

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

**August 31-September 1, 2010**  
**Room 307, State Capitol**  
**Santa Fe**

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order as a subcommittee by Representative Danice Picraux, chair, on Tuesday, August 31, 2010, at 8:45 a.m. Committee members were reminded that the meeting was being webcast.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Rep. Joni Marie Gutierrez  
Sen. Linda M. Lopez  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

Rep. Jose A. Campos  
Rep. Keith J. Gardner  
Sen. Clinton D. Harden, Jr.  
Rep. Rodolpho "Rudy" S. Martinez  
Rep. Bill B. O'Neill  
Rep. Jeff Steinborn  
Rep. Mimi Stewart  
Sen. David Ulibarri

**Advisory Members**

Sen. Sue Wilson Beffort  
Rep. Ray Begaye  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote (9/1)  
Rep. Miguel P. Garcia  
Rep. John A. Heaton (8/31)  
Sen. Gay G. Kernan (8/31)  
Rep. Dennis J. Kintigh  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Sen. Mary Kay Papen (9/1)  
Sen. Nancy Rodriguez  
Sen. Sander Rue (9/1)  
Rep. Gloria C. Vaughn

**Guest Legislators**

Rep. Gail Chasey (8/31)  
Rep. Edward C. Sandoval

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

**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 are in the meeting file.

**Tuesday, August 31****Welcome and Introductions**

Representative Picraux welcomed the committee and members of the audience. The committee members' attention was drawn to several documents provided in response to previous questions asked by committee members. Committee members introduced themselves.

**Patient Protection and Affordable Care Act (PPACA) Opportunities: Delivery System and Financing of Health Care**

Enrique Martinez-Vidal, vice president, Academy Health, and director, Robert Wood Johnson Foundation State Coverage Initiative (SCI) Program, described what the environment of health care delivery is likely to look like when the PPACA is fully implemented in 2014. Measures intended to reform the health care delivery system are designed to reform reimbursement, improve quality and emphasize outcomes through structures such as medical homes and accountable care organizations (ACOs).

According to Mr. Martinez-Vidal, payment reform is a very important aspect of the law as reimbursement inevitably has a huge impact on how care is delivered and how the provider system is organized. Principles of reimbursement in the PPACA involve aggregation of payment through such vehicles as bundled payment arrangements, shared savings and capitation. In a bundled payment arrangement, payments are made based on an episode of care, over a period of time, for patients with a specific condition. Difficulties occur when determining who actually gets the payment and by what means it is distributed. In shared-savings models, providers agree on a budget of risk-adjusted expenditures for a population. Capitation is a widely used model of reimbursement, especially in Medicaid. Of the models described, capitation has the strongest financial/budget-management incentives.

Mr. Martinez-Vidal identified two major areas of health policy innovation in the PPACA: medical homes and ACOs. Medical homes are based on a presumption that coordinated care coupled with disease management can result in improved outcomes of care. Multipayer medical home initiatives bring major insurers together to implement changes in the interaction between primary care providers and patients. Funding for patient-centered medical homes can be

difficult, as the medical home generally provides additional services not traditionally covered. The economic downturn has made funding of medical homes difficult for states. The September 2009 decision of the federal Centers for Medicare and Medicaid Services (CMS) to allow Medicare to participate in medical home models eliminated a previous hurdle to reimbursement.

Mr. Martinez-Vidal briefly described the characteristics of medical homes and reasons why this is an important model to promote. He described the relationship between medical homes and ACOs. Medical homes bring payers of care together around primary care while ACOs bring a wider array of providers together, including hospitals and specialists. ACOs represent emerging models around which there is no agreement, ranging from virtual organizations to actual models, such as integrated delivery systems. An ACO is a network of providers that come together to assume clinical and financial responsibility for the care of a patient and a population and among whom payment and risk are apportioned. The ability to manage across a continuum of care is vital. ACOs must be able to integrate the elements of financing, patient care and performance measurements. The PPACA affords ACOs the opportunity to offer great flexibility of organization with new payment models, improved risk adjustment and a measure to forestall cuts in fee-for-service models of payment.

Concerns around ACOs include a fear that ACOs will restrain market forces and, if they are successful in reducing costs, about how and to whom the savings will be accrued. Components of an ACO infrastructure include local accountability for cost, quality and capacity; shared savings; and performance measurements. Networks that are created in an ACO are not shown to disrupt a patient's tendency or ability to go to one particular network of providers. ACOs in some ways resemble managed care, but without the intention to limit choice to a specific array of providers. However, providers are incentivized to manage the care because they are responsible for the outcomes of care, regardless of whether or not the patients receive the care from providers in the ACO network.

There remain many questions about what an ACO is and how it can be made to work. The PPACA has funding for demonstrations to promote experimentation with various approaches to implementing ACOs. Pat Montoya, director, Alliance for Quality, New Mexico Medical Review Association, noted that there are entities in New Mexico that are currently attempting to establish an ACO. One difficulty is that much of the patient population is already enrolled in a particular network, making for challenging decisions about new payment reimbursement models. Mr. Martinez-Vidal commented that local experimentation will ultimately lead to new innovations in delivery systems and reimbursement of care. ACOs can only be successful with local leadership and engaged stakeholders, including payers, purchasers, providers and patients. He briefly described the state action on avoidable rehospitalizations initiative, which is seeking to identify ways to set up systems that will improve transitions out of the hospital and into the next setting of care. Many states are looking to implement this initiative for a "quick win" in improving care and reducing the costs of health care.

Mr. Martinez-Vidal provided an overview of specific delivery system and payment reform opportunities in the PPACA. Detailed information was included in his handout. A

critical element is the establishment of the CMS Center for Medicare and Medicaid Innovation, which will be funded at \$10 billion over the next 10 years and will serve as the center for the accomplishment of many of the goals of the PPACA.

Payment reform and new reporting requirements for physicians, hospitals and health plans are contained in the PPACA. Numerous pilot programs are targeted to innovations in Medicaid for medical homes, community health teams, a pediatric ACO, primary care extension hubs, bundled payments and chronic care activities. A significant section of the PPACA focuses on "dual eligibles", i.e., those individuals who are very poor and at high risk of illness. Most of these demonstrations are geared toward changing the reimbursement in order to change the way in which delivery of care is provided. Because Medicare and Medicaid are such major payers of health care, changes to those programs are ultimately expected to affect private insurance. Challenges were identified, such as the role of the federal government versus that of the states, whether there are enough primary care providers to accomplish the goals, how major health plans will participate and how to influence consumers to take responsibility for their own health care.

Mr. Martinez-Vidal covered population health, prevention and wellness measures contained in the PPACA. This is a big area with significant funding. There is a growing recognition that integration of prevention and wellness into treatment is critical. Public health, behavioral health and environmental issues are seen as big drivers of health care costs. Some ideas that other states have put into practice were detailed in the handout. Specific grants promoting population health, prevention and wellness, including ways in which states can participate, were detailed.

Mr. Martinez-Vidal then discussed transparency and all-payer claims databases. The SCI has issued a policy brief on this topic. The purpose of an all-payer claims database is to provide health care information to many different parties. Created by state legislation, these databases typically include data derived from multiple sources, and they are far more inclusive and consolidated than what is currently available through traditional sources. He identified the uses and benefits of all-payer claims databases. Ten states currently have all-payer claims databases. States vary in how these databases are funded and governed. Stakeholder input should identify and determine how the data will be used.

Finally, Mr. Martinez-Vidal described provisions in the PPACA regarding comparative effectiveness, consumer engagement and health information technology. He concluded his remarks by noting that the rising cost of health care is a major impetus to reform, but little has yet been proven to contain those costs. The PPACA provides an avenue for experimentation to see what works, and it is a rare opportunity for active states.

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

- clarification regarding the differences between a medical home and an existing primary care practice (medical homes provide team-based care);
- whether ACO team members are in the office of the primary care provider (Mr.

- Martinez-Vidal informed the committee that they can be);
- what payments are included in payment reform models and ways in which primary care physicians benefit from these models;
  - the challenges of ensuring quality in an ACO and the importance of performance measurements;
  - the necessity for encryption and extreme attention to privacy when collecting and reporting on health care data;
  - the extent to which patients are able to choose a provider under an ACO;
  - whether changes to reimbursement will automatically generate delivery system changes (probably not);
  - why an all-payer claims database would exclude denied claims (this has been what states with such databases have decided; a state could include denied claims);
  - whether the PPACA includes a "physician compare" web site (yes);
  - what "RBRVS" means (it means "resource-based relative value system", and it is the system by which physician payment rates are determined for Medicaid and Medicare);
  - whether states will have the ability to apply for grants to participate in payment reform demonstrations (yes; the time line for grant applications is not yet known);
  - ways in which tobacco prevention and cessation programs have informed opportunities or models for prevention and wellness efforts;
  - an observation that in the 1970s, the country engaged in unbundling of health care payments, and now that trend is being reversed;
  - clarification that ACOs are intended to be more outcome-oriented than other models;
  - whether ACOs will assume risks; this is a critical issue for those who are trying to figure out how to develop and implement ACOs;
  - an observation that disease management companies have not generated the improved outcomes that were expected and how ACOs will be different (the chronic care management will be done much more locally and personally);
  - what states are doing to establish health insurance exchanges, given all the technical challenges and issues (all states are struggling with the requirements of the eligibility system in an exchange; the possibility might exist for the federal Department of Health and Human Services to develop an "off-the-shelf" system for determining eligibility);
  - whether medical homes serve only patients with chronic care needs, or if they serve everyone (it can be both; different models handle the question differently);
  - the extent to which public health efforts will be enhanced in the PPACA (there are numerous measures in the PPACA regarding public health; Mr. Martinez-Vidal will provide information); and
  - ways in which the medical home team assists the primary care physician to manage care.

A quorum being present, the minutes of the August meeting were approved.

## **Consolidated Environmental Review Act — Steps for Improved Health**

Representative Chasey described the goals of the proposed Consolidated Environmental Review Act as the improvement of public health and the environmental health of communities and the streamlining of a cumbersome and duplicative process. Kitty Richards, Bernalillo County Place Matters Team, provided a summary of a proposed bill, the intent of which is to provide environmental protection across all communities, to use evidence-based science to aid the permit decision-making process and to increase transparency of governmental actions regarding environmental protection. The bill requires an environmental assessment for all projects that require a permit under the federal Clean Air Act, the federal Clean Water Act of 1977 and the state Hazardous Waste Act in order to identify the environmental impact on communities early in the permitting process.

Representative Chasey noted that the bill should reduce lawsuits that emerge due to the lack of transparency and early involvement by communities.

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

- the potential health dangers and economic benefits in reopening the uranium mines in New Mexico (the proposed act would ensure full review of these costs and benefits);
- whether the proposed act would apply to activities occurring on federal and tribal lands;
- clarification regarding the effects of this proposed bill (anything that is required by the listed federal acts);
- the potential for this proposed bill to have a negative economic impact;
- an observation that the nuclear processing facility in New Mexico has generated significant economic development and more than 20 applications are underway to replicate this facility in the state;
- a concern that the proposed bill might discourage economic endeavors coming to New Mexico from other states;
- a request for a list of different permits in the state currently regulated as required by federal law, the type of assessments being conducted and the cost of all of this (this information will be provided);
- the current process in place in the Department of Environment and how this bill would change that (this bill would consolidate the process and eliminate duplication);
- whether the Department of Environment could establish this now without legislation (yes, but currently there is no incentive for it to do so);
- whether this could be part of the Government Restructuring Task Force's (GRTF) work (proponents have viewed this proposal as a means of streamlining a process for stakeholders as well as government);
- a general concern regarding overregulation of businesses;
- consideration by the GRTF regarding the consolidation of the Department of Environment and the Energy, Minerals and Natural Resources Department; and
- clarification that the proposed measure does not increase or change regulations, but that it would merely require an environmental assessment and allow communities more input regarding environmental impacts in their neighborhoods.

## **Committee Consideration of Restructuring Options**

Ms. Wells described the complexity of health care financing and administration in New Mexico state government. The presentation included a visual depiction of the effect of certain ideas for consolidation that have been discussed by the GRTF and the LHHS at previous meetings, including the consolidation of the administration of some Medicaid waiver programs from the Aging and Long-Term Services Department into the Medical Assistance Division of the Human Services Department and consolidation of certain functions of the Interagency Benefits Advisory Committee (IBAC) agencies, such as insurance benefits and/or governance. Brent Earnest, analyst, Legislative Finance Committee (LFC), was invited to join the discussion because he and other LFC staff members contributed financial information to the presentation. Following the presentation, Ms. Wells went over a list of ideas mentioned at previous meetings that could be construed as restructuring ideas. The LHHS has been asked to provide recommendations on restructuring to the GRTF for consideration at the GRTF's September meeting.

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

- the amount of funding in DWI block grants (the amount for the current fiscal year is approximately \$10 million);
- the way in which Texas manages prison health and whether that approach could be replicated in New Mexico;
- a request to move slowly on restructuring to allow time to evaluate the impact of the PPACA;
- a request to revisit the requirements of HB 666, passed in 2003, which requires reporting of prescription drug information;
- recognition that a failure to act on the IBAC consolidation could result in cuts to benefits for recipients as budget cuts are implemented;
- an observation that many health care programs and services, especially Medicaid, exist in silos and could be centralized;
- whether behavioral health services could be put back into the Salud! Program to eliminate the contract with a statewide entity for behavioral health;
- the extent to which the IBAC agencies would benefit from a common actuarial analysis;
- whether savings could be achieved through consolidation of health care rules and regulations; and
- a reluctance to vote on any ideas without full information and an assessment of the unintended consequences of such a vote.

Anna Otero Hatanaka, executive director, Association of Developmental Disability Community Providers (ADDCP), stated that the ADDCP feels strongly that the developmental disabilities (DD) waiver should be kept in the Department of Health and administered with other related disability programs.

After an attempt to vote on ideas to be presented to the GRTF failed, the committee decided not to take action at this time.

## **Public Comment**

Deborah Dennison read a letter from a consumer who experienced a poor transition from a nursing home to the Coordination of Long-Term Services (CoLTS) Program waiver and a lack of sufficient services in the community.

Ms. Hatanaka told the committee about the ninetieth birthday celebration of former New Mexico Representative J. Paul Taylor in Mesilla, New Mexico.

Ellen Pinnes noted that the state law called Money Follows the Person in New Mexico Act (MFP) is a model for moving people from institutions into the community by taking the money being spent by the state to cover their care in an institution and using that money to cover their care in the community. She said that the state has refused to implement the MFP. Instead, the state is using a mechanism called "community integration" to accomplish this, which does not increase the number of people being served in the community. The PPACA has a provision to fund a new iteration of grants for the MFP, and New Mexico can apply.

Representative Espinoza suggested that the state be called to task regarding its refusal to implement the law. She moved that a letter be written to ask the responsible departments why they are not implementing the MFP. The motion was seconded by Senator McSorley and adopted by the committee.

Gail Thompson thanked the committee for thinking about ideas to restructure and said she appreciates the position that restructuring should not be rushed. She recommended that the committee take the time to study the PPACA and what other states have done. She also provided personal testimony about an experience she had that resulted in one overnight stay in a hospital and a charge of \$10,000. She urged the committee to incorporate best practices and stop wasting money by overtesting and overtreating patients.

## **New Mexico State University (NMSU) and the Future of the Health Care Work Force**

Telahun Adera, Ph.D., dean, College of Health Sciences, NMSU, addressed what NMSU is doing in response to provisions in the PPACA and what the state can do to take advantage of its opportunities. He spoke briefly about what NMSU is doing to address work force needs and the future. Dean Adera spoke about the history of public health in the country and in New Mexico. He identified some successes and failures in past initiatives. Health disparities remain, with New Mexico standing at thirty-first out of the 50 states — a decline from 2008 when the state was thirty-eighth in the nation. Poor graduation rates, poor child health, high numbers of uninsured people and poor prenatal care are contributing factors. He noted that the cost to the state of obesity alone is \$430 million per year. The PPACA promises much change, especially in ensuring greater access to insurance and care. The law offers unprecedented opportunities to highlight prevention and wellness and put it in the forefront. It includes many measures to increase the size of the health care work force. As a state, New Mexico can focus on Title 4 (prevention of chronic disease and improving public health) and Title 5 (health care work force). NMSU has been training health care professionals in various ways; it has more than 30 degree programs related to health care. The College of Health and Social Services offers pre-dental,

pre-pharmacy, nutrition, training of health educators, counseling and psychology and social worker degrees.

Pamela Schultz, Ph.D., interim director, School of Nursing, NMSU, noted that NMSU offers a bachelor of science in nursing degree plus three online nursing programs. NMSU was the first school in the state to establish a doctorate of nursing in clinical psychiatry; however, the program has not been implemented due to lack of funding. The need for this program is crucial in the southern part of the state.

Questions and comments from the committee included the following:

- clarification on how implementation is being held up (the LFC must review and approve the funding request);
- whether there has been any effort at NMSU to examine why people leave the health care field (no concerted effort to examine this has occurred, but it is a concern; in the field of nursing, the working environment has become a more critical factor than salaries);
- whether NMSU students are being denied admission to the University of New Mexico (UNM) School of Medicine and then go elsewhere (there have been some denials, but Dean Adera does not know if there has been a systematic effort to refuse acceptance to NMSU students; he can provide this information);
- a suggestion that NMSU be demanding regarding its funding for health care programs in order to be able to fill jobs and create economic opportunity in the state (NMSU was urged to make a strong case about the need for a program in clinical psychology); and
- whether NMSU has applied for any work force grants (it has applied for a rural work force grant program for nurses' training for \$3.6 million over five years).

### **Medical Homes: Background, Opportunities in the PPACA and New Mexico's Experience**

Nancy Eisenberg, a public health student at UNM who is serving a practicum with the LCS, provided information about the development of medical homes in New Mexico. She identified the interviews she conducted, noting that she provided the names of interviewees in an attachment. She described medical homes, where they are located and how they earn recognition by the National Committee for Quality Assurance (NCQA). The NCQA identifies three levels of recognition to become a medical home site. One drawback to the NCQA is that it does not recognize nurse practitioners as primary care providers, as provided for in New Mexico law. The PPACA does not mandate using medical homes, but it provides funding for several demonstration projects. Ms. Eisenberg discussed findings from her interviews, noting leadership is needed at all levels to move forward on implementing medical home models of care. It is challenging to develop such a model in rural areas of the state. Payment is an important and unresolved issue. There are successful models in other parts of the country that can serve to guide New Mexico in this effort.

Questions and comments from the committee included the following topics:

- whether medical homes in New Mexico are multipayer (the Taos model has multiple

- payers); and
- whether medical homes will result in shared savings (Dr. Sun of Molina Healthcare mentioned that Molina is interested in pursuing pay for performance and shared savings).

There being no further questions, the committee recessed at 5:10 p.m.

### **Wednesday, September 1**

The committee reconvened at 8:45 a.m. The chair announced that the meeting was being webcast. Members of the committee and staff introduced themselves.

#### **Native Americans and the PPACA**

Alvin Warren, secretary, Indian Affairs Department (IAD), greeted the committee in his native language. He reminded the committee of tragic health problems that persist among Native American populations and the federal trust to provide health care to Indian tribes, pueblos and nations in the country. Despite that responsibility, it is well-documented that the Indian Health Service (IHS) continues to be severely underfunded. He noted that the state has an opportunity to hold the federal government accountable in this area.

Health care is one of the four top priorities of the IAD, Secretary Warren said. He identified five areas in which the PPACA will have the largest impact on states and their Native American populations: (1) health exchanges; (2) Medicaid and the Children's Health Insurance Program (CHIP, formerly known as the State Children's Health Insurance Program, or SCHIP); (3) the IHS; (4) the federal Indian Health Care Improvement Act; and (5) grant opportunities for Native Americans, tribes and tribal organizations. The establishment of health insurance exchanges will benefit Native Americans by providing special monthly enrollment periods; by eliminating cost-sharing for Indians enrolled in insurance through the exchange as well as through the IHS; and because there will be no penalties for a failure to carry minimum coverage.

Lisa Marie Gomez, policy analyst, IAD, discussed provisions related to Medicaid and CHIP that are relevant to Native Americans. The IHS, Indian tribes, tribal organizations and urban Indian organizations are identified in the PPACA as eligible to serve as "express-lane agencies", thereby facilitating the enrollment of Indian children into CHIP. Grants are available to fund outreach and enrollment efforts. The IHS is identified in the PPACA as the payer of last resort, and the sunset provision for Medicare Part B services furnished by IHS hospitals and clinics is eliminated by the act. Ms. Gomez noted that the PPACA permanently authorizes the Indian Health Care Improvement Act. Among the provisions in this act are direction to the IHS to establish comprehensive behavioral health, prevention and treatment services; authorization for hospice, assisted living, long-term care and home- and community-based services; and updates to current law regarding collection of reimbursements from Medicare, Medicaid and CHIP by Indian health facilities.

Secretary Warren highlighted PPACA provisions that expand the Community Health

Aide Program (CHAP), allowing Indian tribes to elect to implement a dental health aide program, as has been done in Alaska. Grant opportunities that can benefit Indian tribes include funding for maternal and child health services (three tribes have applied) and trauma centers and to strengthen and improve tribal primary care and other work force occupations. He concluded that, as a member of the executive health reform leadership team, he made sure that specific goals were included in the strategic plan. First, grant opportunities should be coordinated to address Native American needs and disparities. Second, tribal consultations should occur as state agencies pursue policies that will have an impact on Native Americans. Third, state agencies should address actions to implement the PPACA. Finally, an ad hoc work group should be established to ensure adherence with and effective implementation of the Indian Health Care Improvement Act.

Three general recommendations were offered to committee members: (1) read the strategic plan; (2) be mindful of Native American provisions in legislation; and (3) inquire about and hold state agencies accountable for coordination with tribes.

Questions and comments from the committee covered the following areas:

- whether the migration of tribal members to other states will be affected by this act (the PPACA does not address this; special enrollment periods in exchanges might mitigate the problem);
- whether restructuring proposals being considered by the GRTF will help or harm Native Americans (Secretary Warren is not aware of any proposals affecting the IAD);
- whether Native American businesses will be obliged to provide health insurance to workers (this is not known yet);
- whether the Bernalillo County Off-Reservation Native American Health Commission will be able to serve as an "express-lane" enrollment entity (probably not, as it is a county-based entity and is not mentioned in the act);
- clarification about other individuals who are exempt from the requirement to obtain health insurance (e.g., those who are incarcerated, those with economic hardships and others);
- clarification regarding the percentage of Indians who receive health care services primarily through IHS facilities (Secretary Warren will try to obtain this information);
- whether measures have been taken to increase the Native American work force (not at a state level due to budgetary considerations);
- what behavioral health services are needed for Native Americans in New Mexico (many recommendations have been made through the Interagency Behavioral Health Purchasing Collaborative, and negotiations are underway with OptumHealth; substance abuse and suicide are critical issues, and a greater commitment to their prevention is necessary; the Native American treatment delivery system needs to be recognized as a best practice and thus be eligible for reimbursement);
- whether the IHS system is adequate and if it is comparable to other providers (many IHS facilities are good, but they are faced with challenges due to lack of funding; there remains a lack of services and a lack of providers);

- whether tribal representatives are working with the newly created Office of Health Care Reform (yes); and
- whether the education system is sufficient to train a Native American health care work force (Indian youths have a graduation rate below 50%; recruitment into health care career paths must start before the end of elementary school).

### **UNM Health Sciences Center (UNM/HSC) and the Future of the Health Care Work Force**

Paul Roth, M.D., executive vice president for health sciences, UNM/HSC, began with a review of the programs and schools at the UNM/HSC to train health care professionals. He provided information regarding known and projected shortages, noting that New Mexico will need 6.5% growth per year in primary care physicians to have an adequate supply by 2035. He provided updated information on students enrolled in the UNM School of Medicine's Bachelor of Arts-to-Medical Doctor (BA/MD) Program, two-thirds of whom are from rural New Mexico. In order to fund the continuation of the BA/MD program, the UNM/HSC is requesting funding of \$732,900. Dr. Roth highlighted a new part of the curriculum of the school of medicine, called poverty medicine, in recognition that socioeconomic issues greatly affect health and the subsequent treatment for illness. The UNM/HSC has developed the first public health certificate program in the nation to be required of all medical school students. The focus of the program is disease prevention, health promotion, health policy development and other elements of a public health curriculum.

Dr. Roth noted that the UNM/HSC is striving to maintain the physician assistant program despite severe budgetary constraints. He provided information regarding the critical need for dentists in New Mexico, especially for Navajo children. New Mexico subsidizes nine dental students per year through the Western Interstate Commission on Higher Education, and the UNM/HSC developed a dental residency program in 2004; 37 residents have gone through the program since then. Dr. Roth described plans to increase the number of dentists, which include the creation of a bachelor of arts and regional doctor of dental surgery degree and, when feasible, the establishment of a dental school. He provided information about nursing shortages in the state. New Mexico ranks last in the nation for registered nurses per 100,000 population. The UNM/HSC estimates that more than 100 additional faculty members are needed to address the shortage. The goal is to train more advanced practice nurses. He highlighted the partnership with NMSU for a cooperative pharmacy program and noted that 91 students are enrolled for the fall semester in the College of Pharmacy program at UNM. Allied health professionals are being trained in a variety of programs, including physical therapy, occupational therapy, dental hygiene, emergency medical services, medical laboratory sciences and radio/nuclear imaging.

Dr. Roth identified a capital request of \$11,250,000 to complete the Domenici Center for Health Sciences Education and a program request for \$732,900 for the seventh year of the BA/MD program. In conclusion, he identified underlying objectives for the PPACA that serve to increase health insurance coverage, alter reimbursement for providers to focus on quality and cost, address the health professional shortages, invest in wellness and prevention and cut waste in the system. He noted that the UNM/HSC has established work groups to track grants, guidance and development of regulations in the areas of Medicaid and insurance reform, value-

based performance, the work force and alternative delivery models. Seminars and retreats are planned to address these areas.

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

- concern that New Mexico is not well represented regionally in the numbers of doctors trained at the UNM/HSC who are practicing in underserved areas (geographic maldistribution is an ongoing concern; many approaches have been tried to address this, but it remains a problem; the UNM/HSC does not control where graduates will practice);
- whether a dental school must be located in Albuquerque (it does not have to be; it will just cost more to hire additional faculty to locate it elsewhere);
- concern regarding the effect of the PPACA provision imposing penalties for readmission to a hospital and whether the PPACA addresses the behavior of patients that leads to readmission (the regulations and details have not yet been developed);
- concern regarding the lack of dental care for Navajo children;
- clarification regarding the need for increasing the nursing faculty (the projections are based on estimated future retirements coupled with the number of qualified applicants the school is currently not able to accept);
- whether provisions in the PPACA will unduly reduce reimbursement to physicians (the goal of the act is more focused on increasing the size of the primary care work force);
- concern regarding a negative impact on specialty care physicians and whether the supply of specialty care physicians will be reduced as a result of the PPACA (reimbursement for hospitals and physicians should reflect patient acuity);
- whether the UNM/HSC can require community service as a condition of graduation (Dr. Roth stated that he does not think so);
- the percentage of medical students who go into the practice of primary care medicine (about half; however, the number is declining in New Mexico and nationwide);
- ways in which public health and the poverty-in-medicine curriculum are integrated into practice (students do rotations in clinics; further details will be provided);
- where pharmacy students are coming from and what is known about their future plans (information will be provided);
- the importance of developing a pipeline into health care professions beginning in middle school and high school (the PPACA has funding opportunities that the UNM/HSC is seeking to use to reinvigorate that pipeline; it just received a grant to work with Indian children);
- whether geriatric medicine is being offered or promoted at UNM (fewer students are electing this as a specialty nationally; the new trend is to build geriatrics into primary care training in medicine as well as in nursing);
- a request for specific information regarding the number of applicants from Chaves County who are denied admission at the UNM School of Medicine (Dr. Roth noted that more than 225 New Mexicans apply and the school is only able to accept 75);
- whether penalties regarding readmission to a hospital will apply to behavioral health readmissions (behavioral health is not included right now; further details will be

- forthcoming in the regulations);
- clarification regarding clinical pharmacists and their role (pharmacists who undergo additional training and certification can obtain prescriptive authority); and
- a request for an update on Project ECHO (this telehealth program is very successful and ongoing; it has been expanded to incorporate 10 or more clinical conditions that can be treated; Dr. Sanjeev Aurora received an international award for developing this program and technology).

### **Accountable Health: The Hidalgo Proposal and Institute for Healthcare Improvement (IHI) Support of Learning**

Charles Alfero, M.A., chief executive officer, Hidalgo Medical Services (HMS), offered a brief overview of the array of services provided at HMS. HMS cares for approximately 50% of the population of Hidalgo and Grant counties in the southwest corner of New Mexico. He described four components of an effective health care delivery system as prevention, diagnosis, treatment and management of care. He identified the current payment paradigm as one that mostly benefits expensive procedures and pays the least for primary care under a relative value system. This system results in a spiraling cost cycle wherein subspecialty training and high cost procedures are encouraged. One way to change this paradigm is to focus more on health care outcomes and to have goals to keep people healthy and out of hospitals. The HMS initiative, called accountable health services, places greater emphasis on prevention and care management to address patient health, health care costs, community priorities and population health. In order to pursue this goal, HMS has joined the IHI "triple aim" collaborative, a program dedicated to the pursuit of population health, enhanced individual care and controlled costs. He identified national and international sites that are prototype sites for the triple aim project. The project focuses on three dimensions of value: population health, experience of care and per capita cost. Mr. Alfero described the design of a triple aim enterprise. He provided an example of one such enterprise: an entity in Bolton, England, that established disease registries to allow intentional focus on specific diseases. This entity was successful in reducing hospital admissions for myocardial infarction threefold.

Mr. Alfero described the organizational focus of HMS, which involves patient self-management, primary care redesign, prevention and health promotion, integration and linking and cost control at the population level. He noted that high school graduation is the single most important predictor of the cost of health care. HMS has been successful in reducing teen pregnancies, and Mr. Alfero noted that the rate of teen mothers attending college has risen in the counties served by HMS. Working with two of the Salud! entities, HMS was successful in reducing by 72% the cost of the most expensive Medicaid care and services. The IHI model is predicated on change happening at the organizational level. HMS is learning to set measurable goals and measure results. Elements of a triple aim site were described. Mr. Alfero is interested in developing legislation that would use HMS as a pilot site to carve out the populations HMS serves, to require HMS to apply for a Medicaid waiver to serve that population and to test the triple aim model. He supports holding HMS accountable for outcomes of care. HMS would continue to provide all core services, and it would commit to capitated payments utilizing a primary care team. There are development costs, and HMS would like legislative support to

cover them.

Committee members had questions and comments in the following areas:

- whether HMS is applying for federal PPACA grant money (yes);
- whether state legislation is needed in support of HMS grant applications (legislative support is needed to promote the triple aim model, much like the legislation requiring the establishment of medical homes under Medicaid);
- clarification regarding contracts with Salud! managed care organizations (MCOs); HMS has contracts with all the Salud! MCOs but has special contracts with two of them to manage the health care costs of high-cost patients;
- whether the HMS model will ultimately result in a different mix of needed health care providers (nationally, there is a need to move toward a mix with more primary care physicians and fewer specialists);
- whether there is the potential for group outpatient counseling for drug-addicted youths at federal qualified health centers after hours;
- clarification regarding how the graduation and college entry rates were raised for teen mothers (HMS works collaboratively with the educational system and promotes child care, home schooling, child development and other things that will keep children in school); and
- clarification regarding the waiver that HMS is seeking (the reference to a waiver was hypothetical; any reform that involves Medicaid might require a waiver).

### **Behavioral Health and Health Professional Managed Care Concerns and the Proposed Amendment to the Patient Protection Act**

Hannah-Leigh Bull, M.A., licensed marriage and family therapist, described the purpose of the state's Patient Protection Act, which is to regulate aspects of managed health care and specify patient and provider rights. Senator Ortiz y Pino has agreed to sponsor an amendment to that act to strengthen the protections to all health care providers and their patients. Behavioral health providers today are facing serious challenges at the hands of the MCOs, resulting in provider staffing and financial hardship issues. Among the challenges are recoupment at a much later date than payments previously received; problems with timeliness and denial of claim payments; the burden of multiple credentialing requirements; and technological and other administrative requirements. Problems are exacerbated in rural areas and safety net facilities by the long distances providers must drive, by a fragile rural health care infrastructure and by difficulties ensuring continuity of care for seriously mentally ill patients. Some providers are experiencing stress and burnout, and provider turnover is high.

Ms. Bull described the proposed amendments, which will require real-time reporting of managed care data, especially claims data, and stronger notification and appeal rights for recoupments. The amendments establish communication protocols and streamline the credentialing process with uniform, online credentialing applications. MCOs would be required to provide immediate technical assistance for providers building information technology infrastructure and to ensure ongoing training. Providers would be reimbursed for administrative tasks required by MCOs. A managed health care ombudsman office would be created to

investigate and resolve provider complaints. These amendments are being proposed as a means of sustaining the network of rural and safety net providers and to maintain continuity of care for patients.

Dora Wang, M.D., licensed psychiatrist and assistant professor at the UNM/HSC, spoke in favor of the proposed legislation to amend the state's Patient Protection Act. She summarized the complex and costly process by which providers get reimbursed by MCOs and how the advantages all appear to rest with the MCOs. She elaborated on what she characterized as a tedious mechanism for obtaining prior authorization to provide care. MCOs do not need to deny claims if they do not approve them in the first place, Dr. Wang said. She asked for legislative support to give health care providers more protection. Dr. Wang described the history of health care in the nation and in New Mexico. She contends that health care does not work in a free market system. She provided an example of a physician whose practice and patients suffered under a for-profit system of reimbursement. In her personal experience, the care at the UNM Mental Health Center likewise suffered. John Hyde, a former patient of the physician previously described, shot five people, leading to consideration of Kendra's Law requiring mandatory outpatient treatment. Dr. Wang feels the impact of changing the health care system to a for-profit system is demonstrated by these examples. According to one study, managed care in a for-profit environment has led to much poorer outcomes for those suffering with mental illness. These and other indicators have led her to support the idea that health care providers are in need of protection in order to ensure safe and quality care for patients.

Committee members had questions and comments in the following areas:

- whether this measure should be a separate bill rather than an amendment to the Patient Protection Act (Senator Ortiz y Pino told the committee that he was willing to have it redrafted as a separate act instead of as amendments to the Patient Protection Act).
- a comment that the health care environment for people with mental illness may be better as a result of outreach, education and parity laws;
- an observation that the PPACA has some provisions that protect providers and patients and provides for appeals (on September 23, 2010, a number of provisions will go into effect, including limits on the medical loss ratio and prohibitions on rescissions);
- an observation that the proposed bill needs to be reviewed in light of PPACA changes and a suggestion that the proposers contact the Insurance Division of the Public Regulation Commission (ID/PRC) with these questions;
- Ms. Pinnes testified that some of the requested measures are already addressed in the current law; the issues may be more of a need for enforcement than a need for new legislation;
- an agreement that the system for reimbursing mental health care providers has failed and a reminder that OptumHealth was fined \$1 million for its mistakes;
- a reflection that John Hyde is not the best "poster boy" for reform of the mental health system;
- agreement that a measure like this is necessary, but in a separate bill;

- an observation that whatever happens to harm providers has an effect on patients as well;
- an observation that the Patient Protection Act includes all the definitions that are needed for this measure;
- clarification regarding the percentage of patients that are Medicaid recipients; Ms. Bull stated that about 50% of her patients are Medicaid recipients;
- whether Medicaid is subject to the Patient Protection Act (according to Ms. Pinnes, it is; yet over the years, various Medicaid directors have ignored that provision);
- a suggestion that careful review be conducted of the existing Patient Protection Act and regulations pursuant to that act with the ID/PRC, and whether the law is being enforced;
- the need for a common credentialing process (this measure might be better handled in a separate bill);
- commendation for Dr. Wang's book;
- clarification regarding the reasons given for recoupment (lapsed policies after prior authorization was granted);
- an observation that MCOs do not reimburse interpreters for deaf people in need of mental health services; and
- the importance of working with the New Mexico Medical Society and others on the bill.

### **Public Comment**

Dr. Bill Weise commented that in his personal experience with the UNM Family Practice Clinic, the clinical structure did not meet either the needs of his patients or his ability to provide care for them. In his view, this is a primary reason why physicians leave their practices. Additionally, he has had numerous experiences with physicians "gaming the system" for their own economic gain. He is convinced that it is a widespread problem. The expansion of coverage and the anticipated demand for services will lead to huge problems unless the cost of care can be contained. The issue of system reform has to be addressed. He recommends supporting well-thought-out innovation, such as the HMS proposal; considering a mandate that would lead Medicaid to commit to promoting accountability of care; and revisiting the current "lock-in" of the Medicaid MCOs. Senate confirmations of new cabinet members should hold them to a commitment to accountability. The system of capital investment needs to be restrained.

Katheryn Veilleaux, a family practice provider, said that her credentialing process took a year before she could get reimbursed for services. Additionally, Presbyterian Health Plan has resisted paying for some of her clients, stating that the clients were not eligible at the time of care.

Paula Ingerson, a nurse practitioner, expressed support for the proposed legislation. Accounting challenges keep her up until 1:00 a.m. each night; she would prefer to take care of patients.

There being no further business, the committee adjourned at 5:10 p.m.