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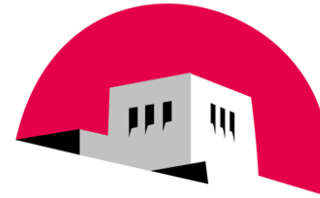

Maternal Care and the Affordable Care Act in New Mexico: Some Unresolved Issues

October 10, 2013

Dr. Lee A. Reynis, Director

UNIVERSITY OF NEW MEXICO
BUREAU OF BUSINESS & ECONOMIC RESEARCH
303 Girard Blvd. NE
MSC06 3510 / Onate Hall
Albuquerque, New Mexico 87131

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Basic Data on Maternal Care for NM

Annual number of births in NM has held at about 27,000, was 27,251 in 2011.

In 2011, 98% were hospital births.

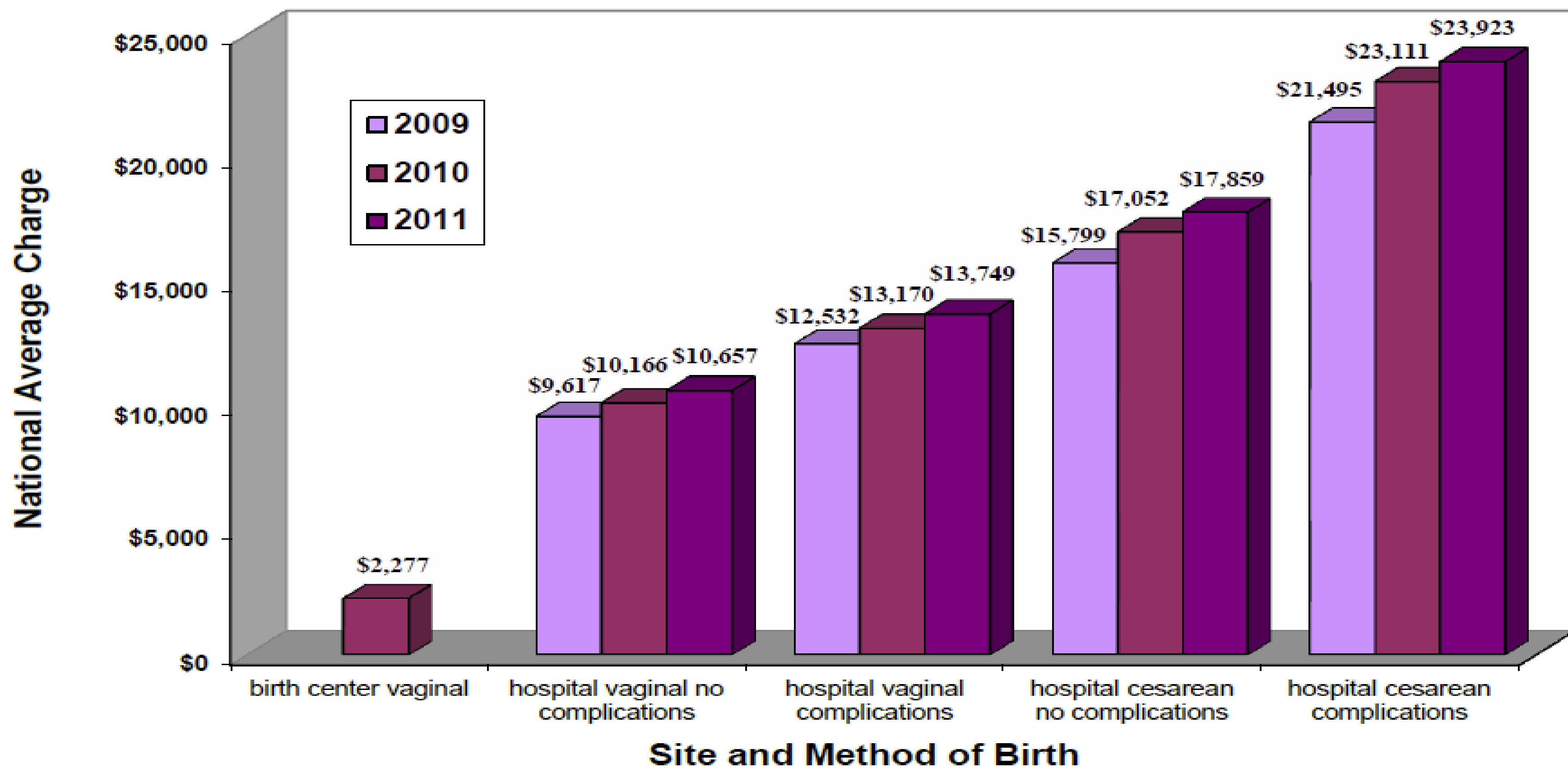
Medical doctors attended at 66% of the births in 2011, down from 88% in 1990; certified nurse midwives attended 24%, up from 10.6% in 1990; licensed midwives, 4.5%, up from 0.9% in 1990.

Vaginal births 76%, down from 80% in 1997. C-sections 23%, up from 17% in 1997, a 36% increase.

In terms of age, just under 10% to teenagers, with 1% to those under 18; 29% to 20-24; 28% to 25 to 29. Birth rates have been declining for all groups of women except those 30-44.

Single women now over 50% of births, up from 35% in 1990.

Costs of Maternal Care and Coverage

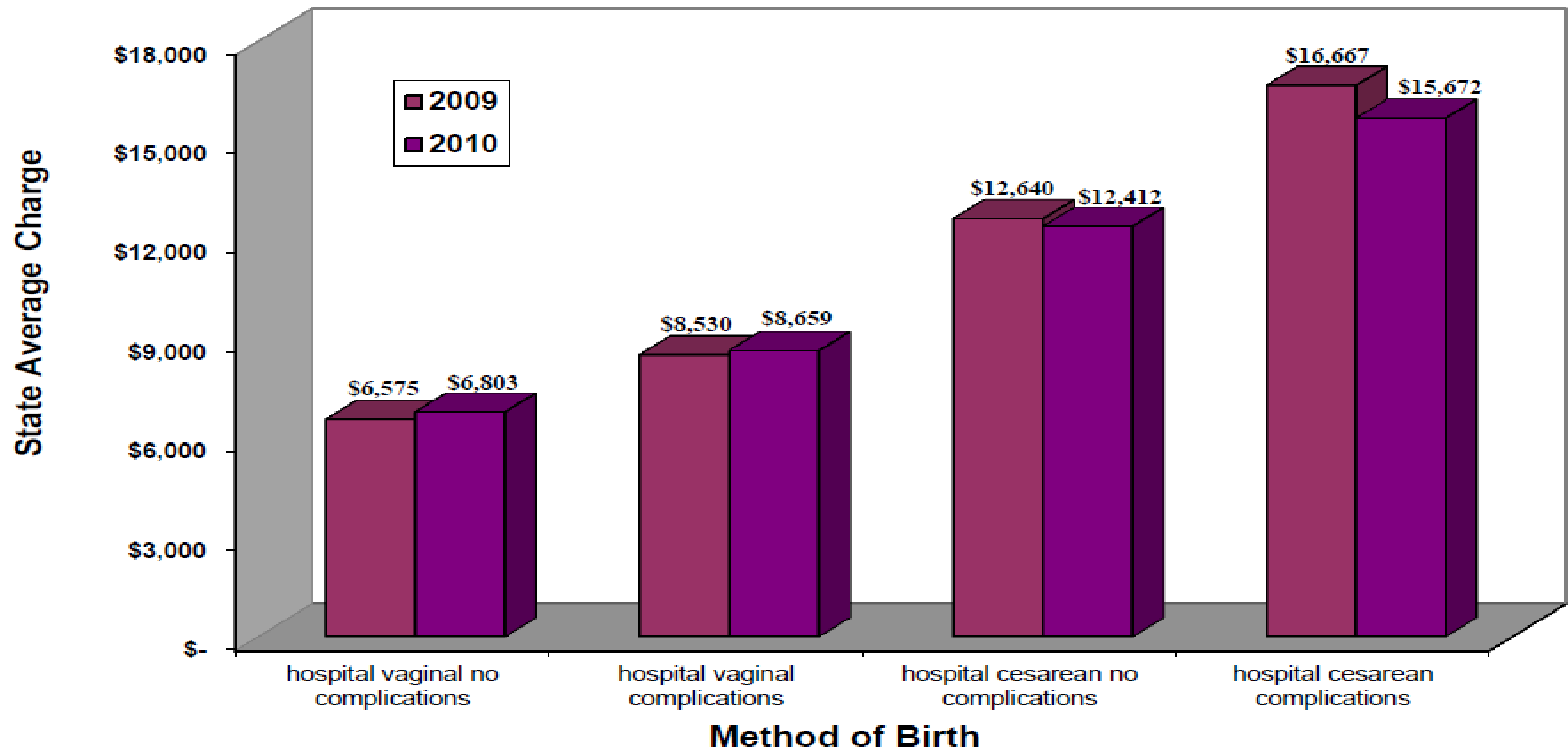


Notes: Figures in graph do not include the following:

- additional anesthesia services charge for all cesarean and most vaginal births in hospitals
- additional newborn care charge for all births in hospitals
- additional maternity provider charge for all births.

Payments of third-party payers typically reflect a discounting of charges.
Birth center figure is average charge reported by 61 out-of-hospital birth centers.
Average birth center charge not available for 2009 and 2011.

Sources: U.S. Agency for Healthcare Research and Quality, *HCUPnet, Healthcare Cost and Utilization Project*. Rockville, MD: AHRQ. Available at: http://hcupnet.ahrq.gov/
American Association of Birth Centers. *Uniform Data Set*. Perkiomenville, PA: AABC, 2011.



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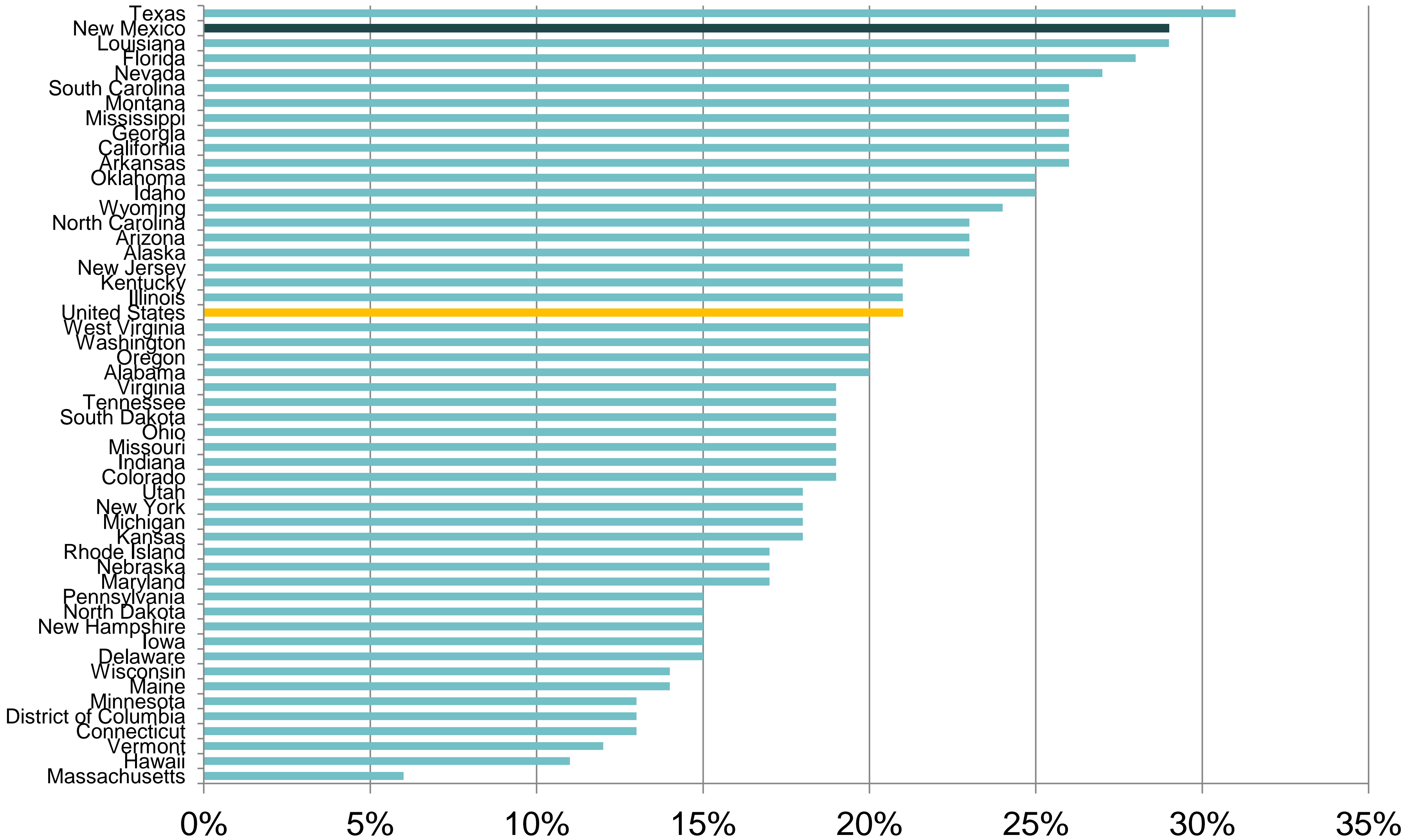
- additional anesthesia services charge for all cesarean and most vaginal births in hospitals
- additional newborn care charge for all births in hospitals
- additional maternity provider charge for all births.

Payments of third-party payers typically reflect a discounting of charges.
New Mexico participation in HCUP database began in 2009.

© 2012 Childbirth Connection. Download source: transform.childbirthconnection.org/resources/datacenter/

Source: U.S. Agency for Healthcare Research and Quality, *HCUPnet, Healthcare Cost and Utilization Project*. Rockville, MD: AHRQ. Available at: http://hcupnet.ahrq.gov/

% of Adults 19-64 Uninsured by State,2010-11



Source: Henry J. Kaiser Family Foundation

Health Insurance Coverage of Women 19-64

% of US and NM Women with Coverage Listed and New Mexico Ranking among the States and DC

Type of Coverage	Employer	Individual	Medicaid [a]	Other Public [b]	Uninsured	Total
United States	58%	7%	12%	3%	20%	100%
New Mexico	48%	6%	14%	4%	27%	100%
rank	51	22	7	13	3	

a New Mexico was one of 7 states with 14% women insured by Medicaid.
b New Mexico was one of 13 states with 4% women covered by other public insurance.

Sources: : Henry J. Kaiser Family Foundation

Insurance Coverage for Maternity Care

(Pre-Natal, Care, Labor & Delivery)

Current Situation (Pre-ACA)

Private Insurance

"Childbirth and pregnancy-related conditions are leading causes of hospitalization in the U.S., accounting for nearly 25% of hospital stays. Although the Pregnancy Discrimination Act requires that employers with at least 15 employees offer plans that cover expenses for pregnancy-related conditions on the same basis as for other medical conditions, coverage for maternity care is not currently included in many individual insurance plans. " National Women's Law Center found that women must typically pay more than men for individual plans. At best, maternity coverage may only be available with purchase of separate rider, which can be extremely costly and often requires a waiting period.

Medicaid

"All state Medicaid programs already cover pregnancy related care up to at least 60 days post-partum, and in fact, Medicaid currently covers 48% of all births nationwide. Many women, however, lose Medicaid coverage after the post-partum period since they no longer qualify for coverage because income eligibility thresholds for parents are considerably lower than those for pregnant women."

-- Kaiser Family Foundation, *Health Reform: Implications for Women's Access to Coverage and Care*

Insurance Coverage for Maternity Care

(Pre-Natal, Care, Labor & Delivery)

Current Situation (Pre-ACA) New Mexico

Individual insurance market – No maternity coverage unless rider that can be purchased. Presbyterian had one but could be purchased only on renewal date. See Lovelace offering below.

Medicaid -- Pregnant Women up 133% Federal Poverty Level, full coverage; above that, up to 185% of FPL of Medicaid coverage for pregnancy related care only.

Premium Assistance for Maternity (PAM)

Pam was a state program that provided maternity coverage for women who could not afford such coverage but are ineligible for Medicaid – basically for women whose income is above 185% of poverty. Women with health insurance could qualify for the program if their coverage excludes pregnancy, a situation which is all too common in the individual insurance market. Unfortunately, the **program ended Sept. 1, 2010.**

LOVELACE HEALTH PLAN
Individual PPO Plan
Optional Maternity Benefit Rider

The Maternity Rider is available for purchase with the Lovelace Individual PPO Plans only. It is not available with an Individual High Deductible Health Plan or Child Only Policy.

Premium Rate is $144 per month, in addition to your monthly medical plan premium.

Covered Services	Description	
Maternity Care	Prenatal and postpartum care Delivery – all physician and hospital services for mother during confinement, including full term delivery, miscarriage or termination of pregnancy Newborn child is covered from birth only if enrolled within 31 days of birth. (Benefits for Inpatient & Outpatient Care are Combined.)	
Benefits[1, 2]		
First Year	**Second Year**	**Third Year & Later**
0%	50% up to a maximum benefit of $1,500	100% up to a maximum benefit of $3,000 per pregnancy

(1) Benefit amounts reflect the amount that Lovelace Insurance Company will pay towards Maternity Coverage.
(2) Benefits are available for In-Network Participating Providers only. Out-of-Network services will not be covered.

COVERED BENEFITS AND SERVICES

With your Lovelace Individual PPO Maternity Benefit Rider, you are entitled to receive maternity services and benefits listed in this section. Some Covered Services may require Prior Authorization by the Plan before services are provided.

Prenatal Maternity Care

This Maternity Benefit Rider includes coverage for Prenatal Care, including:

- a minimum of one prenatal office visit per month during the first two trimesters of pregnancy
- a minimum of two office visits per month during the seventh and eighth months
- a minimum of one office visit per week during the ninth month and until term by a Participating Provider.

Each office visit shall also include; prenatal counseling and education, necessary and appropriate screening, including history, physical examination and the laboratory and diagnostic procedures deemed appropriate by the Participating Provider/Practitioner. This is based upon recognized medical criteria for the risk group of which the patient is a member;

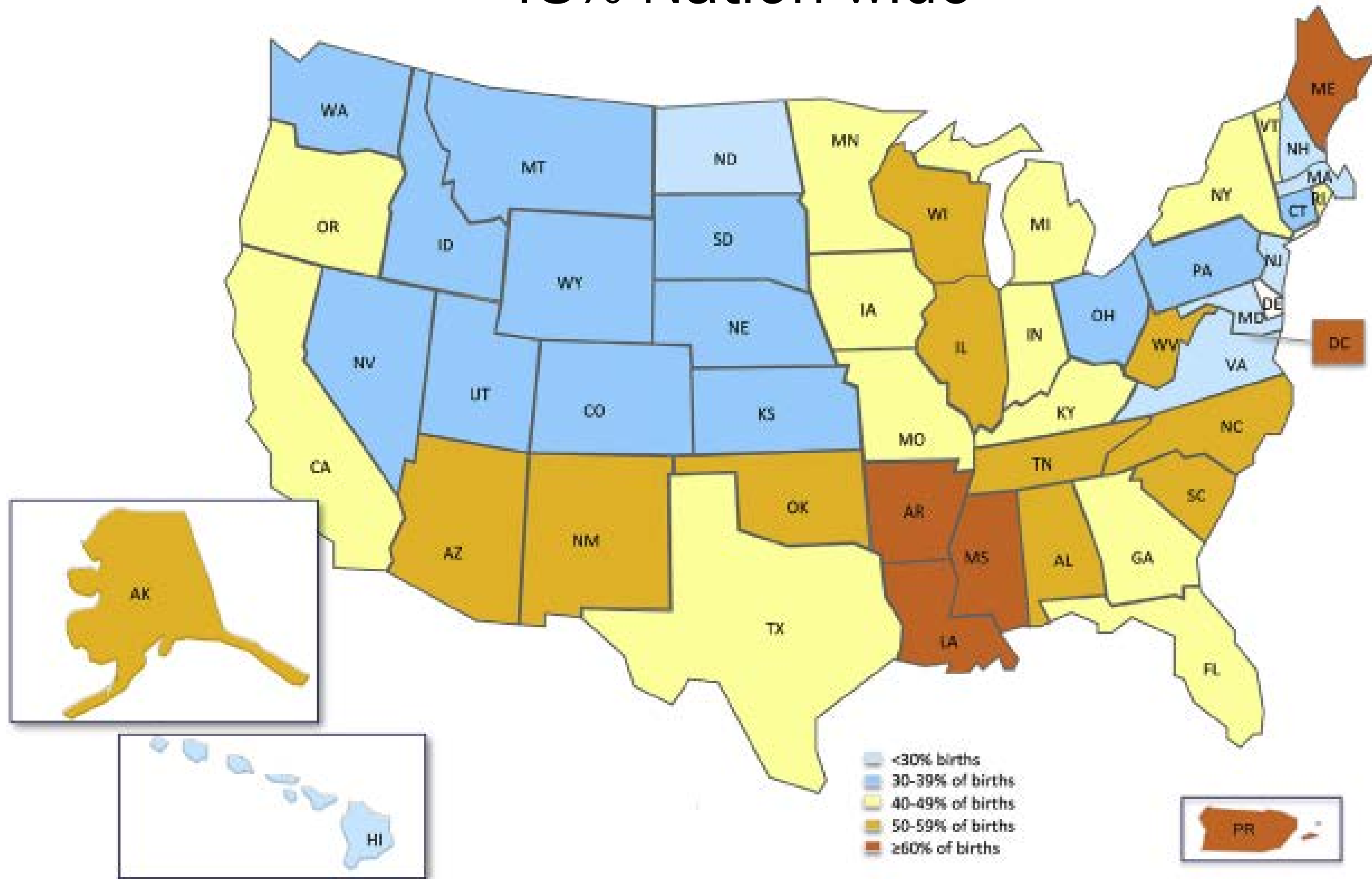
Table 1. 2013 Federal Poverty Level

Household Size	100%	133%	150%	200%	300%	400%
1	$11,490	$15,282	$17,235	$22,980	$34,470	$45,960
2	$15,510	$ 20,628	$23,265	$31,020	$46,530	$62,040
3	$19,530	$ 25,975	$29,295	$39,060	$58,590	$78,120
4	$23,550	$ 31,322	$35,325	$47,100	$70,650	$94,200
5	$27,570	$ 36,668	$41,355	$55,140	$82,710	$110,280
6	$31,590	$ 42,015	$47,385	$63,180	$94,770	$126,360
7	$35,610	$ 47,361	$53,415	$71,220	$106,830	$142,440
8	$39,630	$ 52,708	$59,445	$79,260	$118,890	$158,520
For each additional person, add	$4,020	$5,347	$6,030	$8,040	$12,060	$16,080

Source: Families USA

Percentage of Births Covered by Medicaid, 2010

48% Nation-wide



Source: Anne Rossier Markus, JD, PhD, MHS, Ellie Andres, MPH, DrPH, Kristina D. West, JD, Nicole Garro, MPH, Cynthia Pellegrini, BA, "Medicaid Births 2008 Through 2010 in the Context of the Implementation of Health Care Reform," *Women's Health Issues*, 23-5, 2013.

Insurance Coverage for Maternity Care

(Pre-Natal, Care, Labor & Delivery)

Affordable Care Act

- Maternity and well-baby care are part of the essential benefits package that must be offered by plans in the Exchanges and new plans offered in the individual and small group markets.

- New private plans required to cover **without cost sharing** prenatal visits, a wide range of preventive prenatal services, and breastfeeding supports and the costs of breast pump rentals for lactating women.

- In states that expand their Medicaid programs, millions of women will gain Medicaid, and the ACA will preserve continuity of coverage by helping low-income new mothers maintain their coverage before pregnancy, during the prenatal and postpartum period and beyond.

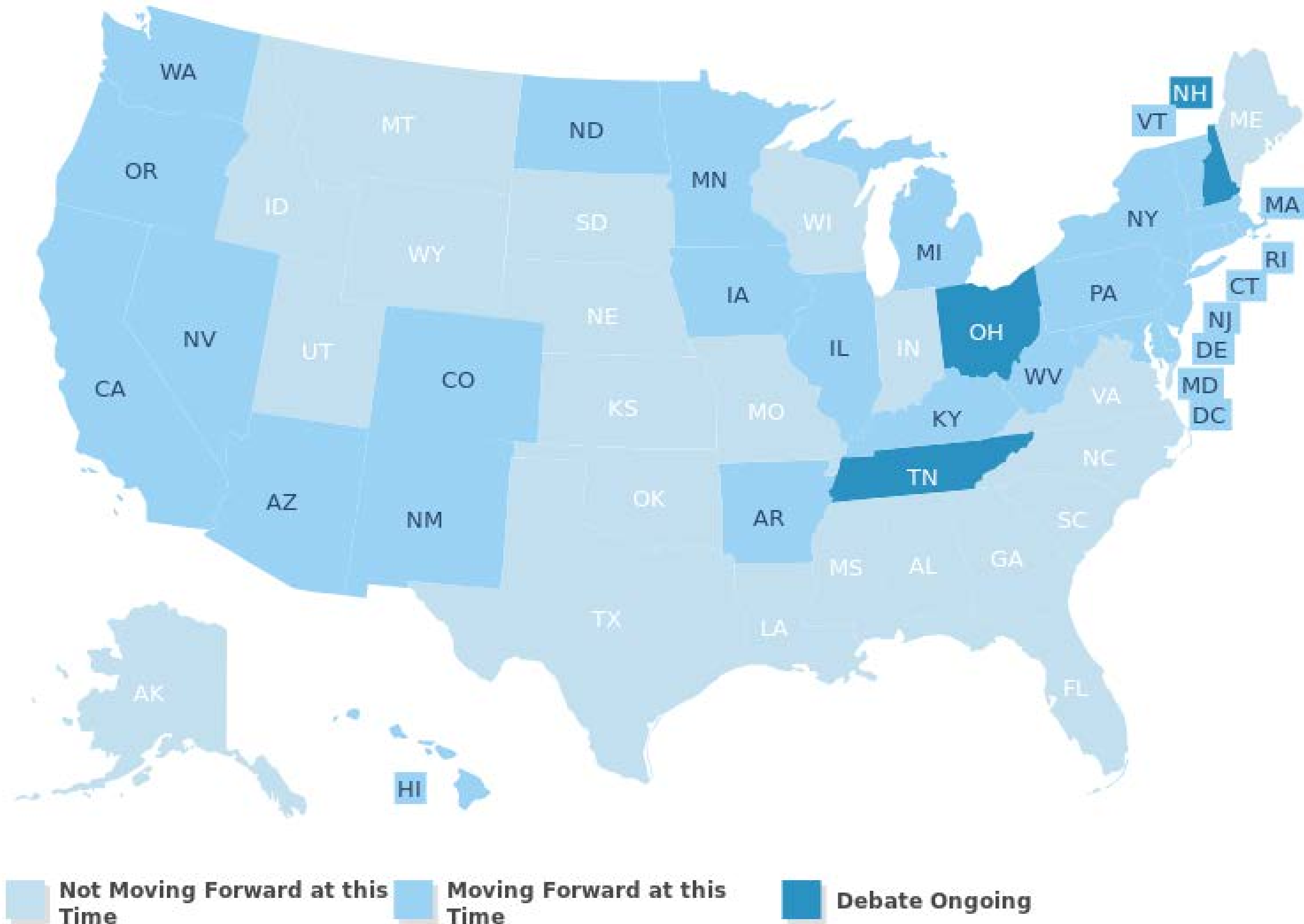
Insurance Coverage for Maternity Care

(Pre-Natal, Care, Labor & Delivery)

Affordable Care Act

- All newborns lacking any other acceptable coverage are eligible for Medicaid.
- Fair Labor Standards Act to require employers with at least 50 employees to provide break time to nursing mothers for up to one year as well as a private space that is not a bathroom to express milk. (NM law}
- New private health plans must provide breastfeeding supports, including lactation consultation with a certified consultant and breast pump rental for the duration of breastfeeding.
- Increased support for higher reimbursement of nurse midwives, birth attendants, and free-standing birth centers.
- New investments in maternal, infant and early childhood home visiting programs.
- Requires coverage of comprehensive tobacco cessation programs for pregnant women.
- Education and support services to women with postpartum depression, as well as funding for research into the causes, diagnoses, and treatments of postpartum depression.

Status of State Action on the Medicaid Expansion Decision, as of September 16, 2013



Source: Henry J. Kaiser Family Foundation

Estimated NM Medicaid Enrollment

Table 4. Estimated Medicaid Enrollment under ACA (up to 138 percent FPL)

	FY14	FY15	FY16	FY17	FY18	FY19	FY20
Baseline	554,274	574,773	588,787	602,402	616,304	630,503	645,002
Woodwork*	14,089	15,677	17,292	18,910	20,587	22,265	22,538
Expansion **	123,019	136,081	149,075	150,067	146,979	147,775	144,492
Total	691,382	726,531	755,154	771,379	783,870	800,543	812,033
Net ACA Change	**137,108**	**151,758**	**166,367**	**168,977**	**167,566**	**170,040**	**167,030**

Source: NMHSD -- January 17, 2013

*Enrollment by those who are already eligible but enroll primarily because of the mandate

**Includes those formerly covered by State Coverage Insurance Program.

The Affordable Care Act gives states the option to expand their Medicaid programs to 19-64 year old adults.

New Mexico opted to implement Medicaid Expansion for adults 19-64 who are at 133% or below of the FPL.

Most adults who are eligible for New Mexico's Medicaid Expansion will receive their services through Centennial Care.

Native Americans who are eligible for the Expansion can choose to receive their services through Fee for Service Medicaid or from a Centennial Care MCO.

Centennial Care: the Concept of a Medical Home

The medical home (or health home) model comprises networks of providers addressing all of the patient's ealthcare needs. Care coordinators (typically nurses or social workers) ensure that the patient accesses resources dentified in an individualized care plan. Teams often receive a per-member-per-month fee with bonuses for neeting cost and care targets. The ACA also envisions increasing use of community prevention interventions and ncrease use of community health workers to promote positive health behaviors and outcomes. Additionally, elehealth may be used to connect remote practitioners to specialists, while emergency medical technicians (EMTs) nay also be used to administer basic primary care services in communities which lack access to primary care. Eastern New Mexico University is currently piloting a community medic model in Eunice, Lovington, and Taos, vhich will train EMTs and paramedics to provide intervention and prevention services to promote community ealth and reduce costly emergency transports to hospitals.

Insurance, but what about access?

Evidence of Underutilization of Health Care Services by NM Women

ACCESS & UTILIZATION									
		New Mexico Rates							
NM Dimension Score[2]: Worse than Average	U.S. All Women	All Women	White, non-Hispanic	All Minority[3]	Black, non-Hispanic	Hispanic	Asian and NHPI	American Indian/ Alaska Native	NM DISPARITY SCORE[4]
No health insurance (%)	17.7	25.6	17.4	32.1	-	28.5	-	49.7	1.84
No personal doctor/health care provider (%)	17.5	22.6	16.9	28.3	-	26.8	-	37.7	1.67
No routine checkup in the past two years (%)	15.9	20.6	21.6	19.4	-	21.0	-	15.6	0.90
No dental checkup in the past two years (%)	28.7	32.6	28.0	36.5	-	37.7	-	31.6	1.30
No doctor visit in the past year due to cost (%)	17.5	20.4	16.8	23.2	-	25.3	-	17.4	1.38
No mammogram in the past two years for women ages 40-64 (%)	25.5	31.1	29.7	33.3	-	33.2	-	37.4	1.12
No Pap test in the past three years (%)	13.2	14.0	13.8	14.6	-	12.9	-	21.9	1.06
Late initiation of or no prenatal care (%)	16.2	30.9	23.2	34.4	31.8	33.3	23.9	40.8	1.48

Source: Kaiser Family Foundation, Factsheet on New Mexico from *PUTTING WOMEN'S HEALTH CARE DISPARITIES ON THE MAP: Examining Racial and Ethnic Disparities at the State Level*, June 2009.

The Economic Challenges in Providing Health Care Services in NM

1. Low population density over a vast geographic area – the 5th largest among the states
2. Low income
3. Lack of health insurance coverage
4. Lack of facilities
5. Lack of providers & high turnover (after loans paid)

These challenges are magnified for maternal care.

Why density matters -- much of it boils down to economics

Geographic access – how long it takes to get to a provider (can be critical for problems that can arise during pregnancy) and the costs of getting there (e.g.,travel costs, time off from work, babysitter, etc.)

Patient revenues – and these relative to costs -- will generally determine if and the kinds of health care services that can be supported

- Patient population served – anticipated volume
- And sources of payment – whether insured, type of coverage
- Economies of scale in service delivery – Need to cover fixed costs, including professional liability insurance

Adequate redundancy. For a hospital, more than one doctor with an obstetrical practice and trained to do C-sections).

Major Omission: ACA does nothing for tort reform

Nothing to reduce burden of professional liability insurance

In New Mexico, where costs are typically less than other states because have very successful claims review program that involves lawyers and physicians:

NM OB-GYN with obstetrical practice, no claims: $84,000

Certified Nurse Midwife: $35,000

These costs for an annual policy are way above what other physicians pay because need to purchase "tail" as well as policy to cover what happens during the year. Malpractice suits related to labor & delivery can be filed many years later. High cost of liability insurance is a major incentive to leave private practice and become an employee. FQMCs can provide protection under federal tort but they only provide prenatal care through the 28th month.

ACA Limited Help for Immigrants

Immigrants and the Affordable Care Act (ACA)

NATURALIZED CITIZENS

Same access and requirements for affordable coverage as U.S.–born citizens.

LAWFULLY PRESENT IMMIGRANTS

Limited federal coverage.

- Subject to the individual mandate and related tax penalty (exempt if low-income or meet specific exemptions).
- May enroll in a "qualified health plan (QHP)" from the state insurance exchanges.
- Eligible for premium tax credits and lower copayments.
- No waiting periods for enrolling in state insurance exchanges or premium tax credits.
- Eligible for the Pre-Existing Condition Insurance Plan (PCIP) and the Basic Health Plan (when available in a state).
- Current federal immigrant eligibility restrictions in Medicaid maintained, including the five-year-or-more waiting period for most lawfully residing, low-income immigrant adults.
- Since April 2009, states can choose to provide Medicaid and Children's Health Insurance Program (CHIP) benefits to lawfully residing *children and pregnant women without a waiting period*. But in states that do not elect this option, these children and pregnant women must still wait five years or more before they can get affordable health care coverage.
- Citizens of Compact Free Association states who reside in the U.S. remain ineligible for federal Medicaid.
- EXCEPTION: As of August 2012, Deferred Action for Childhood Arrivals (DACA) grantees are ineligible for Medicaid, CHIP, and ACA benefits.

UNDOCUMENTED IMMIGRANTS

No federal coverage.

- Not allowed to purchase private health insurance at full cost in state insurance exchange(s).
- Not eligible for premium tax credits or lower copayments.
- Exempt from individual mandate.
- Not eligible for Medicare, nonemergency Medicaid, or CHIP.
- Remain eligible for emergency care under federal law.
- Eligible for Emergency Medicaid if low-income.
- Citizen or lawfully present *children of undocumented parents* are eligible:
  - To purchase from the state insurance exchange.
  - For premium tax credits and lower copayments.
  - For Medicaid or CHIP.
- May seek nonemergency health services at community health centers or safety-net hospitals.

Subject to VERIFICATION REQUIREMENTS

This explanation of how immigrants are included in health care reform is per provisions in the Affordable Care Act of 2010 (ACA) (encompassed in the Patient Protection and Affordable Care Act (Pub. Law No. 111-148) as amended by the Health Care and Education Act of 2010 (Pub. Law No. 111-152)).

"In NM rural & frontier counties, [prenatal and delivery] resources are scarce, unavailable or difficult to access even for women with insurance and/or ability to pay."

– draft report based on data from Local Health Councils, 2009, Data below updated for hospitals.

Catron	No providers of prenatal nor delivery care
DeBaca	No deliveries, Referals outside for prenatal.
Guadalupe	No providers of prenatal nor delivery (except emergency)
Harding.	No pregnancy services.
Hildalgo	No deliveries. No prenatal providers but care available locally from Silver City providers who travel.
Mora	Prenatal in Wagon Mound only.
Quay	No providers of prenatal; Tucumcari has ended deliveries.
Roosevelt	No deliveries.
Sierra	No prenatal, no deliveries.
Torrance	Prenatal but no delivery
Union	No longer do deliveries.
Valencia	No hospital, no deliveries.

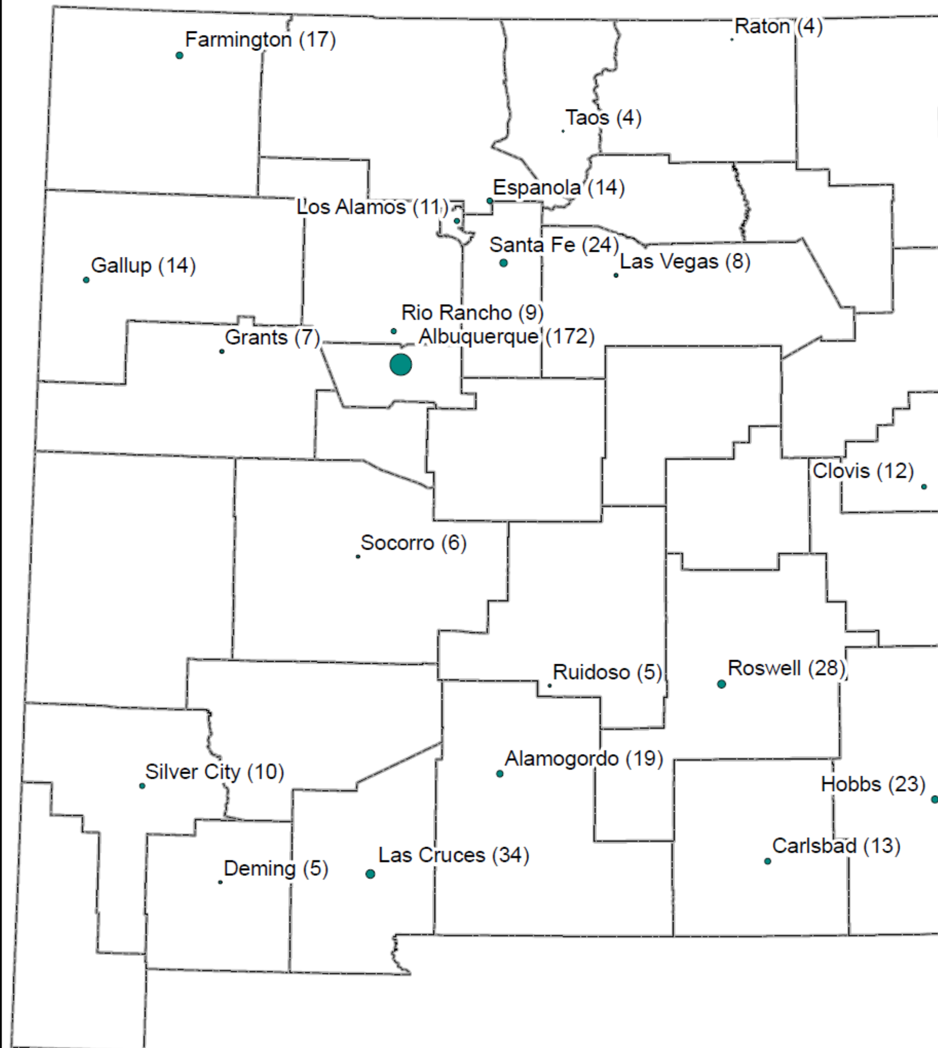
Percent of Births by Level of Prenatal Care, 2011

Note: This table uses the Modified Kessner Index.

	No Prenatal Care	Low	Moderate	High	Unknown
New Mexico	1.6	10.2	29.7	51.6	6.9
County					
Bernalillo	0.6	9.1	29.5	51.7	8.9
Catron	0.0	13.6	54.5	18.2	13.6
Chaves	1.3	15.7	32.3	49.0	1.7
Cibola	1.5	18.0	28.9	44.1	7.6
Colfax	0.7	9.1	33.6	51.7	4.9
Curry	1.2	10.3	30.0	56.0	2.6
De Baca	4.2	4.2	37.5	54.2	0.0
Dona Ana	4.8	10.9	33.1	50.6	0.6
Eddy	0.5	7.6	22.4	40.9	28.6
Grant	2.4	5.1	25.0	66.1	1.4
Guadalupe	0.0	7.9	52.6	39.5	0.0
Harding	0.0	0.0	57.1	42.9	0.0
Hidalgo	1.3	10.5	32.9	47.4	7.9
Lea	1.4	8.9	30.4	51.2	8.1
Lincoln	0.5	16.7	31.8	49.0	2.0
Los Alamos	0.0	2.6	13.7	79.7	3.9
Luna	2.2	9.5	23.5	46.8	17.9
McKinley	3.0	13.0	34.9	41.9	7.1
Mora	0.0	6.8	36.4	52.3	4.5
Otero	2.5	5.7	26.3	54.7	10.8
Quay	1.8	15.3	34.2	44.1	4.5
Rio Arriba	1.9	11.3	27.6	54.7	4.5
Roosevelt	2.5	8.9	34.4	50.7	3.5
Sandoval	0.4	8.0	30.1	53.6	7.9
San Juan	1.7	15.6	30.5	49.3	3.0
San Miguel	0.9	11.0	21.8	64.4	1.9
Santa Fe	0.6	4.2	21.2	71.0	2.9
Sierra	1.1	16.1	47.1	32.2	3.4
Socorro	2.1	16.8	34.5	38.2	8.4
Taos	2.4	15.2	31.4	48.2	2.7
Torrance	0.0	13.3	34.1	36.4	16.2
Union	2.5	12.5	12.5	70.0	2.5
Valencia	0.9	10.9	29.4	46.3	12.5
Health Region					
Northwest	2.1	14.9	31.9	46.0	5.0
Northeast	1.1	7.8	24.3	63.6	3.2
Metro	0.6	9.2	29.7	51.3	9.2
Southeast	1.2	10.9	29.8	49.6	8.5
Southwest	3.8	9.9	31.2	50.9	4.2

See Technical Appendix for information on the Modified Kessner Index.

New Mexico Department of Health, *New Mexico Selected Health Statistics*, 2011



Note changes since 2008-09:

Artesia -- Closure of 6 bed unit

Tucumcari – Closure of 2 bed unit

Clayton – Closure of 2 bed unit

Deming – Loss of 3 beds

Rio Rancho – New 9 bed unit at Rust

Carlesbad – Gain of 3 beds

Nurse-Midwifery Practices in New Mexico

Northern Navajo PHS Indian Hospital (5)

Southwest Midwives (3)

Los Alamos Medical Center (1)

Women's Health Institute (3)

La Familia Medical Ctr (1)
Women's Healthcare of NM (1)
Santa Fe Indian Hospital (2)
Rio Luna Family Care (1)
Christus St. Vincent (1)

San Juan Regional Medical Center (3)

Rehoboth McKinley Christian Hospital (2)
Gallup Indian Medical Center (5)

Fort Defiance Indian Hosp (5)

Alta Vista Regional Hosp/Alumbra Women's Health & Maternity Care (3)

Family Health Partnership (3)

Pres Rust Medical Ctr (3)
Pres Medical Group ** (8)
ABQ Health Partner/Lovelace Women's/Westside (18)
University Midwifery Assoc ** (12)
UNM Maternity & Family Planning (3)
Women's Specialists of NM (7)
Dar a Luz Birth Center (3)

Plains Regional Medical Center (3)

Socorro General Hospital (1) *

Eastern NM Medical Center (4)

Cassie Health Center for Women (1)
Hidalgo Medical Services (2)

Lea Regional Medical Center (1)

First Step Center (6)
Women's Medical Assoc (3)
OB/GYN Consultants (2)

SHIPROCK
AZTEC
FARMINGTON
BLOOMFIELD
CHAMA
RATON
TAOS
CLAYTON
GLADSTONE
ESPANOLA
LOS ALAMOS
FORT DEFIANCE, AZ
GALLUP
SANTA FE
MOSQUERO
LAS VEGAS
BERNALILLO
EDGEWOOD
TUCUMCARI
ALBUQUERQUE
LOS LUNAS **
BELEN **
SANTA ROSA
MCINTOSH
CLOVIS
QUEMADO
FORT SUMMER
PORTALES
MAGDALENA
RAMON
SOCORRO
LUNA
ROSWELL
RUIDOSO
TRUTH OR CONSEQUENCES
ALAMOGORDO
ARTESIA
HOBBS
SILVER CITY
LAS CRUCES
CARLSBAD
LORDSBURG
DEMING
RODEO

Red = UNM graduate

Availability of Physicians in Rural Areas of NM

In an older but still relevant study, Johnson et al (2006) assessed disparities in provider availability in rural and urban areas and found that primary care physicians were over four times more available in urban areas than in rural New Mexico. Similar ratios were found for other physician groups, and the availability of registered nurses in urban areas was twice that of rural areas as well. New Mexico could explore ways that hospitals, particularly sole community providers, and managed care organizations may expand rural primary care networks.

Table 10. Urban/Rural Physical Health Provider Disparities in New Mexico

Provider Group	Rural		Urban		Disparity Ratio*
	Number	Ratio of Provider to Population	Number	Ratio of Provider to Population	
Primary care physicians	630	1:1824	1586	1:429	4.25
Family practice	229	1:5017	369	1:1843	2.72
OB/GYN	52	1:22095	127	1:5356	4.13
Emergency Medicine	47	1:24445	125	1:5442	4.49
Pediatrics	78	1:14730	271	1:2510	5.87
Internal Medicine	223	1:5152	629	1:1081	4.76
PAs	146	1:7869	163	1:4173	1.89
Registered nurses	2566	1:448	3581	1:190	2.36
NPs	231	1:4974	329	1:2068	2.41

Source: Administration and Policy in Mental Health and Mental Health Service Research

*Disparity ratio = number individuals served per provider in rural area divided by number served per provider in urban area.

-- Exerpted from Department of Health and Allied Agencies, *Adequacy of New Mexico's Healthcare Systems Workforce,* Presentation to the Legislative Finance Committee, May 15, 2013

Issue of Medicaid Reimbursement

Nationally, Medicaid pays physicians approximately 59 percent of the reimbursement rate paid by Medicare for primary care services. In New Mexico, the Medicaid-to-Medicare ratio is better than average; the state has the 9th smallest discrepancy among the states, with Medicaid reimbursing 85 percent of Medicare rates for primary care (Kaiser, 2012). However, Medicare's reimbursement rate is about 80 percent of what commercial insurance pays (CMS, 2010). As 78 million baby boomers gain Medicare coverage over the next two decades, financial pressures may deter providers from serving the aging population, exacerbating existing shortages.

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New Mexico has long faced the problems of inadequate capacity to meet health care needs as well as huge disparities in the access to care. The Affordable Care Act in extending health care coverage to populations previously uninsured holds out the hope that the health care needs of all New Mexican will be met. It offers the challenge as well as a means of financing the expansion and development of NM's health care workforce and facilities. Many of the reforms with their emphasis on medical homes and coordinating health services are specifically designed to curb the escalating health care costs, enabling the state to do much more with limited resources.

In a certain sense and precisely because the State has used Medicaid so aggressively to meet maternal care needs, there is reason to believe that the gap here, although large and challenging, can and will be met.