she suggested, because oncology doctors are guilty of using expensive drugs that improve survival for a month and that should have higher co-pays.

A committee member pointed out that if the insurance companies are paying for the treatments, as opposed to the patient, premiums increase for the pool to cover a few individuals' diseases. The member warned that, given this scenario, one should be careful to not demonize the pharmaceutical and insurance companies. Dr. McAneny agreed that insurance premiums have gone up 180% over the past decade, which is faster than medical inflation. She said an additional problem exists when generic drugs become inexpensive to the point of not being profitable for the pharmaceutical companies and those companies opt to stop producing those drugs.

A few committee members asked if reports are received from the Indian Health Service about cancer outbreaks on Native American land. Dr. McAneny said this information is gathered and that there is a cancer center in Gallup for this purpose. She said the Navajo Nation does better than most communities in gathering information because tobacco use and uranium mining are aspects of the problem. She said the increased cost of insurance goes beyond what many residents of McKinley County can pay and that the patients in Gallup will benefit tremendously from the legislation.

Senator Feldman asked about ethnic disparities in terms of the incidence of cancer and mortality rates. Dr. McAneny informed the senator that data are collected among the states to determine how various populations should be treated. She noted health disparities among the states and said that New Mexico has a concentration of gallbladder cancer. Dr. McAneny said the New Mexico Tumor Registry provides data on the average rate of cancer for Native Americans versus other races and ethnic groups. Senator Feldman suggested having a meeting focused on patients living near New Mexico's borders who are seeking health care in the border states.

Committee members asked what is being done to remedy drug shortages. Dr. McAneny said that President Obama attempted to require the federal Food and Drug Administration to provide advance notification on a drug shortage, but the unintended reaction would be the stockpiling those drugs. She said that one solution would be to have the pharmaceutical companies provide notification of when they plan to switch away from manufacturing certain drugs. She said a concern lies with the idea of importing drugs from other countries because the drugs may have been labeled incorrectly.

When asked what steps the state can take, Dr. McAneny suggested moving fourth tier drugs without a generic substitute to the third tier.

### **Prescription Drug Donation (SB 37, 2011 Regular Session)**

Bill Harvey, R.Ph., executive director, Board of Pharmacy, stated that Senate Bill 37 (2011), sponsored by Senator Feldman, allows health care professionals who know their patients to safely reuse pharmaceuticals. He said that the Board of Pharmacy has drafted policies and procedures for this practice, such as requiring recipient and donor forms. He said that there is no fee for doctors who wish to practice this policy. He added that controlled substances and some drugs are not eligible for reuse.

Dr. McAneny brought an oral therapy for cancer that cost \$2,000 and that was returned to her by a patient who did not open the bottle. She emphasized that the legislation allows this unopened medicine to be given to another patient free of charge. She said Dr. Harvey has done an amazing job of writing a series of easy, step-by-step applications that allows doctors to institute this policy. She thanked the committee and the Board of Pharmacy for this legislation.

The members of the committee expressed concern about doctors' liability for reuse of pharmaceuticals and inquired about litigation. Dr. McAneny said doctors share that concern, and she said that her attorney has conducted thorough research concerning this issue and concluded that no such lawsuit exists. She said a concern exists that the original keeper of the drugs would not properly store the drugs, resulting in side effects for the person who takes the drugs. She clarified that the doctors who participate in this program will be trained to ensure that this will not happen. In addition, she explained that the patient who receives the medication will sign a release. A request was made for Mr. Hely to analyze the legislation to ensure that doctors are protected.

Senator Feldman said this legislation is fraught with difficulties and that it is a landmark that required good will. She thanked everyone for working on the bill. She asked about the dissemination of information. Dr. McAneny said she has been charged to provide information for the New Mexico Medical Society's newsletter, and it is on the Board of Pharmacy web site. Dr. Harvey added that a press release is being developed and said the board is in instant communication with all pharmacists in the state. Senator Feldman asked that the press release be sent to the committee.

### **Medical Malpractice: An Analysis of HB 267 (Regular Session, 2011)**

Mr. Hely introduced Teresa "Tessa" Ryan, a student at the UNM School of Law who served during the summer of 2011 as an LCS law intern, and the topic of House Bill 267 (sponsored by Representative Jim R. Trujillo), which was passed in the 2011 regular session and then vetoed by the governor. Mr. Hely pointed out that the governor's House Executive Message 22 regarding HB 267 was included in the committee materials.

Ms. Ryan provided the committee with information about the New Mexico system of medical malpractice insurance. She stated that her presentation would address: 1) the debate regarding this issue; 2) challenges involved in predicting and identifying the effects of the increased cap; and 3) how she approached finding these effects and findings. She provided a handout setting forth:

(1) the types of damages in medical malpractice suits, including economic damages and non-economic damages (slide 3 of the handout);

(2) New Mexico's two-tiered system of physician insurance (slide 4 of the handout, which includes:

(a) a primary layer of coverage with a cap of \$20,000 on all but punitive damages; and

(b) a secondary layer of coverage for the remainder of all non-economic damages up to the \$600,000 cap and all remaining damages;

(3) background on HB 267 (slides 5 through 7 of the handout), including:

(a) a \$600,000 cap established in 1992 and put into effect in 1995; and

(b) that doctors and trial attorneys negotiated amendments to the Medical Malpractice Act to raise the damage cap from \$600,000 to \$1 million beginning in 2012;

(4) reasons for the governor's veto (slide 8 of the handout):

(a) the legislation could reduce the number of doctors in the state;

(b) the legislation could lead to frivolous lawsuits;

(c) the legislation could increase insurance rates; and

(d) cap increases could deter doctors from practicing;

(5) her research on the effects of malpractice caps in New Mexico and challenges in finding answers (slides 8 through 10 of the handout):

(a) New Mexico has a two-tiered system where most states have a one-tiered system; and

(b) biased research is dominant; and

(6) her findings and conclusion (slides 14 through 19):

(a) the proposed cap increase will result in the average physician paying 3% more in annual premiums;

(b) premium increases would stem from the Patient's Compensation Fund surcharge;

(c) the cap increase would raise the average cost of premiums;

(d) a relationship exists between caps and physician supply;

(e) tort reform is associated with a modest increase in physician supply;

(f) no strong relationship exists between caps and the frequency of malpractice lawsuit filing;

(g) there is evidence suggesting that caps reduce defensive medicine;

(h) evidence links a modest decrease in defensive medicine with states imposing initial caps;

(i) imposing caps reduces the average size of malpractice awards; and

(j) statutorily limited award sizes disproportionately burden the most severely injured patients.

Randy Marshall of the New Mexico Medical Society agreed with the study and the findings. He reminded the committee that the New Mexico Medical Society had worked on the bill with the New Mexico Trial Lawyers Association (NMTLA) and that they reached a consensus.

Discussion ensued between committee members and Mr. Marshall concerning the 3% raise in physicians' annual premiums and additional costs on premiums in the primary layer. Mr. Marshall explained that the primary carrier bills for the coverage and forwards the surcharge to the ID. Committee members said that it makes sense, but it creates an uneven playing field because many physicians are leaving private practice and moving to hospitals. Mr. Marshall said hospitals could qualify, but most have chosen not to. Ms. Ryan stated that the governor is in favor of a clarification to cover corporations. A request was made for Ms. Ryan to research caps placed on attorney fees.

Concern was expressed about the proposed cap increase, and a suggestion was made to see how the courts rule on the caps.

Committee members asked if the governor was asked for input. Mr. Marshall said he and the ID have requested a meeting with the governor about the legislation and litigation process.

Members of the committee inquired whether or not midwives and long-term care nursing facilities are included in the legislation. Mr. Marshall said they are not, and some committee members stated that these concerns should be addressed by the committee in the form of a memorial to the special committee requesting it to add these two groups. Committee members expressed concern that nurse-midwives and nursing facilities should not be left out of this plan and said that this issue requires all groups to be at the table.

D.J. "Don" Letherer, former superintendent of insurance, informed the committee that he worked on the first Medical Malpractice Act, and he said there are issues not being addressed. He said that the term "medical professional" needs to be changed in the legislation. He suggested taking the language from Indiana's statutes.

Former New Mexico Senator H. Dianne Snyder, executive director of the Albuquerque Medical Association, said she represents the largest group of physicians in Albuquerque. She said that current physicians are retiring and that, in the discussions regarding medical malpractice, the input from upcoming physicians is lacking.

Charlie Marquez, lobbyist for the New Mexico Health Care Association, expressed his gratitude for the idea of changing the term "medical professional" to include long-term care facilities.

### **Adolescent Opioid Addiction (SM 56, 2011 Regular Session)**

Linda Roebuck Homer, chief executive officer, Interagency Behavioral Health Purchasing Collaborative, noted the direness of opioid addiction among adolescents in the state.

Harrison Kinney, Ph.D., director, Behavioral Health Services Division, Human Services Department, and Pilo Gleno, director, cultural diversity, OptumHealth, New Mexico, said that

fatal overdoses are a health care crisis in New Mexico. A handout was provided to explain the following:

- (1) SM 56 (page 3 of the handout) requests the Interagency Behavioral Health Purchasing Collaborative to develop a comprehensive statewide plan for treatment of opioid addiction among adolescents, including steps for implementation of the plan;
- (2) the opioid problem and the target population (pages 3 and 4 of the handout):
  - (a) New Mexico has the highest rate of fatal unintentional drug overdoses in the country;
  - (b) New Mexico youths use drugs at an average age of 12, which is younger than any other state in the country; and
  - (c) ages 14 through 24 are the target populations;
- (3) the guiding principles of recovery (pages 4 and 5 of the handout), which include that they:
  - (a) are culturally competent;
  - (b) are trauma-informed;
  - (c) are recovery-oriented;
  - (d) include a clinical home and system of care;
  - (e) include a peer recovery community; and
  - (f) are the best value;
- (4) the current system of care (pages 5 and 6 of the handout):
  - (a) urban and suburban treatment centers are inadequate due to lack of funding;
  - (b) there are limited adolescent treatment centers; and
  - (c) dedicated stakeholders are working to improve the system;
- (5) the comprehensive statewide plan for treatment of opioid addiction recovery (pages 5 through 8 of the handout), including:
  - (a) a centralized statewide information and referral center;
  - (b) a recovery-oriented system of care;
  - (c) linkage to recovery communities;
  - (d) linkage to natural support;
  - (e) funding/data management;
  - (f) work force development/training;
  - (g) prevention-health care promotions;
  - (h) that a recovery system of care intersections with other systems; and
  - (i) continuous quality improvement;
- (6) short- and long-term steps to implement the plan (pages 9 through 13), including:
  - (a) a centralized information and referral center;
  - (b) enhanced components of the system of care;
  - (c) work force development/training; and
  - (d) a recovery-oriented system of care; and
- (7) the executive summary (pages 13 and 14 of the handout):
  - (a) opioid addiction has increased significantly the last several years;
  - (b) opioid addiction is a complex disorder that quickly controls most areas of a youth's life and is resistant to treatment;

- (c) the treatment system is siloed, and funding is fragmented;
- (d) addictions are chronic and prone to relapse and require an array of treatment methods;
- (e) services should be anchored in a person-centered approach that focuses on the strength and resiliency of individuals;
- (f) the recovery-oriented system will take political will; and
- (g) immediate steps can be taken to greatly improve the system.

Members of the committee took note of past politicians who viewed drug abuse as a public health crisis, as opposed to a criminal activity, and it was stated that youth addiction is due to lack of education on the issue, which is the fault of the state. Public service announcements providing the slang terms for heroin were suggested.

Committee members inquired about the technicalities of reimbursements. Ms. Roebuck Homer noted that there is a pilot program to bring Salud Family Health Centers and behavior health providers together to discuss treatment options.

Committee members discussed work force development and training and suggested collaborating with UNM's Department of Psychiatry and the public schools to teach students and public school teachers how to recognize the symptoms of substance abuse prior to addiction.

Senator Feldman asked how the committee can help. Ms. Roebuck Homer said the committee's voice is needed. She said potential Medicaid packages are being examined and that she needs more time to develop particular requests.

### **Prescription Drug Abuse**

Boyd Kleefisch, M.B.A., F.A.C.H.E., chief operating officer, New Mexico Medical Review Association (NMMRA), said the common themes in health care delivery are silos and fragmentation. He provided a handout explaining the following:

- (1) the New Mexico Prescription Improvement Coalition (NMPIC) (page 1 of the handout), which:
  - (a) was established and is facilitated by the NMMRA; and
  - (b) is a multi-stakeholder coalition focused on medication delivery in New Mexico;and
- (2) prescription drug safety activities (pages 2, 3, 5 and 6 of the handout), which include:
  - (a) NMPIC clinical guidelines;
  - (b) an e-prescribing project; and
  - (c) a medication therapy management study.

Galina Priloutsckaya, Ph.D., M.B.A., C.H.C.A., director of analytic services and drug safety, NMMRA, said she has been researching prevention and drug-free work force efforts in Las Cruces.

Dr. Harvey said that the NMMRA is a close ally in e-prescribing efforts and that the board does not have money to upgrade the program on its own. He said the e-prescribing program is used nationwide and helps identify prescription trends and aids a community in deciding where to funnel its resources. He informed the committee that the board is collaborating with neighboring states to share data, track prescription abuse and elicit activity.

Committee members urged the Board of Pharmacy to contact the Department of Public Safety because this is a public safety issue. Information on age, ethnicity, drug-overdose suicides and the accidental death rate was requested. Dr. Priloutska mentioned several drug abuse methods used by adolescents, including dumping prescription drugs into a bowl and taking a handful of them. Dr. Kleefisch stated that 20 drug-related deaths have occurred in New Mexico over the last 12 months, which is second to automobile deaths over the same amount of time.

### **Public Comment**

Dr. Harris Silver, epidemiologist, told the committee that he was appearing for Dr. Bill Weiss, R.W.J. Regarding that a drug policy task force, Dr. Silver stated that the cost of substance abuse is enormous and that the treatment benefit cost ratio is 12:1, whereas the prevention cost benefit ratio is 28:1. He said there are problems on the ground, and it has been studied long enough. Dr. Silver stated that addiction is a complex chronic brain disease that disables people from making appropriate decisions. He stated that prevention and treatment programs have been severely underfunded, and they lost \$3 million this past year. He pointed out that there are no detoxification centers for adolescents in the state. He explained that most people with substance abuse issues have other disorders and that essential residential treatment should be covered by insurance.

Paco Parrietos, citizen, said he has heard a lot of discussion about prescription drug abuse and the doctors who may or may not be over-prescribing prescription drugs. He said that this is not always the case because one can order the same drugs from a Mexican web site and have them delivered. He said it is that simple, and the doctors are not necessarily to blame.

Larry Lowe, citizen, discussed the use of medical cannabis as a treatment option for addictions to pharmaceutical drugs. He encouraged the education of physicians on this option.

Pete Kassetas, deputy chief of police, New Mexico State Police, Department of Public Safety, stated that law enforcement cannot arrest its way out of this issue. He said it is easier for youths to steal their parents' prescriptions than it is for them to purchase beer. He explained that state police officers are on a joint drug unit with the Drug Enforcement Administration office in Albuquerque to attempt to tackle this issue.

### **Friday, November 4**

The committee reconvened at 9:35 a.m.

## **Workforce Solutions Department: Update on Programs and Priorities**

Celina Bussey, secretary of workforce solutions, offered the committee an update of the department's progress. She provided a handout setting forth:

- (1) the September 2011 New Mexico unemployment rate (page 2 of the handout):
  - (a) unemployment is at 6.6% with a labor force of 930,725 people; and
  - (b) 41,000 people are certifying for unemployment insurance (UI);
- (2) the maximum UI benefits and federal extensions (pages 3 and 4 of the handout):
  - (a) in New Mexico, a claimant can be eligible for a maximum of 86 weeks of UI;
  - (b) regular UI is 26 weeks, paid from the trust fund; and
  - (c) federally funded extensions include 13 weeks and an additional three-tier system;
- (3) a chart illustrating the increase in UI claims from 2008 to 2011 (pages 5 through 7 of the handout);
- (4) UI program priorities (page 8 of the handout), including:
  - (a) UI modernization projects;
  - (b) UI integrity; and
  - (c) reemployment;
- (5) the UI modernization project (page 9 of the handout), including:
  - (a) a combined UI and tax benefits program;
  - (b) benefits to business through an automated self-service system;
  - (c) benefits to claimants through a user-friendly online model with personal mailboxes; and
  - (d) that it is funded with federal American Recovery and Reinvestment Act of 2009 (ARRA) and federal Department of Labor (DOL) funds;
- (6) UI integrity and initiatives (pages 10 through 16 of the handout), including:
  - (a) intensifying efforts to prevent, detect, reduce and collect overpayments;
  - (b) the responsibility of the Work Force Solutions Department (WSD), employers and UI claimants;
  - (c) a departmental cross-functional integrity task force;
  - (d) a UI integrity institute;
  - (e) additional staff;
  - (f) a public awareness campaign;
  - (g) separation issues;
  - (h) employment services registration;
  - (i) follow-up calls to claimants for failure to register completely;
  - (j) a work search verification pilot project; and
  - (k) a 10-week pilot program with 50 staff members;
- (7) reemployment initiatives (pages 17 and 18 of the handout), including:
  - (a) the creation of five business liaison representative positions;
  - (b) training staff on business service goals;
  - (c) being a partner for the 2011 New Mexico Employment Summit; and
  - (d) working with individual communities;
- (8) the existence of an integrity grant of about \$2.5 million (page 19 of the handout);
- (9) information about the UI call center (page 20 of the handout);

- (10) a chart depicting the UI peak season (page 21 of the handout);
- (11) the anticipated time lines for the UI projects (page 22 of the handout):
  - (a) call center calls wait times are reduced to four minutes from one hour and six minutes;
  - (b) claims adjudicators issue decisions within four to six weeks; and
  - (c) UI benefits appeals are dealt with in 65.12 days; and
- (12) information regarding the New Mexico Workforce Assessment and Recommendation Partnership grant (pages 23-24 of the handout).

Members of the committee commended Secretary Bussey for accomplishing a great deal in a short amount of time. Responding to an inquiry, Secretary Bussey said the modernization project drastically improves the claims process. She said each employer will have an inbox, and the necessary forms can be found there. She said communication between the WSD and an employer will be much clearer and will be expedited. Secretary Bussey also said that the content in the complex forms is being rewritten in layperson's terms that can be understood. She said this should ease the pain felt by the employer while dealing with a claim.

The committee members inquired about the reasons for the overpayment of UI. Secretary Bussey said the failure of a claimant to complete the registration process causes the case to be flagged as an overpayment with the DOL when, in fact, it is not. She said that this is the number one cause of overpayments in New Mexico, and the WSD is working to educate the claimants on how to complete the process.

Committee members requested UI exhaustion numbers. Secretary Bussey said these numbers are gathered on a weekly basis with a few hundred individuals doing this every week.

Secretary Bussey explained the drop in the unemployment rate, stating that most economists discern a gap between those who consider themselves unemployed and those who are receiving UI but are considered to be out of the work force. If those people decide to resume their job search, the unemployment rate will go back up, she explained.

Responding to several inquiries, Secretary Bussey said bridges are being built between the various areas of the department to ensure that claimants have completed the registration process. First, she said, the local unemployment offices will verify that a claimant who wants to use the resources in that office has completed the registration. Second, she explained, the customer service representatives at the call center will be able to see this information online. Secretary Bussey explained that the required job searches a claimant must conduct every week will be regulated through the online system.

In response to a question, Secretary Bussey explained that the intent of the governor's initiatives is to redirect the use of UI benefits to a training program for claimants, conducted by an employer, that allows a claimant to receive on-site training with a chance of being hired, as is done in Georgia. She said that Georgia has set up separate accounts outside of the trust fund for payment of benefits, and it diverts funds so that a claimant can still receive UI benefits from

employers from accident liability. She emphasized that these programs are very complicated. Secretary Bussey said New Mexico's Unemployment Compensation Fund has solvency issues, which is a challenge in implementing this program.

Members of the committee inquired about the WSD's budget and the ARRA funds it received. Secretary Bussey said that the WSD is 95% federally funded. She said that she will provide the federal appropriations from previous years to the committee. She said that state funding for fiscal year 2011 was \$7 million, and it was \$3 million for fiscal year 2012, despite a request for a flat budget.

Committee members asked who funds the UI for contractors. Secretary Bussey stated that UI is very complex, and from the contractual standpoint, she must assume that there is not an employer-employee relationship. She said she will provide the distinguishing language for seasonal workers, temporary workers and contractors.

Committee members inquired about a relocation employment program. Secretary Bussey said that New Mexico has not been creative with relocation efforts and that small programs exist that pertain only to those workers who have lost their jobs due to foreign export. She said the state must get past barriers like this.

Responding to an inquiry, Secretary Bussey said that the work force has shrunk over time, and the exact reason has yet to be determined. She said she will provide the numbers to the committee.

Members of the committee asked if ARRA grant funds have been used to increase customer service representation or to find technical solutions to some information technology problems. Secretary Bussey responded that it has. She informed the committee that she would provide more data, per the request of the committee, as well as the age and ethnicity of UI claimants.

### **Aging and Long-Term Services Department Oversight**

Retta Ward, secretary-designate, Aging and Long-Term Services Department (ALTSD), gave the committee an update of departmental activities. Her handout explained the following:

- (1) the mission of the ALTSD and a budget increase request (pages 3 and 4 of the handout);
- (2) the ALTSD's strategic priorities (page 5 of the handout), including:
  - (a) services in homes and communities;
  - (b) prevention of adult abuse, neglect and exploitation; and
  - (c) caregiver support;
- (3) the ALTSD organization (page 6 of the handout);
- (4) graphs depicting:
  - (a) the population growth of New Mexico from 2005 to 2015 and total population versus those aged 60 and over (page 7 of the handout);

- (b) the Consumer and Elder Rights Division general fund (page 8 of the handout);
- (c) the aging and disability resource center (pages 9 and 10 of the handout);
- (d) information about the state's long-term care ombudsman (pages 11 and 12 of the handout);
- (e) information about the Adult Protective Services Division general fund (page 13 of the handout);
- (f) information about the Adult Protective Services Division (page 14 of the handout); and
- (g) information about the Aging Network Services Division general fund (page 15 of the handout);
- (5) the Aging Network Services Division (pages 16 through 18 of the handout); and
- (6) a summary of the ALTSD's request (page 19 of the handout), including:
  - (a) the fiscal year 13 general fund request of \$42.9 million, which is a \$2.3 million increase; and
  - (b) that additional funding maintains the current levels of service.

Members of the committee inquired about the operation of nursing homes. Secretary Ward informed the committee that nursing homes are run by the Department of Health (DOH), although the ALTSD does report complaints. She said these reports are responded to immediately. She informed the committee that the ALTSD submits recommendations to the DOH concerning nursing home facilities and employees. Concern was expressed about the overmedication of the elderly. Sandra Everhart, state ombudsman, ALTSD, told the committee that these instances should be reported to the Adult Protective Services Division. She said the ALTSD has 30 statewide volunteers who are trained to identify circumstances like the one described.

Members of the committee discussed the Senior Olympics and complaints that it is a waste of state resources that could be redirected to care on the Navajo Nation. Secretary Ward said she shares the concern about needing greater collaboration with the Navajo Nation.

Senator Feldman noted the amount of work that the ALTSD does with few resources. She asked why emergency calls and complaints to the ALTSD are increasing. Secretary Ward replied that worsening economic times result in more seniors living on the edge of, and in, poverty.

### **Public Comment**

Susan Loubet of the New Mexico Women's Agenda told the committee that she would like the WSD to develop women-specific reemployment programs.

Nat Dean, disability advocate, told the committee that she has lived with multiple disabilities for 27 years and that she was prescribed 27 medications at one point. She said that this causes a tolerance, which magnifies the complexity of the treatment and often causes addiction. She supports the availability of natural medicine, noting its benefits. She requested that the DOH better monitor the medical cannabis program and its clients and requested that

patient renewals be done within a one-year window, due to the long waits for doctor appointments and the insurance paperwork. In response, members of the committee suggested writing the DOH a letter requesting a breakdown of cost savings with Medicaid for medications that cannabis patients are abandoning in favor of cannabis.

Lisa Schatz-Vance, executive director, Senior Citizens' Law Office, told the committee that she has a strong relationship with the ALTSD and that the department is requesting an increase in its operating budget. She said she supports this request because of the growing aging population in New Mexico. She said it is important for individuals to live independently and to age with dignity.

Jim Parker, executive director of the Governor's Commission on Disability, informed the committee that the commission has been successfully partnering with state entities in addressing senior disability issues, and he said the commission has redirected people to the resource center to provide assistance for construction-related activities.

### **Adjournment**

There being no further business before the committee, the fifth meeting of the LHHS for the 2011 interim adjourned at 1:10 p.m.

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

**November 30-December 1, 2011  
Room 307, State Capitol  
Santa Fe**

The sixth meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on November 30, 2011 at 9:15 a.m. in Room 307 of the State Capitol.

**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  
Sen. Gerald Ortiz y Pino

**Absent**

**Advisory Members**

Rep. Ray Begaye  
Rep. Eleanor Chavez  
Sen. Stephen H. Fischmann  
Rep. Miguel P. Garcia  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill O'Neill  
Sen. Nancy Rodriguez  
Sen. Sander Rue  
Sen. Bernadette M. Sanchez  
Rep. Mimi Stewart (12/1)

Sen. Rod Adair  
Sen. Sue Wilson Beffort  
Sen. Mary Kay Papen  
Sen. John C. Ryan  
Rep. James E. Smith

**Guest Legislator**

Rep. Edward C. Sandoval (12/1)

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

**Approval of Minutes**

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

**Staff**

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

Rebecca Griego, Records Officer, LCS

Abenicio Baldonado, Intern, LCS

Kathleen Dexter, Researcher, LCS

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts and written testimony are in the meeting file.

**Wednesday, November 30****Approval of Minutes**

On a motion by Senator Kernan, seconded by Representative Lujan, the minutes of the committee's November 2-4, 2011 meeting were adopted.

**Prior Notice by Insurers Before Formulary Changes**

Senator Timothy Z. Jennings, president pro tempore, and Amber Pearce, U.S. public affairs and state government relations director for Pfizer, presented a bill for the committee's endorsement concerning reclassification or removal of prescription drugs from formularies specified in the New Mexico Insurance Code, the Health Maintenance Organization Law and the Nonprofit Health Care Plan Law. The proposed bill prohibits reclassification of a prescription drug into a higher tier or removal of a drug from the formulary for a period of one year following the effective date of an insurance policy, and it requires that an enrollee be given 60 days' prior notice if a drug is to be reclassified or removed. The price-stabilization effect of the measure would help people with chronic or otherwise long-term health issues that are treated or managed with drugs, including multiple sclerosis, arthritis, hemophilia, acquired immune deficiency syndrome and cancer.

On a motion by Senator Kernan, seconded by Representative Espinoza, the committee voted unanimously to endorse the bill.

**Medicaid Funding for Nursing Facilities**

Linda Sechovec, executive director of the New Mexico Health Care Association, and Jody Knox, chief executive officer of Lakeview Christian Home of the Southwest, Inc., gave a presentation on recent *Medicare* reimbursement rate cuts for skilled nursing facilities and the impact this has on the state's Medicaid program (Tab 1 of the handout). *Medicare* reimbursements over the past decade have made up for a shortfall in funding for Medicaid, which has been chronically underfunded in the state; however, due to *Medicare* rate cuts that went into effect on October 1, 2011, *Medicare* funding can no longer cover this cost-shifting. The new rates, in combination with service delivery and payment changes, effectively reduced reimbursement for *Medicare* services by 14 percent, or \$68.20, per-*Medicare*-patient-per-day, for an annual loss of \$15.6 million to the state's nursing facilities. The consequent underfunding

to the state's Medicaid program is estimated at \$20 million to \$25 million annually, an estimate that is hampered, in part, by managed care contract provisions that prohibit providers from releasing information on contract rates.

The *Medicare* rate cuts threaten the marginal solvency of New Mexico's nursing facilities. While staff reductions and other operational changes have kept these facilities afloat through past rate cuts, there has been a recent shift in the population in nursing homes, with a much higher percentage of residents now needing staff assistance in activities of daily living. In light of the current precarious situation and probable further *Medicare* cuts in 2013 due to the federal deficit, the presenters urged the committee to support an appropriation of \$7 million to \$8 million, either in the general appropriation act or in a stand-alone appropriation bill, to cover some of the funding shortfall and to prevent further erosion of skilled nursing facility services in the state.

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

*Provider fees.* Ms. Sechovec noted that she has supported the imposition of a provider fee for nursing homes in the past; however, at this point she does not. Forty other states impose a provider fee, and although such a fee has the potential to generate \$20 million in New Mexico and bring in substantial additional federal funds, the current secretary of human services has stated that a bill imposing a provider fee would not be signed into law by the current governor because it would be viewed as a tax.

*Staffing.* In 1993, when all New Mexico nursing facilities became *Medicare*-certified and there was a shift to greater dependence on federal funding, facilities began taking more acute clients who require more care. The recent reimbursement rate cuts exacerbate the problem of hiring and retaining competent staff. While Ms. Knox tries to maintain an overall staffing ratio at her facility that allows 3.25 hours of direct patient care per client per day (the director of nursing and other staff who do not provide direct patient care are not included in this calculation), she has trouble finding staff because of competition from the oil and gas industry, where wages are two to three times higher than in nursing homes. Staffing costs account for up to 75 percent of a facility's expenses, with the balance going to facility, operational and administrative costs. The American Health Care Association stopped doing industry wage surveys, but this information is still being collected by the Center for Nursing Excellence.

*Reimbursement rates.* The state pays more for daycare and prisoners than it does for long-term care services, with current Medicaid reimbursement rates \$20.00 to \$25.00 per day below the cost of services provided. Rates vary across Medicaid managed-care contracts, and transparency in the contracts is critical in order to allow a full audit of the system. *Medicare* reimbursement for nursing home care is 21 days at full reimbursement, with days 22 through 100 qualifying for partial reimbursement with a copayment applied. The copayment is covered by Medicaid for those who are dually eligible.

*Quality of care.* Surveys on nursing facility quality of care are conducted pursuant to licensing and certification requirements. Family involvement increases the quality of care.

*Nursing home populations.* The aging baby boom generation will soon substantially increase the need for nursing care in the state. Relatively young people with traumatic injury, including drug users, account for the current population boom in nursing facilities. At the same time that the need is growing for skilled nursing care, facilities are closing due to insolvency.

*Medicaid redesign.* The American Health Care Association has submitted written suggestions to the Human Services Department (HSD) on Medicaid redesign. One concern regarding the possible collapse of waiver programs in the redesign effort is that the payment process is already difficult and could perhaps be exacerbated with a new structure.

- ★ Senator Feldman directed Representative Espinoza to meet with Ms. Sechovec, Mark Padilla, vice president for government relations at Amerigroup, and Drew Setter, lobbyist for Evercare of New Mexico, to discuss Medicaid payment difficulties.
- ★ Ms. Sechovec will provide a breakdown of nursing facility expenses, including staffing versus administration expenses.

### **Public Comment**

Nancy Bearce, chief operating officer of New Mexico Abilities (NMA), reported on NMA's work to secure employment for persons with disabilities. NMA has 105 members, a mix of individuals, nonprofit organizations and for-profit companies; employs 397 individuals with disabilities; and has 85 current contracts, totaling over \$6.6 million.

Nick Estes, policy analyst for New Mexico Voices for Children, urged the committee to pursue nursing home provider fees. He noted that New Mexico is too poor to pass up the estimated \$20 million in federal funds that would come to the state by enacting such fees.

Charlie Marquez of the New Mexico Health Care Association addressed the problem of funding long-term care services with the baby boom generation on the horizon. He stated that there is insurance available but that it is quite expensive, and he called for a blend of public funding and private insurance to cover all the costs. He also called for tort reform, describing a boutique industry of out-of-state law firms coming into New Mexico to bring lawsuits against nursing homes. On invitation from the chair, nursing home administrators in the audience introduced themselves, including Dan Smith of Sierra Health Care, Inc., in Truth or Consequences; Aaron Rance of the Good Samaritan Society in Alamogordo; Guy Matson of the Good Samaritan Society in Las Cruces; Gerald Hamilton of BeeHive Homes in Albuquerque; and Michael Hainer of Rio Rancho Care and Rehabilitation Center. One administrator pointed out to the committee that there are currently no long-term-care beds available on the west side of Albuquerque.

Ellen Pinnes of the Disability Coalition told the committee that a task force appointed by the governor has been meeting to study possible changes to the State Use Act and ways to

promote employment for the disabled. Kathleen Cates, chief executive officer of LifeROOTS, informed the committee that while there are no nonprofits on that task force, Ms. Cates is available to answer any questions committee members might have about organizations such as hers that secure employment for individuals with disabilities.

### **Further Public Comment**

Edward Keller, an independent advocate for persons with disabilities, urged the committee to support full implementation of the Money Follows the Person in New Mexico Act (MFP), describing it as a civil rights issue and as a cost-saver for the state.

### **Prior Authorization Form and Approval Standards**

Senator John M. Sapien, lobbyist Amber Pearce, Kerrie Copelin and Carroll Howely, the latter two of the Amyotrophic Lateral Sclerosis (ALS) Association, presented a bill for the committee's endorsement that addresses prior authorizations for prescription drug coverage. In a recent study by the American Medical Association, 80 percent of doctors reported that streamlining the prior authorization process is critical. The proposed bill's provisions require that all insurers use a uniform prior authorization form; require that the form be available in both electronic and non-electronic versions; and impose a two-day response deadline on insurers once a form is received. Mr. Howely, who has ALS, described the extreme hardships faced by people with disabilities when navigating the current multistep and time-consuming prior authorization process. He urged the committee to endorse the bill. Speaking from the audience at the invitation of the chair, Ralph McClish, executive director of the New Mexico Osteopathic Medical Association, also urged the committee's endorsement of the bill, saying that the prior authorization process is so time-consuming that most doctors' offices hire full-time staff specifically for this purpose.

On a motion by Senator Kernan, seconded by Representative Espinoza, the committee voted unanimously to endorse the bill.

- ★ Mr. Hely will provide information on the process for appealing to the superintendent of insurance following a denial of prescription drug authorization.

### **Money Follows the Person in New Mexico Act**

Daniel Ekman, disability advocate, Nat Dean, disability advocate, and Adam Shand, statewide advisor for People First, presented a joint memorial for the committee's endorsement concerning the MFP. The MFP, which was signed into law in 2006, allows Medicaid institutional care funds to be used, instead, for community services. The MFP has not yet been fully implemented, and current HSD policy does not allow a person to receive services under a home- and community-based waiver without first being placed in a nursing facility. An HSD study lists the state's current nursing facility population at approximately 5,700, with many of those people able to safely transition to community-based services. The largest age group in this population is the 45- to 64-year-olds, with 25- to 44-year-olds being the second-largest group and the elderly being the third largest. Mr. Shand, who is himself living at home under a Medicaid home- and community-based waiver program, spoke of the contributions that he and

others in his situation make to their communities and families that would not be possible if they were living in institutions. Lack of available and accessible housing is a hindrance, but the presenters noted that housing vouchers issued by the federal Department of Housing and Urban Development could help address this situation.

New Mexico received two grants under the federal Patient Protection and Affordable Care Act of 2010 (PPACA): \$595,000 to implement the act beginning in July 2011 and \$23.7 million to move individuals from nursing facilities to home and community settings. Furthermore, the state's application for an MFP waiver was approved in October of this year. The presenters urged the committee to endorse the joint memorial, which requests that the HSD fully implement the MFP and spells out potential cost savings to be seen.

On a motion by Representative Espinoza, seconded by Senator Lopez, the committee voted unanimously to endorse the joint memorial. Representative Espinoza and Senator Lopez agreed to cosponsor the legislation.

### **Report on Teen Pregnancy**

Sylvia Ruiz, executive director of the New Mexico Teen Pregnancy Coalition, and Marie Bass, who serves on the coalition's board of directors, reported on the coalition's programs directed at reducing teen pregnancy, reducing the negative consequences of teen pregnancy and improving outcomes for teen parents in the state. Though teen birth rates in New Mexico and the nation have steadily declined since 1998, with a 32 percent drop seen in New Mexico from 1998 to 2009 (page 3 of the handout), the state still had the second-highest birth rate in the country in 2008 for teens 15- to 19-years-old and the highest rate for teens 15- to 17-years-old. Poverty, alcohol and drug use, pro-childbearing attitudes among peers and a perception of personal and social benefits to having sex are all strong risk factors for teen pregnancy (page 4 of the handout). The coalition's prevention strategies, endorsed by the Department of Health, include family planning services, service learning programs, adult-youth communication programs, sex education and male involvement programs. Under its Challenge 2015 initiative, the coalition aims to reduce the birth rate among 15- to 17-year-olds and among 15- to 19-year-olds by 10 percent by 2015. Results in the first year of this initiative show a five percent reduction from the baseline to the current average birth rate for 15- to 19-year-olds.

Despite their successes, funding for teen pregnancy prevention programs has been cut, most notably in Doña Ana and Bernalillo counties. Members discussed the need to protect funding for these programs, including the My Power Program in Lea County, which has the highest teen birth rate in the state.

- ★ Senator Lopez will sponsor a bill to appropriate \$500,000 for teen pregnancy prevention programs.

### **Interim Report of the Disabilities Concerns Subcommittee**

Representative Lujan and Senator Rodriguez, chair and vice chair, respectively, of the Disabilities Concerns Subcommittee, presented a report on the subcommittee's work during the

interim. The report is attached as Appendix A to these minutes. The presenters and committee members discussed the need for the subcommittee to be upgraded to a full committee in order to continue working on its broad topic. With only two days of meetings in the current interim, the subcommittee was unable to address some topics that could have a substantial impact on the disabled community, such as the consolidation of Medicaid waiver programs. Members discussed the need for a profile of the state's nursing home population, especially in light of testimony that the two largest age groups are not elderly and, thus, will be needing skilled nursing for a long time.

On a motion by Senator Feldman, seconded by Representative Lujan, the minutes of the October 7, 2011 meeting of the subcommittee were adopted.

- ★ Ms. Sechovec will provide a profile of the state's nursing home population, with totals and a percentage breakdown by age group.

### **Review of Legislation**

The committee voted to endorse legislation on the following topics for the 2012 legislative session. Details on the legislation and committee actions appear in Appendix B to these minutes.

- Joint Memorial: Medical Cannabis Study (187862.1)
- Hospital Charges for Uninsured (187792.2)
- Appropriation: County and Tribal Health Councils (187354.1)
- Appropriation: BA-DDS Program (187848.1)
- Appropriation: Primary Care Physician Tuition Waiver (187864.1)
- Appropriation: Southwestern New Mexico Primary Care Programs (187951.1)

★ Mr. Hely will:

- (1) provide bill numbers from previous years if a bill proposed for endorsement is a repeat of one that was introduced in a previous session;
- (2) draft a separate health insurance exchange bill that incorporates suggestions from the executive;
- (3) provide copies of the statute authorizing tuition waivers for primary care medical students; and
- (4) get a reading from Raúl E. Burciaga, director of the LCS, on the germaneness of vetoed bills that are reintroduced for veto overrides.

The committee recessed at 4:25 p.m.

### **Thursday, December 1**

The committee reconvened at 9:10 a.m.

### **1115 Waivers**

Jane Perkins, J.D., M.P.H., legal director for the National Health Law Project, Alicia Smith, president of Alicia Smith and Associates, Quela Robinson, staff attorney for the New Mexico Center on Law and Poverty, and Jim Jackson, executive director of Disability Rights New Mexico, gave a presentation on 1115 waivers, which may be granted for demonstration and pilot projects within a state's Medicaid program. Waivers are granted in three categories — less-than-statewide coverage, targeted experiments and program restructuring — and are restricted by statute to budget-neutral projects with demonstrated experimental value.

Ms. Perkins suggested that, in preparing its current 1115 waiver application, New Mexico study both what was denied in Arizona's recent waiver application and a court challenge that Arizona recently faced. The Centers for Medicare and Medicaid Services (CMS) denied Arizona's requests to require eligibility redeterminations every six months rather than every 12 months; impose copayments on children and pregnant women; and impose an annual fee on smokers. In addition, in *Newton-Nations v. Betlach*, the federal Ninth Circuit Court of Appeals found that a reduction in benefits imposed as a cost-saving measure within the Arizona Medicaid program does not meet the statutory definition of an "experiment", nor does the imposition of heightened copayments demonstrate anything other than what 35 years of research has shown: when faced with increased copayments, the Medicaid population forgoes care. Ms. Perkins also stressed the requirement for monitoring and evaluation in a waiver project and for public input in the waiver application process.

Ms. Smith informed the committee that she would present a concept paper to the governor on the state's current waiver application. She noted that the waiver will be based on a per capita payment structure, which allows for enrollment growth. The other option was to use an aggregate cap structure, as is used in Rhode Island and Vermont. These states have come to regret using the aggregate cap, however, because while their Medicaid enrollment continues to grow, their Medicaid funding does not.

Mr. Jackson presented a list of general recommendations that the Disability Coalition has made regarding the Medicaid redesign initiative, as well as specific recommendations for the state's developmental disabilities waiver program and its programs for long-term services and supports (lavender handout), especially the personal care option (tan handout). Mr. Jackson emphasized that the primary goal in the redesign should be to improve programs and services, not just to save money. He also cautioned against modeling Medicaid after private insurance programs as these programs do not always meet the needs of low-income or disabled populations, citing two examples: copayments, which are onerous for a person who has a chronic illness or who needs long-term care; and the notion of taking "personal responsibility" for one's health, which is not possible for many with disabilities.

Ms. Robinson spoke about current proposals to impose fees for non-emergency use of emergency rooms. Such a fee would violate a federal requirement that other resources exist, which is not the case in most areas of the state, where a person needing medical attention does not have access to anything but the emergency room at the nearest hospital. Current programs that attempt to alleviate this problem include the diversion program in the emergency room at

Presbyterian Medical Center in Albuquerque, which screens for non-emergency cases and makes clinic appointments for those people within 24 hours; school- and community-based health clinics; and telemedicine programs. She noted that these programs can save money because a person is treated in a timely fashion; if a fee is imposed on non-emergency use of an emergency room, people are more likely to forgo treatment until their condition truly *is* an emergency, at which point, the cost of treatment will be much higher.

On questioning and commentary from committee members, the presenters addressed the following concerns and topics.

*Medical provider shortage.* While there is nothing in the state's waiver application to address the critical shortage of medical personnel, there are grants available for this purpose through the PPACA. In addition, the New Mexico Health Policy Commission recommends legislation for loan forgiveness programs.

*Mi Via program.* Mi Via New Mexico's Medicaid self-directed waiver program can be streamlined as part of the Medicaid redesign initiative to eliminate bureaucratic layers and improve timeliness of payments.

*Provider fees in nursing facilities.* These are used in other states but are seen as taxes. CMS is willing to work with states to put them in place, but they must be enacted through legislation, not through a waiver.

*Copayments.* Federal law allows states to impose copayments on almost all Medicaid recipients, and no waiver is necessary. In 2000, the U.S. Congress allowed states to impose greater-than-nominal copayments on certain populations and on prescription drugs and emergency services. New Mexico's Medicaid enabling statute is not specific on copayments and, instead, cedes authority to the secretary of human services. A "nominal copayment" is defined as \$3.40.

*Legislative approval of waivers.* The New Mexico Medicaid statute does not require legislative approval of waivers, though some other states, such as Connecticut, do have this provision.

*Money Follows the Person in New Mexico Act.* Programs within the act will be incorporated in the waiver. Speaking from the audience, Matt Kennicott, HSD communications director, stated that the department plans to fully implement the provisions of the act by late winter or early spring 2012.

- ★ Mr. Kennicott will provide information on the time line for finalizing and submitting the waiver application.

## **Dialysis Services Income Tax Deduction**

Roman Maes, chief executive officer of New Mexico Public Relations Society, along with Albert Babbitt and Scott Mickelson, president and senior manager, respectively, of State Tax Services, presented a bill for the committee's endorsement concerning tax credits for dialysis facilities. They explained that, under current law, nonprofit dialysis facilities receive a gross receipts tax deduction while for-profit facilities do not. The legislation would provide parity by extending the deduction to all dialysis facilities, similar to deductions that have been enacted for other health care services. There are currently 32 dialysis facilities operating in New Mexico, of which 20 are for-profit facilities (page 3 of the handout).

In discussing the proposed legislation, members considered the potential loss of tax revenue to the state and to local governments with enactment of the deduction. A fiscal impact report from a previously introduced version of the bill projected an annual loss to the state of \$620,000, and members questioned both where that revenue would be made up and what the dialysis providers would do with their savings. Presenters assured the committee that the savings would be reinvested within their New Mexico operations. Representative Edward C. Sandoval, who joined the committee for the presentation, stated that the Legislative Finance Committee (LFC) has prepared a report on how much revenue the state forgoes due to all of the gross receipts tax deductions across the health care industry.

★ Representative Sandoval will provide a copy of the LFC report on deductions.

### **Public Comment**

Penelope Foran, Skillsets tutor and disabilities advocate, spoke against raising current copayments or imposing new ones in the Medicaid program and urged the committee not to make changes to Medicaid on the verge of implementation of the PPACA. Ms. Foran's comments appear in detail in Appendix B to these minutes.

Ms. Bearce spoke in favor of making the Disabilities Concerns Subcommittee of the Legislative Health and Human Services Committee into a permanent committee.

Ms. Cates expressed concerns that small nonprofit agencies that serve the disabled community might not be heard as the State Use Act is reviewed.

Ana Otero-Hatanaka, executive director of the Association of Developmental Disabilities Community Providers, stated her concern that recently announced cost-saving changes to the developmental disabilities waiver would be detrimental to the waiver participants.

Jim Parker, director of the Governor's Commission on Disability, reported that the commission is not getting consensus on its recommendations regarding the State Use Act. He suggested that home- and community-based services should be the norm, with a waiver required, instead, for entry into a nursing facility. He spoke in favor of rating health care agencies in the same manner as nursing homes are rated and of establishing a standardized service package across all waiver programs. Finally, he suggested that the Workforce Solutions Department be more active in finding employment for individuals living with disabilities.

★ Mr. Parker will provide a copy of the commission's report.

### **Review of Legislation**

The committee voted to endorse legislation on the following topics for the 2012 legislative session. Details on the legislation and committee actions appear in Appendix C to these minutes.

- Health Insurance Exchange Act, New Mexico (187843.2)
- Prior Authorizations (187273.2)
- Prescription Drug Formulary Changes (187243.2)
- Primary Stroke Centers (187833.1)
- Appropriation: Consumer and Elder Rights Division Programs (187844.1)
- Medicaid Program Change Fiscal Impact Report (187845.2)
- Data Management Duties Transfer from New Mexico Health Policy Commission to Department of Health (187847.1)
- Health Care Work Force Data Collection Duties Transfer from Department of Health to University of New Mexico (187964.1)
- Medicaid Community First-Choice Program (187850.1)
- Medicaid Program Change Prior Legislative Approval (187853.2)
- Joint Memorial: Money Follows the Person Act Implementation (187861.1)
- Dialysis Facility Tax Deductions (187728.1)
- Basic Health Program for Certain Medicaid Ineligibles (187849.2)
- Joint Memorial: Basic Health Program Study (187981.1)

### **BA/MD Degree Program**

Members discussed the combined BA/MD program at the University of New Mexico to clarify information in a handout provided by the university's school of medicine. Members noted that concerns regarding whether the program truly serves the needs of rural New Mexico, which has a difficult time recruiting medical personnel, should be addressed to the House Appropriations and Finance Committee when the school of medicine makes its presentation on the program during the upcoming session.

### **Adjournment**

There being no further business, the committee adjourned at 3:05 p.m.

- 11 -

- 11 -

## APPENDIX A

### Disabilities Concerns Subcommittee — Interim 2011 Report

The Disabilities Concerns Subcommittee (DCS) of the Legislative Health and Human Services Committee held two meetings this interim: on June 24 and October 7. At each meeting, the DCS received testimony from state agencies, community advocates and the public on issues affecting individuals living with disabilities.

The June 24 meeting was a special meeting of the DCS in response to calls by advocates for a meeting to review changes to the developmental disabilities home- and community-based Medicaid waiver (D/D waiver) program. The DCS heard about plans that the Department of Health and the Human Services Department (HSD), the agencies responsible for administering the D/D waiver, have included in their waiver renewal application to the federal government to use a new rate structure, assessment tool and other restructuring means to cut program costs and open new placement allocations (slots). The DCS expressed its concern that the legislature and the public be provided ample opportunity to comment on any proposed changes to the program and that more slots be opened to individuals on the waiting list.

At its October 7 meeting, the DCS heard testimony relating to the Coordinated Long-Term Services (CoLTS) home- and community-based Medicaid waiver program and the Personal Care Option (PCO) program for Medicaid recipients. Both programs assist people who need help with at least two activities of daily living in order to remain independent. The DCS raised concerns about continued long waiting lists for the CoLTS program, and advocates raised concerns about CoLTS allocations being made only after individuals are placed in nursing homes. The DCS and advocates urged that more individuals be moved from nursing home situations and new slots be opened up. The HSD testified that it is attempting to cut costs through increased integration of services in Medicaid restructuring, through community reintegration and through federal "money follows the person" grants. "Community reintegration" was distinguished from "money follows the person" in that the latter program opens new slots for CoLTS participants while community reintegration does not, but it only moves individuals from nursing homes into the community.

The DCS also heard testimony on business and self-advocacy opportunities for individuals living with disabilities. It discussed ways that individuals living with disabilities can be empowered to move from financial and social dependence on the state and family members to greater independence through self-advocacy, self-employment and skill-building. The Governor's Commission on Disability discussed its attempts to obtain more funding for disabilities programs in the state. The DCS endorsed the concept that advocates put forward to fund five business incubator loans for individuals with developmental disabilities.

## APPENDIX B

Public Comment: Health and Human Services Committee 12/01/2011

Penelope — submitted at the Request of Representative Edward C. Sandoval

1309 San Jose Ave, Albuquerque, NM 87106 live.wire2@comcast.net

Madame Chairman and Members of the Committee:

Thanks for this opportunity to speak with you today. I always enjoy the intimacy of this Roundhouse, and treasure the fact that legislators in New Mexico are accessible to ordinary citizens.

I have been thinking a lot about Medicaid in New Mexico, especially since coming up to a meeting of this Committee in June of 2011. I am a disabilities advocate, every day I interface with people who are covered by Medicaid. Many of us are fearful of Medicaid Redesign, and we depend on you, our legislators to protect us.

At first, my dream was to meet with each and every legislator personally, but I live on SSDI and cannot afford that. As an Alternative I decided to speak to your Committee. When I look around I see people who are here, sitting on this Committee, because they care. Why else would you sit through these hours of testimony on Health and Human Services? So, as I look each one of you in the eye, my message is, this year, more than ever, you are needed as champions of the people.

I am here to ask you to take risks and refute Medicaid Redesign.

- Medicaid Recipients cannot afford Co-pays, and they don't work.
- Dramatic changes in the Medicaid Delivery system BEFORE the implementation of the ACA need to be blocked. A one size waiver does NOT fit all.
- New Mexico cannot afford cuts to Medicaid Spending. Don't Fix what Ain't Broken. Let us DIALOGUE instead about things that ARE BROKEN.
- Third party management corporations with their fingers in the pot, acting as Gatekeepers instead of Facilitators.
- The complexity of compliance and the burden being placed on those least capable of negotiating the byways of benefits.

I wish you the very best of luck in the upcoming session and once again, thank you for listening.

**APPENDIX C**

<b>Legislative Health and Human Services Committee — 2012 Endorsed Bills (12/12/11 version)</b>						
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2	187354.1	Fund county and tribal health councils	\$1.9 million to DOH to fund 38 county and tribal health councils	No	Yes	Sen. Lopez
3	187243.2	Prior notice for drug formulary changes	Insurers to provide prior notice to covered individuals when changing prescription drug formulary	Yes	No	Sen. Jennings
4	187792.2	Limit hospital charges for uninsured	Requires hospitals to limit charges to low-income uninsured and provides for sliding scale	Yes	No	Rep. Eleanor Chavez
5	187833.1	Stroke centers	Legislation providing for DOH certification of hospitals for stroke-related care	Yes	No	Rep. James
6	187844.1	\$2.3 million to ALTSD	\$2.3 million to ALTSD for consumer and elder rights and aging network programs and services	No	Yes	Sen. Lopez
7	187845.2	HSD to submit FIR	Require HSD to submit fiscal impact report when changing state Medicaid plan	Yes, unless seeking veto override	No	Rep. King

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9	187964.1	Work force data collection	Amend Health Care Work Force Data Collection, Analysis and Policy Act to move data collection duties from DOH to UNM	Yes	No	Rep. Stewart
10	187848.1	\$400k for BA/DDS	\$400,000 to UNM to establish BA to DDS program	No	Yes	
11	187850.1	Community 1st Choice Plan (CFCP)	HSD to create a CFCP to provide attendant-care services for eligible individuals	Yes	No	Rep. Begaye
12	187853.2	Legislative approval for Medicaid changes	Mandates that HSD receive legislative approval for any major changes to Medicaid	Yes	No	Rep. E. Chavez
13	187864.1	Primary care tuition waiver	\$300,000 to HED to fund primary care physician conditional tuition waiver at UNM	No	Yes	Sen. Feldman
14	187951.2	Fund coordinated rural health care	\$165,000 to DOH to fund integrated health care in southwestern New Mexico	No	Yes	
15	187849.2	Basic Health Program	Requires HSD to establish Basic Health Program to cover Medicaid-ineligible low-income residents	Yes	No	Sen. Ortiz y Pino
16	187843.3	Health Insurance Exchange — HIA	Establishes a NM health insurance exchange run by a modified health insurance alliance	Yes	Yes	Sen. Feldman
17	187728.1	Dialysis center gross receipts	Provides a gross receipts tax deduction to certain dialysis centers	No	No	Sen. Cisneros

<b>Legislative Health and Human Services Committee — 2012 Proposed Memorials</b>				
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18	187861.1	Money Follows the Person (MFP)	Request HSD to fully implement MFP	Sen. Lopez
19	187862.1	Medical cannabis study	Request the DOH to study effect of medical cannabis on other health care costs	
20	187981.2	Basic Health Program study	Requests HSD to do Basic Health Program study	Rep. Picraux

**MINUTES  
of the  
SECOND MEETING  
of the  
BEHAVIORAL HEALTH SERVICES SUBCOMMITTEE**

**December 2, 2011  
Room 307, State Capitol  
Santa Fe**

The second meeting of the Behavioral Health Services Subcommittee was called to order by Senator Mary Kay Papen, chair, on December 2, 2011 at 8:10 a.m. in Room 307 of the State Capitol.

**Present**

Sen. Mary Kay Papen, Chair  
Rep. Ray Begaye, Vice Chair  
Rep. Dennis J. Kintigh  
Sen. Bernadette M. Sanchez

**Absent**

**Advisory Members**

Sen. Sue Wilson Beffort  
Sen. Dede Feldman  
Rep. Antonio Lujan  
Rep. James Roger Madalena

**Guest Legislators**

Sen. Linda M. Lopez  
Rep. Danice Picraux  
Rep. Edward C. Sandoval

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Rebecca Griego, Records Officer, LCS  
Abenicio Baldonado, Intern, LCS  
Kathleen Dexter, Researcher, LCS

**Minutes Approval**

These minutes have not been approved by the Behavioral Health Services Subcommittee, as the subcommittee has finished its work for the interim.

**Guests**

The guest list is in the meeting file.

**Handouts**

Handouts and written testimony are in the meeting file.

## **Friday, December 2**

### **House Joint Memorial 17 Task Force Report**

Members of the task force formed pursuant to House Joint Memorial 17 (2011), including Grace Philips, co-chair of the task force and attorney for the New Mexico Association of Counties, Chris Tokarski, executive director of Mental Health Resources, Inc., Nils Rosenbaum, crisis intervention team psychiatrist for the Albuquerque Police Department, Ron Gurley of the Doña Ana County Forensic Intervention Consortium, and Linda Roebuck Homer, chief executive officer of the Interagency Behavioral Health Purchasing Collaborative (IBHPC), gave a report on their work during the 2011 interim. The task force was charged with studying the needs of people with mental illness, with a focus on reducing the number of such people who end up in detention facilities or who require law enforcement intervention of some kind. The task force met five times during the interim to develop recommendations that span the following broad areas (and appear in detail on pages 4 through 15 of the handout): system improvements; crisis triage centers; respite services; training; call centers; warm line call center; community crisis system planning; peer services; and criminal laws.

On questioning from subcommittee members, the presenters addressed the following concerns and topics.

*Law enforcement involvement.* Members discussed the concern that law enforcement officers are doing social work when responding to incidents involving the mentally ill. Presenters noted that while urban areas have social work divisions within their law enforcement structures, rural areas have only law enforcement officers to act as first responders and they, along with emergency medical personnel, must be trained to handle the incidents. The New Mexico Law Enforcement Academy will conduct a training for officers in December 2011.

*Warm line call center.* Information from the warm line call center must be shared with law enforcement officers and other first responders for their safety. The nurse advice line in the Department of Health and the state resource center hot line in the Aging and Long-Term Services Department (ALTSD) are existing systems that might be used for setting up the warm line call center.

*Funding.* The IBHPC is working with OptumHealth New Mexico on a financing plan to implement the task force's recommendations, which are broken down into phases beginning in fiscal year 2013. The greatest cost-effectiveness would come if the entire health care system worked together, with behavioral health services integrated with health care.

*Jail diversion.* Jail diversion programs, which arrange for mental health treatment and informal probation in lieu of incarceration, cannot be implemented in districts that do not have pretrial services, and these services do not exist outside of Albuquerque.

*Tribal input.* A representative from Five Sandoval Indian Pueblos, Inc., sat on the task force, and recommendations from tribes statewide were included in the task force's final report.

*Life of the task force and the subcommittee.* Members expressed support for continuing both the task force and the subcommittee, with the latter created as a full interim committee.

On invitation from the chair, members of the audience made brief statements: Michael Hall of the Administrative Office of the District Attorneys spoke in support of the task force's work; Jamie Michael of the Doña Ana County Social Services Department and Charlie Marquez, lobbyist for Doña Ana County, reported on the Doña Ana County crisis triage center's goal of being a regional center and the need for capital outlay funding to complete construction; and Ann Albrink of the National Alliance on Mental Illness spoke of the need for diversion programs so that people no longer need to plead guilty to a crime in order to get mental health services.

- ★ Ms. Homer will provide a report on integration efforts among groups directed by memorials to address behavioral health issues.
- ★ Mr. Rosenbaum and Ms. Homer will provide information on the cost savings from diversion programs.

### **Substance Abuse Issues**

Tim Condon, Ph.D., a visiting research professor at the University of New Mexico (UNM) Center on Alcoholism, Substance Abuse and Addictions, gave a presentation on substance abuse disorders and treatment. With recent advances in science, views on drug abuse and addiction have shifted radically — what was once seen as a moral/social problem is now seen, and treated, as a medical/physical problem. A 2010 study found that approximately 22 million people in the U.S. were addicted to drugs or alcohol, yet fewer than four million people received treatment for their addictions. Included in these statistics is the growing problem of prescription pain medication addiction, opioids that are relatively easy to obtain. Prescriptions in the U.S. increased from 175 million in 2000 to nearly 260 million in 2009 (page 19 of the handout), and as many as 70 percent of pain medication addicts interviewed in a 2009 study cited family and friends as their source for the drugs.

Prolonged drug use fundamentally changes the brain; for this reason, addicts cannot "just quit". Historically, treatment efforts have followed an acute care model, in which an addict was put into treatment for a "cure" of a finite duration and then released, and relapse was the norm. In contrast, the continuing care model that is now used treats addiction as a chronic condition and focuses on recovery rather than cure, employing a continuum of support systems ranging from case managers to family therapy to child care.

On questioning from subcommittee members, Dr. Condon addressed the following concerns and topics.

*Drug abuse, mental illness and treatment.* Some people use drugs to relieve an existing mental illness, such as depression, but the reverse can also be true — drug use can bring on

mental illness. There are biological underpinnings to addiction that are unique to each individual, and a biological trait combined with environmental modeling can be a deadly combination. The federal Patient Protection and Affordable Care Act of 2010 (PPACA) includes funding for substance abuse treatment, including treatment for adult single men with no children.

*Access to and disposal of prescription drugs.* Offshore online purchasing is not as big a problem as overprescribing and unused drugs in medicine cabinets. Four things are necessary to halt the epidemic of prescription drug abuse: 1) education, to get the general public to lock up their medications and get doctors to adjust their prescribing habits; 2) real-time prescription monitoring, to prevent someone from getting several prescriptions from different doctors; 3) appropriate disposal, to give people a safe place to take unused medications and turn them in (the Drug Enforcement Agency has occasional "take-back days"); and 4) stronger law enforcement. Pharmacists need the authority to contact physicians and question prescriptions. They also need statutory authority to take back unused medication, a practice that is legal under the federal Secure and Responsible Disposal Act but restricted to physicians under New Mexico law. One study has shown that unused medication flushed down toilets is the major cause of contamination in the Rio Grande.

★ Senator Sanchez will sponsor a bill on prescription drug monitoring.

### **Posttraumatic Stress Disorder (PTSD) in Returning Military Personnel**

Ms. Homer, Harrison Kinney, executive manager of the Behavioral Health Services Division of the Human Services Department (HSD), and Chris Burmeister, administrator of the Rio Rancho Family Health Center, gave a presentation on IBHPC programs for treating military trauma spectrum disorders. The collaborative has contracted with the Rio Rancho Family Health Center to develop best practices for supporting veterans, National Guard members and their families; has trained a network of providers statewide in treating military PTSD; is promoting specialty courts that will divert veterans with PTSD from jail and into treatment; and has services tailored to work with Native American veterans (page 3 of the handout). As it builds the program, the collaborative plans to develop programs to integrate services into a broad system of care.

On questioning from subcommittee members, the presenters addressed the following concerns and topics.

*Outreach.* The collaborative does outreach through its family readiness group program, which collects names of all returning military personnel and works to help them and their families with both deployments and reintegration. The collaborative is also planning to do outreach to caregivers through the ALTSD.

*Clients.* The clients being served come from all military conflicts, not just the recent wars in Iraq and Afghanistan. One challenge for the collaborative is the definition of "veteran" — while some programs define the term to mean a person who has "seen combat", the collaborative defines it more broadly and will provide services to anyone who has "worn a

uniform".

*Access.* Currently, most services for returning military personnel are concentrated in the Albuquerque-Rio Rancho area. On invitation from the chair, Deputy Secretary of Veterans' Services Alan Martinez, speaking from the audience, noted that the collaborative is also working with the Veterans' Administration (VA) to provide services through its statewide clinic system, a network that will be critical as troops are pulled from Iraq and Afghanistan.

- ★ Deputy Secretary Martinez will provide information on services available through VA clinics.

### **IBHPC Priorities and Budget**

Ms. Homer, who was joined by Brent Earnest, deputy secretary of finance, HSD, and Diana McWilliams, deputy chief executive officer, IBHPC, presented the collaborative's budget request for fiscal year 2013. At approximately \$421.8 million, the request represents a decrease of \$3.2 million over its prior year budget (page 3 of the handout). The presenters provided information on remediation steps taken by OptumHealth following sanctions against the company in 2011 regarding behavioral management and psychosocial rehabilitation services (page 13 of the handout) and demonstrated a matrix used for assessing patient needs based on the intersection of behavioral health factors and physical health factors (page 18 of the handout). The collaborative's priorities include integration of behavioral and physical health care through health homes; a 10 by 10 campaign to increase life expectancy by 10 years for those with behavioral health issues; suicide prevention programs, with a focus on Native Americans; substance abuse treatment, especially for adolescents; memorials for the upcoming session concerning opioid addiction and crisis intervention; and rebidding behavioral health services under the Medicaid modernization initiative (page 17 of the handout).

On questioning from the subcommittee, the presenters addressed the following concerns and topics.

*Residential treatment.* While behavioral health providers saw a three percent overall reduction in funding under Medicaid cost-containment requirements, there was a 10 percent reduction for residential treatment facilities. Because more people were served at a lower cost in fiscal year 2011 than in fiscal year 2010, the rate reduction may not necessarily mean a reduction in services. An audit of such out-of-home care will be conducted beginning in January 2012.

*Prescription drugs.* Switching to generic drugs works for some people, though not all. On invitation from the chair, UNM child psychiatrist Dr. Steve Adelsheim, speaking from the audience, noted that prescriptions for psychotropic drugs for children are a great concern and are the subject of a federal Government Accountability Office report and national news coverage. OptumHealth will be providing data on which prescriptions are being written for children, though not data on the length of time children remain on those drugs.

*Internal review.* An internal review in 2012 will include a review of claim denials.

*Benefits package and the new 1115 waiver.* Behavioral health services are included as

part of the current benefits package available to all, though not everyone is referred for those services. Under the state's current Medicaid Section 1115 waiver application, there will only be a "carve-in" for these services if there is adequate protection for the funding. One goal is to reduce the number of contracts issued and, consequently, the amount paid for administrative fees by requiring that contractors have expertise in all services.

*Future of the collaborative.* The collaborative is created in statute, so it will not disappear with the health reform initiatives unless repealed by the legislature. It could, however, benefit from some streamlining at the policy level.

- ★ Ms. McWilliams will provide an electronic version of the handout used for the presentation and a chart showing payments for behavioral health services, including a percentage breakdown for administrative costs.
- ★ Mr. Earnest will provide information on how the cost savings for residential treatment are achieved and on how federal funds were spent in a Children, Youth and Families Department transformation grant program.
- ★ Ms. Homer will provide the name of the physician who placed two foster children in a home where they later killed an adult and copies of a DVD presentation on prescription drug addiction.

### **New Mexico State University (NMSU) Psychiatric Nursing Program**

Pamela Schultz, Ph.D., R.N., associate dean and director of the NMSU School of Nursing, gave a presentation on the NMSU psychiatric and mental health nurse practitioner program, which has been operating for a decade and has graduated more than 100 students. As the program transitions from a master's-level program to a doctorate-level program, increased funding will be necessary in order to attract appropriate faculty.

In discussing the program, a member expressed concern that advanced degrees might not be necessary for teaching in a nursing school and that there might not be a need to train nurses at the doctoral level because there are already doctors practicing. Dr. Schultz noted that these programs have evolved to meet the needs of communities lacking health care services and that nurse practitioners are the only practitioners available in some clinics due to a shortage of primary care doctors. On invitation from the chair, Albert Dugan, M.D., speaking from the audience, described the current difficulty of getting doctors to stay in primary care and noted that the system needs all practitioners, whether they are doctors or nurse practitioners or assistants.

### **Update on Psychopharmacology Training and Status of Prescribing Psychologists**

Elaine LeVine, Ph.D., ABMP, training director for the NMSU master's program in psychopharmacology, and Jonathan Schwartz, Ph.D., NMSU Department of Counseling and Educational Psychology, gave a presentation on the NMSU psychopharmacology master's degree program available to practicing psychologists. Graduation from the program qualifies a psychologist to become a prescribing psychologist in New Mexico, in Louisiana, for the U.S. military and for the Indian Health Service. The program was created to address a critical

shortage of psychiatrists and access to psychopharmacological care in New Mexico, especially in rural areas where there are only six psychiatrists for every 100,000 people.

On questioning from subcommittee members, the presenters noted that, along with the authority to prescribe, these psychologists also have the authority to un-prescribe, applying treatments other than prescription drugs when they feel medication is not the best approach. They also noted that supervision requirements in statute need to be streamlined.

### **Civil Commitment Proceedings — Report from House Memorial 45 (2011)**

Karen Meador, J.D., senior policy director for the IBHPC, and Gabrielle Sanchez-Sandoval, J.D., acting general counsel for the Department of Health, gave a presentation on the work of the task force formed pursuant to House Memorial 45 (2011), which concerned civil commitment and treatment guardianship for people with mental illness. The task force is looking into the roles of district attorneys, civil commitment and criminal procedures and treatment guardianship processes with a focus on preserving public safety, protecting civil liberties and fostering effective treatment (page 4 of the handout). The task force spent the 2011 interim considering mental health and competency statutes; criminal procedures; myths about violence and mental illness; treatment guardians and advance directives; adult protective services; intimate partner violence; services available through the New Mexico Behavioral Health Institute; and recommendations in House Joint Memorial 17 (2011) (page 7 of the handout). Final recommendations from the task force will be presented in the summer of 2012.

On invitation from the chair, several members of the task force in the audience introduced themselves, including Frank Fajardo of the Office of Guardianship; Daphne Rood-Hopkins, HSD behavioral health clinical manager; Mr. Gurley; Desiree Perriguet; Mr. Rosenbaum; Ms. Philips; and Nancy Koenigsberg of Disability Rights New Mexico.

In discussing the presentation, subcommittee members noted that mental illness is a very big problem in the state, especially for law enforcement officers who are at risk of being harmed or killed when confronting someone with mental illness. The issue is also a drain on the Medicaid system, and it needs to be addressed in a more permanent fashion than by a two-day subcommittee. Members supported the idea of a memorial requesting continuation of the subcommittee for the 2012 interim and additional days in its meeting schedule. At the end of the 2012 interim, the members will consider legislation for the 2013 session to create the body as a permanent statutory committee.

- ★ Representatives Kintigh and Picraux will jointly sponsor a memorial requesting continuation of and additional days for the subcommittee.

### **Public Comment**

Mr. Gurley spoke in favor of treatment guardianships and of leaving a guardian's authority uncompromised. He also cautioned against combining Medicaid Section 115 waivers.

Becky Beckett submitted written comments in support of continuing the subcommittee in the future because the body has "given mental illness a voice".

**Adjournment**

There being no further business, the subcommittee adjourned at 4:05 p.m.

## **ENDORSED LEGISLATION**

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