

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

**August 2-4, 2010  
Room 322, State Capitol  
Santa Fe**

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order as a subcommittee by Senator Dede Feldman, vice chair, on August 2, 2010 at 9:10 a.m. Members of the audience and committee members introduced themselves. The committee was reminded that the meeting would be webcast. With the arrival at 9:15 a.m. of Representative Danice Picraux, chair, a quorum was established.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Rep. Nora Espinoza  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Sen. Rod Adair  
Rep. Joni Marie Gutierrez  
Sen. Linda M. Lopez

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Sen. Gay G. Kernan  
Rep. Dennis J. Kintigh (8/2)  
Rep. James Roger Madalena (8/3, 8/4)  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen (8/3, 8/4)  
Sen. Nancy Rodriguez  
Rep. Gloria C. Vaughn

Rep. Jose A. Campos  
Rep. Eleanor Chavez  
Rep. Keith J. Gardner  
Sen. Clinton D. Harden, Jr.  
Rep. John A. Heaton  
Rep. Rodolpho "Rudy" S. Martinez  
Sen. Sander Rue  
Rep. Jeff Steinborn  
Rep. Mimi Stewart  
Sen. David Ulibarri

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

**Guest Legislator**

Rep. Nick L. Salazar

**Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Karen Wells, Researcher, LCS  
Zelda Abeita, LCS

## **Guests**

The guest list is in the meeting file.

## **Handouts**

Handouts and written testimony are in the meeting file.

## **Monday, August 2**

### **Government Restructuring: Review of Agency Input**

Ms. Wells presented a summary of the testimony received from state agencies at the July meeting of the LHHS in which the agencies provided information on ways in which they have responded to budget cuts and suggestions or ideas they had for restructuring. Nancy Eisenberg, a public health graduate student and intern with the LCS, provided an in-depth overview of various programs within the Department of Health (DOH) based on interviews with key staff members of the DOH and a comparison of accepted principles of public health.

Committee members had questions and made comments in the following areas:

- the amount of savings that would be realized through contract revisions in the Children, Youth and Families Department (CYFD);
- the long-term impact of regionalization of public health offices in the DOH;
- a request to provide the committee with a complete list of long-term-care Medicaid waivers and related programs reflecting where and how each program is administered and the status of waiting lists for each program;
- a suggestion that the Medicaid program enhance access to non-emergency services rather than considering limiting visits to emergency departments;
- concerns regarding the impact of limiting prescription drugs to mail order in the Medicaid program;
- general opposition to merging the Aging and Long-Term Services Department (ALTSD) with the Human Services Department (HSD);
- whether there is potential for strengthening a partnership between the University of New Mexico (UNM) and the DOH; the current partnership is a research-based rather than an operational relationship;
- the need for clarification regarding the relationship between the state and counties in providing public health offices and services;
- clarification regarding the general fund portion of the Medicaid budget: approximately \$600 million in the current fiscal year, plus an additional \$62.5 million that is transferred to the DOH to administer the developmental disabilities waiver; currently, Medicaid constituents constitute approximately 11% to 13% of the general fund budget;
- the potential for UNM Hospital to become the contractor for medical services in the correctional facilities, thereby making available the discount prescription drug program pursuant to Section 340B of the federal Veterans Health Care Act of 1992; and

- whether national models exist for regionalization of public health offices.

### **Government Restructuring: Opportunities in the Federal Patient Protection and Affordable Care Act (PPACA)**

Mr. Hely identified elements in the PPACA that give rise to potential restructuring, including the establishment of health insurance exchanges (HIEs), health insurance regulation, health information technology (HIT) and health care delivery and workforce planning. He provided additional details regarding each of these areas and identified PPACA mandates and options regarding HIEs with examples of how other states have structured them. Mr. Hely noted that the PPACA does not mandate that Medicaid be provided through the exchange but that it must be interoperable with insurance coverage available through the exchange for easy transitions between public and private coverage. Access to coverage is ensured in part through the requirement that states set up health insurance consumer assistance or ombudsman programs. The federal government will be involved in the regulation of insurance to the extent that rate setting and rate review will now be overseen by the federal Department of Health and Human Services. States will still be responsible for regulating insurance, which in New Mexico is handled by the Public Regulation Commission (PRC). Information technology (IT) needs will be profound, not only in the exchanges but also through community-based collaborative care networks, including telehealth, and other efforts to integrate care creating partnerships among caregivers. Workforce development planning and implementation is another major area of importance in the PPACA that could result in the restructuring of the State Workforce Development Board. Substantial grant funds are available for these efforts, including \$8 million for a state health care workforce planning grant and up to \$150 million for implementation. Up to \$7.5 million in additional funds will be available for workforce analysis center partnership grants, as well as numerous health professional student grants, loan repayment programs and scholarship programs. The PPACA establishes primary care extension programs to promote best practices in primary care, and that could result in new partnerships for that purpose. Mr. Hely noted several functions that could be consolidated in a state or other agency in New Mexico, such as data collection, coordination of planning and workforce education, outreach, recruitment and retention, and health care financing and administration. He described structures that have been established in other states for these purposes.

Questions and comments about Mr. Hely's presentation included:

- whether the structure of the high-risk pool could be used to establish an HIE; the answer was that this was possible;
- whether New Mexico has a statewide workforce investment board; Mr. Hely responded that there is, indeed, a statewide workforce investment board;
- where the legislature should start its planning and implementation pursuant to the PPACA's many requirements, including the establishment of an HIE, monitoring of data collection, workforce planning, collaboration and more;
- whether the state is partnering effectively with stakeholders regarding the exchange planning grant, the grant for consumer protection and others; the legislature would like input into those applications, as well as the ALTSD's ombudsman program and the attorney general's consumer protection agency responsibilities;

- a suggestion to use grant applications as opportunities to form advisory groups on these topics;
- workforce grants pursuant to the PPACA for which UNM has applied;
- the importance of coordination between entities applying for grants as grants are released;
- clarification regarding what data are currently being collected by the New Mexico Health Policy Commission;
- whether or not the PPACA mandates the creation of a new entity to collect workforce data; the answer was no;
- clarification regarding the essential benefits required by the PPACA and the role of an exchange in that regard;
- an observation regarding the potentially negative effects on insurance coverage in the state if no insurance company chooses to participate in an exchange;
- opportunities to adopt a structure that has already been developed in another state that would meet New Mexico's needs;
- acknowledgment that the high-risk pool is funded in part by awarding premium tax credits to participating insurance companies; there was recognition that those credits, especially to health maintenance organizations, will go away when the risk pool goes away;
- clarification regarding the current membership of the State Workforce Development Board; health care workforce expertise should be represented; and
- recognition of the difficulty of planning for an exchange prior to regulations being released.

### **Health Care Common Interests: Review of SJM 1, 2009**

Ruby Ann Esquibel, health policy coordinator, HSD, reviewed the findings of the SJM 1 (2009) "Health Care Services Common Interests" report, identifying the requirements of SJM 1 and the entities that participated in the process. She reviewed recommendations as they relate to the PPACA, including insurance exchange and insurance market reforms; essential benefits; systems and payment reform; electronic health records (EHRs) and HIT; and consumer protection and transparency. Ms. Esquibel noted that not all of these recommendations were uniformly endorsed by all participants, but all were discussed and included in the report as findings. She concluded by drawing the committee's attention to resources online, including the strategic plan of the governor's health reform leadership team and a link to grant applications that is updated weekly.

Questions and comments from committee members covered the following areas:

- the impact of prescription drug changes on small, local businesses;
- whether New Mexico will be able to unify IT requirements and opportunities in the PPACA;
- the potential for savings by consolidation of Interagency Benefits Advisory Committee participating agencies in insurance purchasing (savings could be enhanced through group purchasing in addition to group procurement);
- opportunities inherent in incentivizing lifestyle changes in favor of healthy choices;

- problems with fixed payment methodologies for rural hospital outpatient services and transparency; the PPACA requires much more reporting of payments and rates;
- the possibility of charging retirees more for more "Cadillac" coverage and not having the state pick up that expense;
- clarification regarding the level of insurance coverage for state retirees who are Medicare-eligible;
- the impact of pooling younger workers with older workers;
- concerns regarding pay for performance and the extent to which physicians can actually control outcomes of care;
- clarification regarding pharmaceutical cost-containment recommendations and the interface with Medicaid;
- clarification regarding grant applications that have been submitted and those that are planned, particularly the application for planning for an exchange, who is involved and how the application is being developed;
- a request for the LHHS to receive a copy of the exchange planning grant application before it is submitted;
- a request for a delineation of the grant applications that have already been made and by whom; weekly updates on the status of grant applications are posted on the web;
- whether any of the grants provide recurring funding; most of them do not;
- an observation that SJM 9 (2010) called for the implementation of many of the recommendations contained in the report discussed today;
- a request for the Legislative Finance Committee (LFC) to conduct a fiscal analysis of the recommendations in SJM 9 (2010); and
- whether the LFC is tracking grant applications independent of the executive, to which the answer was no.

### **Government Restructuring: Discussion and Committee Recommendations**

Committee members expressed opinions and offered ideas regarding potential restructuring of health and human services agencies and programs, many of which are characterized as follows: restructuring should not be implemented solely for the purpose of restructuring; it should only be done after a careful and deliberative process. The ALTSD has come a long way in its short history, and with the growth of the aging population, this department should be maintained. It was suggested that committee members should keep in mind that restructuring might not save money in the short run but would be good in the long run and that they should look at consolidating boards and commissions that serve health and human services agencies before cuts are made to vulnerable populations. The LHHS should look at the complete list of Medicaid cuts that are being considered. A request was made that Ms. Wells work with Brent Earnest of the LFC to look at restructuring the personal care option (PCO) program and to look at other programs providing home and community-based services within the context of the PPACA and restructuring. The SJM 1 Health Care Reform Working Group (HCRWG) is planning to make recommendations to the LHHS regarding the PPACA, and Secretary Kathryn "Katie" Falls, HSD, is working hard to keep legislators informed about the activity of the governor's health care reform leadership team. Concern was reiterated regarding the Workforce Solutions Department (WSD) recommendations and the need to look carefully at

all WSD suggestions, especially those that affect health professional workforce issues. A request was made for the status of one-stop shop plans and the composition of the State Workforce Development Board in support of health professional workforce development. A suggestion was made that medical homes be explored more fully, with identification of ways in which this opportunity in the PPACA could be implemented. Mr. Hely was asked to make a summary of the medical home provisions in the PPACA.

### **Public Comment**

Doris Husted, public policy director, ARC of New Mexico, commented that the presentation made by the disability coalition to the HCRWG could be of value to the LHHS. She requested that care be taken to consider potential conflicts of interest when making restructuring recommendations.

Ruth Hoffman, director, Lutheran Advocacy Ministry, suggested that the HSD secretary's presentation of a Medicaid primer be made available to the committee.

James Ogle, president, National Association for the Mentally Ill-New Mexico, commented on recommendations to provide pharmacy benefits via mail order only. In his view, this would have a very detrimental effect on those with mental illness and would have a net cost increase in the long run.

The committee recessed at 4:00 p.m.

### **Tuesday, August 3**

Senator Feldman, vice chair, reconvened the meeting at 9:10 a.m.

### **PPACA: IT Overview**

Bob Mayer, deputy secretary, Department of Information Technology, offered information regarding the IT landscape in New Mexico. He reviewed features contained in HITECH, the IT law included in the federal American Recovery and Reinvestment Act of 2009 (ARRA). Key provisions include incentive payments to health care providers to expand the use of EHRs, so long as they are able to demonstrate "meaningful use". Additional incentives assist New Mexico in expanding access to high-speed internet services through broadband accessibility. The state received a grant of \$7 million to implement an HIE and another \$6 million to establish an HIT extension center. Mr. Mayer noted that the state did not apply for workforce development grants that were available through the HITECH provisions of the ARRA, known as the Health Information Technology for Economic and Clinical Health Act, to train providers in the use of EHRs. Asked whether these funds are still available, Mr. Mayer said he does not know. A grant application has been made for mapping and broadband access that could amount to close to \$40 million. The combined impact of HITECH on the state has been impressive, including the establishment of an HIE, HIT, public health reporting and the sharing of immunization records. Medicaid is in the process of developing a definition for "meaningful use" consistent with federal regulations as well as mechanisms for making incentive

payments to providers who participate in the incentive program.

Mr. Mayer described IT features of the PPACA that are intended to expand access and improve quality of care through the expansion of Medicaid; standard benefit plans; accountable care organizations; increased transparency and reporting of information; and the development of HIEs. Many opportunities exist through pilot and demonstration programs. IT implications arise in all of these areas. The HIE will consist of an online marketplace for the purchase of insurance, and it must allow frequent shifts in eligibility. The HIE must allow individuals to enroll in Medicaid if they are eligible. Medicaid expansions and any interface with the HIE will require updates in IT systems. Pilot projects rely on widespread sharing of medical information. Transparency requirements include publication of statistics on health care costs and outcomes. Mr. Mayer emphasized the urgent need for coordination, collaboration and communication among a state HIT coordinator, the Medicaid IT plan and the HIE strategic and operational plan to ensure effective implementation of these requirements. In New Mexico, Mr. Mayer is the state health information coordinator.

Questions and comments from committee members included the following:

- whether incentives for implementation of EHRs are available for any provider; providers must meet certain qualifying criteria;
- whether there is uniformity of health information systems being implemented throughout the state, and whether the systems will be able to effectively communicate and share information;
- ways in which HIEs are funded;
- an observation that implementation of EHR systems will disproportionately affect independent rural providers;
- whether Mr. Mayer is a member of the State Workforce Development Board (he is not);
- whether the work to establish an HIE could serve as the foundation for development of an HIE; it would be a new project;
- whether the sharing of health information is protected by privacy requirements;
- a request was made to communicate to community colleges and other eligible entities to encourage them to apply for available ARRA workforce development training funds;
- a request was made that Mr. Mayer be invited to serve as a member of the State Workforce Development Board;
- a motion was made to write an editorial notifying physicians and other health care providers that they are not permitted to require social security numbers to be divulged as a condition of receiving care; and
- clarification regarding "meaningful use" requirements.

### **Medicaid IT and the EHR Incentive Program**

Julie Weinberg, deputy director, Medical Assistance Division, HSD (MAD/HSD), offered more detailed information regarding the incentive program funded under the ARRA for health care providers to establish EHR systems. The purpose of the program is to offset the cost

of establishing such a system, but is not intended to cover the entire cost. The Medicaid incentive program officially begins in January 2011 and lasts for any given provider for six years. Providers can start as early as 2011 or as late as 2016 and can receive a maximum of \$63,750 over that period of time. Incentive payments are awarded after a provider demonstrates compliance with requirements of the program. A provider can participate in either the Medicaid or the Medicare program, but not in both. The Medicare program contains penalties if goals are not met for meaningful use. The Medicaid program carries no penalties. Hospitals can also participate in the Medicaid incentive program, which can last from three to six years. Hospitals can participate in both the Medicaid and the Medicare programs. The amount of incentive a hospital receives is based upon a complex formula. Eligible providers were identified. Ms. Weinberg noted that legislation was introduced that will add behavioral health providers to the list of eligible providers. She described specific criteria that a provider must meet in order to be eligible to participate, including the volume of patients who are covered by Medicaid; adoption, implementation or upgrading of a certified EHR system; and qualifying as a meaningful user of the certified EHR system. Meaningful use criteria were described and examples were given. A state Medicaid HIT plan must be in place and approved by the federal Centers for Medicaid and Medicare Services (CMS) prior to implementation of this incentive program. Criteria and details for the plan were discussed. New Mexico received close to \$521,000 in federal planning funds and will be prepared to implement the program in January 2011. The HSD is in consultation with provider groups, managed care organizations (MCOs) and other stakeholders during this planning phase. Staffing needs to implement the program, funded 90% by federal funds, were identified. The MAD/HSD expects that there will be disbursement of \$300 million of federal funds into the New Mexico economy over the life of the program, that there will be cost savings to the Medicaid program and other private health plans by eliminating duplication and that there will be improved care management of chronic conditions. A glossary of terms was included in Ms. Weinberg's handout.

Committee members asked questions and made comments in the following areas:

- clarification regarding the vendors and ways in which they receive ARRA funds; vendors are software developers and manufacturers of equipment;
- whether information is currently available regarding which physicians in New Mexico serve Medicare and Medicaid patients; Medicaid information is well known by the MAD/HSD, but information is not currently available regarding the volume of Medicaid patients served;
- whether the percentage of physicians and dentists who serve Medicaid clients is available; the information will be provided;
- under what conditions a provider would choose to participate in Medicare versus Medicaid; some providers might meet the Medicare threshold for participation and not the Medicaid threshold;
- whether the incentives are considered taxable income; Ms. Weinberg stated that she did not know;
- whether patients can request that their records not be entered into an EHR system; Ms. Weinberg stated that patients could indeed request this;
- clarification regarding eligible providers and why behavioral health providers were

- not included in the original bill;
- ways in which the privacy of medical information will be protected; the process of certification of an EHR system requires privacy and security;
- how the planning funds will be distributed; and
- how widely available health information will be to health care providers, and how privacy can be assured in this situation.

### **PPACA: Medicaid Eligibility and the Exchange**

Carolyn Ingram, director, MAD/HSD, began her presentation by briefly describing the purpose and function of an HIE, noting that currently only Massachusetts and Utah have state-based exchanges operating at this time. Transitions between commercial and government programs must be seamless to the individual accessing the exchange. She highlighted enrollment and eligibility issues that will be part of the exchange, some of which are already handled in New Mexico through the Insure New Mexico web site, the New Mexico Health Insurance Alliance, the New Mexico Medical Insurance Pool (NMMIP) and the PRC. Key issues for Medicaid revolve around the requirement for a single application for Medicaid, the Children's Health Insurance Program and commercial plans within the exchange. The state is required to have an exchange implemented by 2014; by January 2013, the state will have to demonstrate its readiness to do this, or the federal government will step in and establish an exchange for the state. Other requirements of the law were described, including choices each state will need to make to operate an exchange. The state will have a role in tracking compliance, including interface with tribal governments. Significant IT challenges exist in operating an exchange in order to screen, link and enroll people into products, including public assistance and subsidies. Many states are beginning to consider regional purchase of some products that will be needed to accomplish these functions. The time line for making these decisions and being ready to implement an exchange is short. Ms. Ingram identified specific implications for the MAD/HSD in operating an exchange, including a seamless interface between Medicaid and the exchange. HSD technology issues will only be resolved through replacement of the current Medicaid eligibility (ISD2) system, HIPAA 5010, which has subsequent privacy requirements; implementation of a new reimbursement system called ICD10; and implementation of an automated verification system that is now required. All of these IT requirements will be costly and are currently not funded.

Ms. Ingram identified the current state of eligibility for medical assistance programs. At present, 541,000 people are enrolled in Medicaid programs, with an additional estimated 273,000 individuals who will become eligible in 2014. At that time, new rules for eligibility through a process of modified adjusted gross income (MAGI) will be required. The MAD/HSD will have to track newly eligible individuals and currently enrolled populations, and certain populations that are exempt from MAGI will need to be tracked separately. Finally, Ms. Ingram described a PPACA option to create a "basic health program" to cover individuals between 133% and 200% of the federal poverty level. Individuals who enroll in such a program would not be eligible to obtain coverage through an HIE. The subsidies that would go to those individuals through an HIE would instead go to the state to cover the cost of the program. She presented questions and decision points that New Mexico will have to consider in determining what kind of HIE to

establish. The overarching consideration is to have an exchange that is simple and easily understood. New Mexico should look at teaming up with other states in a regional approach to implementation. New Mexico's experience in operating the State Coverage Insurance (SCI) program teaches that insurance companies can make a profit in an HIE. She recommended that any insurance company that contracts with Medicaid be required to offer a product on an HIE.

Committee members had questions and made comments in the following areas:

- concern regarding individual mandates to purchase health insurance and possible constitutional conflicts of such mandates;
- clarification regarding adoption of MAGI and income disregards in New Mexico;
- the impact of adopting MAGI on current enrollees; New Mexico and other states are mapping out the impact;
- clarification regarding the application for the exchange planning grant and who is involved; a formal response will be provided;
- clarification regarding opportunities for partnering with other states to implement an exchange on a regional basis;
- clarification regarding the match rate should the state pursue a basic health program, and whether the match is permanent;
- the need for legislative as well as executive support in deciding the model of exchange to be implemented;
- clarification regarding New Mexico's obligation in implementing an automated verification system; this provision was originally passed in the federal Deficit Reduction Act of 2005, and New Mexico is charged with being a pilot state; Ms. Ingram has written letters without success to request that those obligations be dropped;
- clarification regarding uninsured residents in New Mexico and how many of them will, or already do, qualify for Medicaid;
- opportunities and challenges of enrolling Native Americans in Medicaid;
- opportunities for regional HIEs to standardize benefit packages and pools;
- a request for staff to write a letter to the National Conference of State Legislatures for guidance on regional exchanges and standardization on benefit packages and pools;
- whether a list is being developed regarding the actions the legislature will have to take to implement the PPACA; it has not been suggested, but it is a good suggestion;
- an observation that the LHHS should be proactive in recommending legislation to implement the PPACA;
- an observation that the HCRWG will be bringing legislative recommendations to the LHHS;
- whether the executive leadership team will have a specific recommendation regarding exchanges; yes, that is expected; and
- a reflection that a side-by-side comparison has been created that shows New Mexico insurance law versus PPACA insurance requirements.

### **Payment and Reporting for Health-Care-Acquired Infections**

Dr. Alfredo Vigil, secretary, DOH, and Dr. Joan Baumbach, Infectious Disease

Epidemiology Bureau chief, DOH, presented an update on New Mexico's health-care-acquired-infections program. Dr. Baumbach provided a historical perspective. The National Nosocomial Infections Surveillance System (NNIS) was developed by the federal Centers for Disease Control and Prevention (CDC) during the 1970s. The National Healthcare Safety Network was developed by the CDC in 2005 and has replaced the NNIS. She defined "health-care-associated infection" (HAI). New Mexico's HAI program was developed to improve the health status of New Mexicans through improved health care outcomes. She provided the program's legislative history, beginning in 2007 with HJM 67, which called for a study of the feasibility of gathering statewide information about HAI. In 2008, an advisory committee was established in the DOH that recruited six hospitals to engage in a pilot project. These hospitals agreed to track and measure health care worker influenza vaccination rates and central-line bloodstream infections (CLBSI). In 2009, the New Mexico Legislature passed the Hospital-Acquired Infection Act, which formalized the advisory committee and established goals for the expansion of indicators and hospitals' involvement. The act also identified the composition of the advisory committee. Currently, 25 health care facilities are reporting influenza vaccination rates for health care workers, and 17 intensive care units are reporting CLBSI. A learning collaborative has been established by the advisory committee to help additional hospitals by sharing best practices regarding CLBSI. Currently, more than 20 health care facilities are participating in this learning collaborative regarding CLBSI. In 2010, two new indicators have been added, as required by law: CLBSI incidence outside of intensive care units; and *Clostridium difficile* infection (CDI), a condition whose symptoms include painful gastrointestinal issues. This month, New Mexico and nine other states will pilot a study to determine HAI prevalence among patients in acute health care facilities, with plans for nationwide implementation. The HAI advisory committee also is scheduled to provide training to various audiences regarding health care worker influenza vaccinations, to validate data that have been provided on CLBSI and to start a second learning collaborative on CDI. The findings of 2009-2010 will be published in October 2010, and a public HAI web site will be launched. Dr. Baumbach asked the committee for input on ways to improve communication on this important topic. The first annual report with facility-specific data is planned for publication by July 2011. The advisory committee is eager to serve as a resource to the legislature. Dr. Baumbach noted that CMS recently passed a rule that ties reporting of CLBSI to reimbursement that will go into effect in 2013, and with which New Mexico facilities are well positioned to comply. Funding to sustain this program is an ongoing issue. Secretary Vigil emphasized the critical nature of training of health care facility personnel in ensuring a reduction in HAI.

Committee members asked questions and made comments in the following areas:

- clarification regarding the ultimate goal of the program;
- clarification regarding the causes of CLBSI;
- whether hospitals have the authority to require visitors to take precautions to limit the spread of CLBSI and other infections; policies exist, but they vary based on the condition of the patient and are very hard to enforce;
- clarification regarding the corporate status and size of participating hospitals;
- clarification regarding ARRA funds received in support of this program; ARRA funding has resulted in the hiring of more staff;

- clarification regarding the proposed web site reporting HAI data;
- whether the study in New Mexico and elsewhere has resulted in reduced deaths due to HAI;
- where the ultimate authority rests for poor compliance with hospital safety and infection control practices;
- why CDI was chosen as an indicator instead of the indicators recommended in the state law and at what point will training begin on CDI;
- whether the DOH intends to ask for money to continue the HAI program; it is very unlikely that the DOH will ask for additional general fund dollars during this current fiscal crisis; and
- an observation that the DOH is not protecting public health programs and infrastructure sufficiently; the real value of public health must be better publicized.

Ellen Pinnes, Esq., health policy consultant, was recognized for public comment to respond to previous questions regarding Medicaid home and community-based services waivers. She distributed a summary fact sheet that was developed by Jim Jackson, Esq., the executive director of Disability Rights New Mexico.

### **Physician Quality and Outcome Reporting**

Dan Jaco, chief executive officer, New Mexico Medical Review Association (NMMRA), introduced Dr. John Seibel, medical director, NMMRA. Mr. Jaco presented on the reporting of physician data both now and in the future. He provided a historical perspective of the NMMRA and its role in quality improvement in the health care system and then identified key activities in which the NMMRA is involved. Mr. Jaco recognized Dr. Seibel as an innovator in the field of EHRs who is nationally recognized by the American Medical Association. He offered basic information and definitions regarding performance measurement, quality indicators and quality measures. To be valid, indicators must be evidence-based and process- or outcome-oriented. He made the point that, currently, physicians are paid mostly in terms of the volume of services provided, although the system is changing to one of value-based purchasing. He recognized the trend toward greater transparency in the system. Public reporting on physicians will allow patients to make informed choices and be more aware of unintended consequences of treatment. In 2006, federal legislation established the Physician Quality Reporting Initiative (PQRI), which provided incentive payments to physicians for reporting to the CMS using evidence-based quality measures. The PQRI has not been widely embraced by physicians, but the CMS continues to try to improve the program. He noted the critical importance of establishing an electronic infrastructure for capturing, exchanging and reporting physician data. The ARRA, which contains incentive funding to encourage development of EHRs by physicians, is important in advancing this goal. The PPACA contains a national strategy to improve the quality of health care in the country. It reinforces payment penalties for failing to submit data on quality measures for covered services and provides for timely feedback to physicians on data submitted. The PPACA also contains numerous payment reform pilots, demonstrations and models to transform the delivery system through bundled payments, medical homes, accountable care organizations and more. According to Mr. Jaco, New Mexico is well positioned with regard to mandated physician reporting due to work that is already underway to expand broadband access,

establish an HIE and encourage participation in ARRA-funded incentives to embrace EHRs. The Robert Wood Johnson Foundation has funded an initiative known as "Aligning Forces for Quality" that is bringing together providers, health plans, businesses and consumers around quality initiatives such as those already mentioned.

Dr. Seibel noted that he has been involved in approval of practice guidelines for physician practices. An unresolved question involves how data that can be extrapolated from these guidelines will demonstrate real quality. Progress has been made toward a process that will allow physicians to gather data easily from EHRs and submit the required data. Regulations and guidance are not yet finalized.

Committee members had questions and comments on the following topics:

- the ultimate cost of implementing EHRs within a physician's practice;
- the median age of a physician in New Mexico and whether there is a correlation between age and the reluctance of the physician to establish an EHR system; there does not appear to be a correlation;
- whether noncompliance of patients serves as a disincentive to physicians to participate in outcome-based reimbursement; and
- clarification regarding the concept of bundled payments, and who gets the payment.

### **Medical Homes and PPACA**

At the request of the chair, Mr. Hely provided information to the committee regarding medical home demonstrations that are funded in the PPACA. Section 6860 of the PPACA provides for community-based teams to support the patient-centered medical home that is based on a model of medical homes that exists in Vermont. Section 2703 of the PPACA provides that Medicaid medical home demonstration projects will be funded for individuals with two or more chronic conditions or one serious and persistent mental illness. The project is more limited than the pilot project that is being implemented in New Mexico pursuant to state law. Sections 3021 and 10,306 provide for the establishment of the Center for Medicare and Medicaid Innovation within the CMS to test payment and delivery models, including medical homes, in order to reduce expenditures while improving quality of care. Section 5301 will fund training in family medicine, general internal medicine, pediatrics and physician assistantship that includes training in medical home models of care. The primary care extension program, Sections 5405 and 10,501 of the PPACA, will offer grants to states to promote best practices in primary care, including medical homes. Finally, Sections 1001, 10,101 and 1004 all contain reporting requirements for group health plans and insurers on quality of care, including care coordination through medical home models of care.

Committee members had questions and comments in the following areas:

- whether state matching funds are required for grant applications. Mr. Hely indicated that there are state matching funds required for some grants, but that some requirements may be met through existing funding streams;
- how the training grants will raise awareness of the medical home model of care; federal Department of Health and Human Services regulations, when issued, will

- flesh out the intention of this section;
- whether requests for proposals have been issued for any of these projects; and
- whether the core service agencies being established through the Interagency Behavioral Health Purchasing Collaborative would qualify as a medical home for the purposes of the Section 2703 grant for Medicaid "health homes" that can cover serious mental illness.

### **Public Comment**

Ms. Husted stated that she believes that the Presbyterian Health Plan is working to develop a medical home model for commercial lines of business.

### **Wednesday, August 4**

The meeting was reconvened by Representative Picraux at 9:05 a.m. Committee members were reminded that the meeting is being webcast.

### **Health Reform Leadership Team: Strategic Plan; and HM 43: Native American Medicaid Category**

Secretary Falls provided a report on the plans for implementation of the PPACA as recommended by the governor's health care reform leadership team established on April 20, 2010 by Executive Order 2010-012. She noted that the strategic plan is an evolving document because many of the provisions of the PPACA have not yet been implemented and further guidance and regulations will be needed. She identified the membership of the team. The team organized and reflected its work in a series of matrices per department represented on the team. A comprehensive matrix summarizes all of the work and the progress of all of the departments to date. Secretary Falls also noted that through the HCRWG, there is important coordination and collaboration around the steps that will need to be taken to implement the PPACA. After receiving the strategic plan, the governor recommended several measures that should be pursued immediately. These measures include the continuation of the leadership team; expansion of membership to include other executive agencies such as the Higher Education Department and Department of Finance and Administration; creation of an office of health care reform to be attached to the HSD; identification of state statutes that will require amendment or enactment to be in compliance with the PPACA; and tribal consultation regarding health care reform initiatives. Links were provided to the full report and other resources.

Secretary Falls noted that the strategic plan is organized with decision points, a number of which she highlighted for the committee. In addition to the measures already recommended by the governor, she identified the importance of fiscal analysis to identify the impact of the PPACA on New Mexico. Analysis will also need to be conducted to update demographics and conduct mapping of the number of uninsured, the impact on the health care market and the impact on Medicaid. Analysis of the federal tax and subsidy options and their impact on the state will be needed. A list of options for Medicaid, SCI and other Insure New Mexico programs will be examined, and legislation that may be needed will be identified. The leadership team will consider whether New Mexico should develop a basic health plan option, and how it could

be enacted. Decisions to create an HIE will be key and will involve many decisions. New Mexico will need to determine whether it will develop one exchange or two separate exchanges, one for individuals and one for small businesses. The type of exchange is an important decision to be made; options include allowing the federal government to establish an exchange for New Mexico, whether it should be operated by a nonprofit agency or by state government, whether New Mexico should join in a regional effort to establish an exchange, and/or whether New Mexico should have regional exchanges within the state. Identifying the legislation that will be needed to establish an exchange will be necessary. Consideration will need to be given to establishing a seamless interface between the exchange and Medicaid. A request for proposals has been issued, and the HSD will be applying for a planning grant that will provide about \$1 million in funds to assist in making these decisions. A handout highlights health reform grants that have been or will be submitted by New Mexico. The DOH is monitoring and tracking all grant opportunities, including those that are outside of state government.

Secretary Falls spoke briefly about HSD activity in response to HJM 43, which called for establishment of a separate category of Medicaid eligibility for Native Americans. The HSD has established a tribal-state work group to look at this and other Medicaid issues. The goals of the work group include developing and recommending a protected Indian plan within Medicaid; reviewing and making recommendations regarding cost containment within Medicaid; and planning for national health reform and authorization of the Indian Healthcare Improvement Act within the PPACA. A concept paper has been drafted and a letter submitted to the CMS to establish the separate Medicaid category for Native Americans.

Committee members had questions and comments in the following areas:

- concern regarding cuts to important Native American programs and access to services;
- recognition that Native Americans have serious health problems that need unique attention;
- the importance of applying for all grants, especially health professional workforce grants;
- whether New Mexico State University (NMSU) has applied for or intends to apply for any workforce grants; NMSU is remaining attentive to grant opportunities and is collaborating with other institutions of higher learning; there was a request for a list of all grants for which NMSU has applied or is considering applying;
- concern regarding the magnitude of the mandates in the PPACA, especially the mandate for an individual to purchase insurance;
- clarification regarding who in the HSD will be developing the exchange planning grant application; there was a request that small businesses, in particular, be involved in the planning for an exchange;
- the possibility of collaborating with other states both to establish an HIE and to purchase the needed IT;
- clarification regarding who will conduct needed fiscal analyses and how that activity will be funded; the HSD has some bonus funding it is hoping to use to obtain outside help with these analyses;

- recognition of the level of assistance that is needed to help nonstate agencies to apply for available grants; for example, assistance for school-based health centers;
- ways in which communication regarding grant opportunities is occurring;
- whether the executive or the legislature will determine the type of HIE New Mexico will have; the leadership team expects to make a recommendation, but the legislature will make the ultimate decision through legislation;
- the nature of anticipated cuts to Medicaid and whether Native Americans will be spared; Native Americans will be spared to the extent that they receive services through the Indian Health Service;
- recognition of Regina Roanhorse as an important advocate of Native American health care issues;
- clarification regarding to whom the 100% federal medical assistance percentage (FMAP) for Medicaid will apply in 2014; only those who are "newly eligible" for Medicaid;
- clarification regarding who will run the office of health care reform; Secretary Falls has assigned Ms. Esquibel to lead the office with staff from other departments identified as resources to the office;
- ways in which the transition of knowledge and expertise occurs when a new administration take office; classified employees are being appointed as lead personnel regarding PPACA implementation efforts; and
- clarification regarding the impact of the PPACA on small businesses and tax penalties on individuals who do not comply with the mandate to purchase health insurance.

The chair interrupted the questions and comments to read an email just delivered that stated the United States Senate had taken preliminary action to support a phased-down extension of the enhanced Medicaid FMAP through the second calendar quarter of 2011. Secretary Falls provided some clarification regarding the impact of this information, although the exact details of the measure were not, at that time, fully known. A quorum being present, Senator Feldman made a motion, which Representative Lujan seconded, to send a letter requesting members of the New Mexico congressional delegation to vote in support of the proposed amendment to H.R. 1586 to extend the enhanced FMAP. Representative Espinoza made a motion for a roll call vote, which Senator Kernan seconded. As the roll call vote was called, Representative Espinoza excused herself from the room. After brief discussion, the motion carried with four members voting in support: Representative Picraux, Senator Feldman, Senator Ortiz y Pino and Representative Antonio Lujan, and one member absent from the vote, Representative Espinoza. Clarification regarding the rules by which a vote is valid were reviewed. A comment was made that the vote sends a misleading message regarding the meaning of the vote. A suggestion was offered that the letter state that the majority of the committee voted in favor of the motion.

Questions and comments resumed as follows:

- clarification regarding how emergency care is provided to undocumented residents, and whether they are eligible to be covered under the PPACA;
- clarification that the PPACA requires insurers to allow dependents to be covered

- under parents' policies until the age of 26;
- clarification regarding the portions of the PPACA that have already been implemented;
- recognition that implementation of major health reform is occurring at a complex time when many other major initiatives are also underway; and
- the importance of the timing of imposing any new taxes on employers because taxes may compromise the ability of many businesses to remain in business.

### **Health Reform and Medicaid: Challenges to the Provider Community**

Steven Hansen, chief executive officer, Presbyterian Medical Services (PMS) highlighted key features of the PPACA that are expected to both help and challenge federally qualified health centers (FQHCs) in New Mexico. Mandatory federal grant funding of \$11 billion will be available between fiscal years 2011 and 2015 to expand FQHC sites and operations through the PPACA; however, it is not certain how much of that New Mexico will be able to obtain. He described the anticipated breakdown, by payer source, of patients who will receive health care services through FQHCs in 2014, once the PPACA is fully implemented. Specific challenges that he expects the PMS will face include provider recruitment, a pent-up demand for services, a need for facility improvements and infrastructure development and a disproportionate share of the uninsured seeking services at PMS clinic sites.

Robert Garcia, vice president for regional administration, Presbyterian Healthcare Services (PHS), offered remarks about the specific impact of the PPACA on hospitals in the challenging fiscal environment. He characterized the PHS as an integrated delivery system and provided information about how it is structured and how it currently serves New Mexico. He noted that hospitals agree that they are facing dramatic challenges, including reductions in payments, but together with the executive and legislature, they believe they can rise to the occasion. Hospitals believe that quality care will be more cost-effective; individuals will take more responsibility for their own care; and emergency room care will be truly emergency care. Pilots and demonstrations to bundle payments and develop accountable care organizations will alter the way in which health care is delivered. Mr. Garcia asked the committee to continue to look at ways to increase the supply of health care providers in New Mexico, especially mid-level providers.

Dr. Larry Shandler, a pediatrician and member of the Medicaid Advisory Committee, observed that the PPACA contains many provisions to increase support for training and stipends to promote workforce development. He expressed the need for more pediatric specialists. He noted that more women are entering the profession of medicine, especially in primary care and pediatrics. He observed that although primary care physicians are paid less than specialists, physicians practicing in primary care tend to have more job satisfaction and remain in practice longer. Laws now limit the hours that residents can work before taking a break; the impact of this on the profession has yet to be fully evaluated. Physicians continue to argue for better reimbursement for their services. The PPACA requires that Medicaid reimbursement rates move closer to Medicare rates; New Mexico is already close, but Medicare reimbursement is lower in the state than elsewhere in the nation. Additionally, Medicaid reimbursement is about two-thirds

of commercial payments. The PPACA has many opportunities, but there are still challenges.

Committee members asked questions and made comments in the following areas:

- ways in which bundled-payment mechanisms work, including who distributes the dollars and how out-of-network providers participate; it was explained that much is not yet known about this;
- an observation that the rising cost of health care is of major concern to patients;
- an observation that many system reforms in the PPACA are already underway, such as medical homes;
- clarification regarding a medical home pilot project at the Pueblo of Isleta; early findings seem to indicate individuals enrolled have shorter lengths of stay in hospitals and better outcomes;
- an observation that community health clinics and FQHCs have been providing care in the medical home model for decades;
- clarification regarding the amount of federal support received for FQHCs under the ARRA and what is anticipated through the PPACA; the PMS received around \$2 million under the ARRA for capital improvements; under the PPACA, the grants are very competitive, and New Mexico might be in a disadvantaged position to receive any money because the state already has a large number of clinics; early indications are that the first round of grant dollars will go to establishing new sites around the country;
- whether the addition of a fourth SALUD! provider has made either a positive or negative difference in the provision of health care to New Mexicans; Mr. Garcia stated that he did not know;
- the difficulty of understanding and negotiating reimbursement rates with new HSD rules that govern MCOs and the MCOs independent initiatives around reimbursement;
- whether all SALUD! MCOs negotiate the same rates with their providers;
- how emergency room physician staffing is determined and by whom; Dr. Garcia stated that it varies based on the demand;
- clarification regarding the number of psychiatrists employed by the PMS in clinics, and where the clinics are located; the PMS utilizes telehealth to reach rural New Mexico;
- clarification regarding where health care provider shortages are the most profound;
- the urgent need for trauma providers;
- the importance of telemedicine;
- whether enough primary care providers are graduating; the answer was no, federal caps have limited the number of providers who can go into residency programs; and
- an observation that primary care providers have great job satisfaction and tend to stay in the profession longer.

### **Report from the HCRWG**

Debbie Armstrong, chair, HCRWG, provided an update on the progress of the working group, noting that it will meet on August 5 at 9:00 a.m. to discuss workforce issues and system

reform issues. Advisory groups have been formed on a voluntary basis and will draw on their own networks statewide to gather information and provide a report and recommendations to the LHHS in November 2010. The HCRWG has been looking at major key provisions, time lines for implementation and granting opportunities. Ms. Armstrong updated the committee on grants that have already been applied for and some that are currently being developed. The federal high-risk pool, one of the first mandates of the PPACA, has been established under the aegis of the NMMIP. Ms. Armstrong updated the committee on how this was accomplished, including a decision by the NMMIP board to extend subsidies to low-income enrollees by using state resources because the federal grant does not permit use of its funds for that purpose.

Committee members had questions and made comments as follows:

- clarification regarding the \$37 million in federal funds for the federal pool; those funds are to pay claims of participants enrolled in the federal plan;
- clarification regarding the differences between the state high-risk pool and the new federal high-risk pool;
- information regarding the characteristics of the new enrollees in the federal program;
- an update about exchanges and recommendations from the HCRWG; this will be discussed at the October meeting and brought to the LHHS in November;
- clarification regarding other areas in which the HCRWG will be making recommendations;
- an observation that the request for proposals for the exchange planning grant must be submitted by a state agency and requires stakeholder input; and
- clarification regarding maintenance of effort requirements for high-risk pools.

#### **Public Comment**

There being no public comment, the committee adjourned at 3:15 p.m.