

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

**July 6-8, 2011  
Taos**

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

**Present**

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

**Absent**

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

**Advisory Members**

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

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

**Guest Legislator**

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

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

**Staff**

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

**Guests**

The guest list is in the meeting file.

**Handouts**

Copies of all handouts are in the meeting file.

**Wednesday, July 6****Call to Order**

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

**Native American Health Concerns**

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

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

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

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

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

Priscilla Caverly of the Office of Health Care Reform (OHCR) in the Human Services Department (HSD), stated that the HSD will protect Indian Health Service (IHS) and self-governed tribal "638" entities established pursuant to the federal Indian Self-Determination and

Education Assistance Act of 1975 (Public Law 93-638) from cost-containment measures that will affect other populations. Ms. Caverly stated that there has been no OHCR director since Governor Susana Martinez took office, and the governor has discussed the possibility of absorbing OHCR into the Governor's Office. The committee asked whether the governor is opposed to health care reform. Ms. Caverly responded that the governor, in vetoing SB 38 (2011 regular session), said that she supported the health insurance exchange and health care reform but wanted more information.

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

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

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

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

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

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

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

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

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

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

Ms. Spruce-Bly then listed some possible solutions:

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

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

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

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

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

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

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

### **Native American Suicide Prevention**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Public Comments**

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

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

The meeting recessed at 6:00 p.m.

### **Thursday, July 7**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Friday, July 8**

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

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

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

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

#### **IT at DOH**

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

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

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

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

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

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

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

### **Funding Cuts Affecting DOH**

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

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

### **Medical Marijuana**

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

### **Tobacco Settlement Funds**

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

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

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

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

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

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

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

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

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

## **Public Comment**

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

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

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

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

### **Consumer Stakeholders Group**

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

### **Insurance Stakeholders Group**

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

### **Medicaid Stakeholders Group**

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

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

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

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

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

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

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

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

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

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

### **Further Stakeholder Input Solicited**

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

### **Health Insurance Exchange Deadlines**

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

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

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

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

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

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

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

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