

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

**July 9-10, 2012
Ralph Edwards Auditorium
400 W. Fourth Street
Truth or Consequences**

The second meeting of the Legislative Health and Human Services Committee was called to order by Senator Dede Feldman, chair, on July 9, 2012 at 10:07 a.m.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair
Rep. Nora Espinoza
Sen. Gay G. Kernan
Rep. Dennis J. Kintigh
Sen. Linda M. Lopez
Rep. Antonio Lujan (July 9)
Sen. Gerald Ortiz y Pino

Absent

Advisory Members

Sen. Rod Adair (July 9)
Rep. Ray Begaye (July 9)
Sen. Stephen H. Fischmann (July 10)
Rep. Miguel P. Garcia
Sen. Cisco McSorley (July 9)
Rep. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. John C. Ryan (July 9)
Sen. Bernadette M. Sanchez
Rep. Mimi Stewart

Sen. Sue Wilson Beffort
Rep. Eleanor Chavez
Rep. James Roger Madalena
Sen. Sander Rue
Rep. James E. Smith

Guest Legislator

Rep. Dianne Miller Hamilton (July 9)

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

Additional guests are recorded on the guest list in the committee file.

Staff

Michael Hely, Legislative Council Service (LCS)
Shawn Mathis, LCS
Rebecca Griego, LCS
Melissa Candelaria, LCS

Handouts

The following handouts are in the meeting file:

1. ECHO project — Extension for Community Healthcare Outcomes;
2. Project ECHO Map;
3. Project ECHO Center for Medicare & Medicaid Innovation Project Abstract;
4. New Mexico CHW/CHR Scope of Practice: Roles and Related Tasks;
5. Josh Ewing, State Legislator Magazine, *Rural Rx: A program developed in New Mexico may change how health care is delivered in rural America* (May 2012);
6. Leavitt Partners, New Mexico Legislative Health and Human Services Committee (July 9, 2012);
7. New Mexico Department of Information Technology, *New Mexico Broadband Program Health Initiatives*;
8. NMHIC Handout;
9. Molina Medicaid Managed Care: Telehealth and Innovations in Coordinated Care;
10. New Mexico Legislative Council Service Information Bulletin (July 6, 2012);
11. Chart of Changes to New Mexico Law as a Result of PPACA;
12. The Lewin Group, *The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending*;
13. Buettgens, Dorn and Carroll, *Consider Savings as Well as Costs — State Governments Would Spend at Least \$90 Billion Less With the ACA than Without It from 2014 to 2019*;
14. Southwest Women's Law Center, *Understanding the Affordable Care Act: Consumer Protections for Insured New Mexicans*;
15. Senator Jeff Bingaman Health Reform 2012, *Health Reform Two Years Later: Benefits to New Mexico*;
16. Domenica D. Rush, *Meeting Meaningful Use at SVH*; and
17. NM HITREC Presentation.

Monday, July 9

Welcome and Introductions

Senator Feldman called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

Project ECHO — Extension for Community Healthcare Outcomes

Dr. Sanjeev Arora, professor of medicine (gastroenterology/hepatology), Department of Medicine, University of New Mexico Health Sciences Center, and director of Project ECHO, and Erika Harding, the education and outreach manager of Project ECHO, gave an update on this innovative and internationally recognized model for expanding access to the medically underserved. Dr. Arora explained that, while Project ECHO originally focused on training rural

health practitioners to treat and manage hepatitis C, the model has now been expanded to address 19 separate disease areas, including: cardiac risk reduction, asthma, prevention of teenage suicide, palliative care, rheumatology, chronic pain, substance abuse, high-risk pregnancy, complex care, HIV, geriatrics/dementia, Prison Peer Educator Program, childhood obesity and antibiotic stewardship.

The Project ECHO model uses multipoint video conferencing and internet technology to leverage scarce health care resources. Patient outcomes are improved by reducing variation in care, as rural practitioners attending weekly video clinics learn "best practices" through co-management of patients with a team of University of New Mexico Health Sciences Center specialists. Patient outcomes are monitored via a federal Health Insurance Portability and Accountability Act-compliant web-based database that provides data to monitor both outcomes and program effectiveness.

In addition to benefiting patients, Project ECHO benefits participating rural clinicians by providing no-cost continuing medical and nursing education required to maintain professional credentials. Further, it addresses the most common complaint of rural providers: professional isolation. Through Project ECHO, rural clinicians regularly consult and collaborate with similarly situated peers and a multidisciplinary team of medical and behavioral health specialists. This, in turn, creates "knowledge networks".

Dr. Arora described Project ECHO as "building bridges" among the University of New Mexico Health Sciences Center, the Department of Health (DOH), private practitioners and community health centers. Using existing community clinicians, it is a force multiplier. Currently, Project ECHO has over 400 points of contact throughout New Mexico. The Project ECHO model has been successfully replicated in the federal Veterans' Health Administration (chronic pain, diabetes, congestive heart failure and hepatitis C), in the United States Department of Defense (chronic pain), the University of Chicago (difficult to treat hypertension), in other states and in several foreign countries.

Importantly, a peer-reviewed study published in the *New England Journal of Medicine* found that treatment outcomes for Project ECHO hepatitis C patients are as good as those of patients who are treated in person at the University of New Mexico Health Sciences Center. Additional findings were that outcomes for Project ECHO patients exceeded national success rates. According to Dr. Arora, an important factor in these favorable outcomes is eliminating the need for the patient to travel outside the patient's community for treatment. Furthermore, the savings associated with reducing patient travel are significant. Most recently, Project ECHO received a grant from the Center for Medicare and Medicaid Innovation (CMMI) for a complex disease pilot study to improve the quality of care for 5,000 of two states' (Washington and New Mexico) most expensive Medicaid patients while achieving an estimated cost savings of 10%.

Next, Ms. Harding told the committee about the use of the Project ECHO model to train paraprofessionals, also referred to as "community health workers" or "promotores" or "community health representatives". This "emerging work force" is composed of persons

already embedded in medical care settings in local communities. Project ECHO trains these embedded health care workers to provide social support and advocacy for patients with diabetes and complex medical conditions. This training is currently offered for free, via short face-to-face and telehealth training over a period of six months. The goal of the program is to train teams, not just individuals. It requires ongoing participation and training, and trainees are tested. Community health workers in the diabetes program are predominantly Native American, Hispanic and African American. To date, Project ECHO has trained nearly 100 community health workers in 32 New Mexico communities. Project ECHO also conducts similar programs on prisoner health (to address hepatitis C and HIV prevention in the prison population) and retinopathy screening.

Dr. Arora reminded the committee that, during the economic downturn, Project ECHO's state funding suffered a "massive cut". He noted that, while Project ECHO is compensated for consulting with other states and countries to build programs based on the Project ECHO model, it lacks sufficient funding to keep its work going in New Mexico.

Questions and Requests from Committee Members

*In response to a question from a committee member, Dr. Arora requested restoration of Project ECHO's pre-2008 annual appropriation of \$2.5 million. A motion that the committee endorse the restoration of, or an increase over, Project ECHO's pre-2008 funding carried.

A member asked Dr. Arora whether Project ECHO is having difficulty accessing non-state funding sources. Dr. Arora indicated that all New Mexico programs had been put on hold, with expansion slowed. When available, Project ECHO attempts to obtain charitable foundation funding and was able to replace recent cuts in state funding with funds from the Robert Wood Johnson Foundation. However, this funding will end in Fall 2012, and it is not expected to be renewed. According to Dr. Arora, most Project ECHO private funding now comes from outside the United States; he expressed concern that Project ECHO not become a strictly international phenomenon.

A member asked how the Patient Protection and Affordable Care Act (PPACA) will impact Project ECHO. Dr. Arora stated that the federal government is very interested in the Project ECHO model with respect to the expansion of Medicaid. Dr. Arora predicts a dire shortage of primary care practitioners. He stated that chronic disease management is a "team sport", so training paraprofessionals will be critical. Project ECHO can play a key role in expanding the state's capacity to train these health workers.

A member requested more information about the CMMI grant. Dr. Arora explained that the total award is \$8.5 million, of which \$1.5 million will go to Project ECHO. The pilot is expected to save \$300 million over three years.

A member asked about challenges unique to the Native American community. Dr. Arora explained that, while the federally qualified health center system has good broadband coverage, connectivity is a problem for the Indian Health Service and Native American health clinics. He

assured committee members that, if state funding is restored, Project ECHO would "go all out" to engage with Native American health services. This would include offering medical education to Indian Health Service providers.

A member complimented Dr. Arora on Project ECHO's success, recommending that those who have benefited from its programs be encouraged to contact their state legislators to remind them of the cost savings, continuing education provided, providers helped and consultations made. The member also urged Project ECHO to seek legislative support to expand its training to high school students.

Another member asked about Project ECHO collaborating with community colleges. Dr. Arora stated that many community colleges do train community health workers, but that funding has also been a challenge for these institutions. Further, Project ECHO's focus is training community health workers who are in communities that are too small to have a community college. Dr. Arora added that there needs to be reimbursement for services provided by community health workers.

*A member requested more information about community health worker training programs available at community colleges around the state to ensure that these programs receive support.

Human Services Department Report on the Health Insurance Exchange

Sidonie Squier, secretary of the Human Services Department, and Dan Schuyler, director of Leavitt Partners, appeared before the committee to report on the state's plan to establish a health insurance exchange under the PPACA. According to Secretary Squier, the administration has decided that federal election year uncertainty combined with forecasts for a shrinking federal budget make reliance upon the federal government to operate an insurance exchange "dicey". Since New Mexico has the second-highest uninsured rate in the country, the administration intends to act decisively by establishing an insurance marketplace for consumers to access vital health insurance information. Insurance companies will offer products and compete on the basis of price and quality.

Secretary Squier advised that New Mexico's exchange will operate differently than a federal exchange. The state's approach will be to build component parts of the exchange on a phased basis, for one-stop shopping. Phase I will build the four core components of the exchange to comply with federal requirements. She emphasized that the exchange will not be created in a vacuum; it is part of overall health reform. The exchange will increase transparency, improving the payment and delivery system. Over the next six to eight months, the department plans to engage stakeholders in more meaningful ways. A New Mexico Health Insurance Exchange Task Force has been established. The New Mexico Health Insurance Alliance should remain central to the planning. It will be an exchange designed by New Mexico, for New Mexico.

Leavitt Partners has been hired by the department to assist in setting up the state-based exchange. Mr. Schuyler provided some details regarding the proposed exchange. It will work like online travel retailers Travelocity or Priceline. It will be open to all insurance carriers

licensed in New Mexico. Leavitt Partners deliverables include: 1) program integration and cost allocation (April 2013); 2) stakeholder consultation (April 2013); 3) health insurance market reforms (April 2013); 4) establishment of a grant application plan (June 2013); and 5) technology procurement assistance (September 2013).

Questions and Requests from Committee Members

*A member asked Secretary Squier several questions in an effort to find out how many uninsured New Mexicans would qualify for and use a state-based insurance exchange. Secretary Squier stated that state and federal employees, and those covered by Medicaid, would not qualify for the exchange. The member expressed concern that the expense to establish a state-based exchange might not be justified given the number of end users.

The member asked Secretary Squier how much it would cost to build the exchange. Secretary Squier stated that estimates are from \$25 million to \$40 million to build in all the PPACA requirements and \$100 million to build the exchange "from the ground up".

The member also asked how many people a day would be using the exchange. Mr. Schuyler stated that under a limited or soft launch, several thousand persons a day would use the exchange. He stated that there would be "a question of resources" on the customer service side.

The member asked how many people per day would be using the exchange once it is built. Mr. Schuyler stated that it would depend on how well the state advertises the exchange. Qualified consumers would check into their plan, so this could add up to several million transactions.

The member criticized the department for going forward with a state-based exchange before making a determination of how many New Mexicans will actually qualify for, and use, the exchange. The member stated that he does not believe that participating in the federal exchange is ill-advised if more than half of the state is already participating in federal health insurance programs (Medicaid, Medicare and federal workers). Secretary Squier stated that the information on the number of end users and encounters with the system will be available once the core components of the exchange are built.

Another member stated that her constituents who participate in federal health care programs are satisfied, and if so, why would it not be reasonable to participate in the federal insurance exchange? Secretary Squier replied that the state is "already overwhelmed" by the federal government and that the state "needs to keep some autonomy".

A member asked whether insurance companies that choose not to be listed on the exchange will essentially be out of business. Mr. Schuyler confirmed that federal insurance premium subsidies would only be available for coverage purchased through the exchange.

A member asked how much federal grant money the state has already received to establish the state-based exchange. Secretary Squier stated that New Mexico has received \$34 million, most of which has not been spent yet.

A member asked how much Leavitt Partners is being paid. Secretary Squier said that she thinks the Leavitt contract is for \$1 million.

In response to a member's question about who would operate the exchange, Secretary Squier stated that the New Mexico Health Insurance Alliance would be the site of the state exchange. She stated that she does not envision a large staff for the exchange.

A member noted that, after receipt of the \$34 million federal grant, contracts were on the verge of being let, then withdrawn. The member wanted to know whether the contracts are being rewritten. Secretary Squier confirmed that the contracts are being rewritten because the original request for proposals (RFP) did not fit New Mexico's needs, so Leavitt Partners is rewriting a New Mexico-specific RFP.

Another member stated that the former director of the New Mexico Office of Health Care Reform, Dr. Daniel Derksen, is from New Mexico, that he worked for U.S. Senator Jeff Bingaman and that Dr. Derksen was on leave from the University of New Mexico, yet a Utah consultant [Leavitt Partners] has been hired to create a "New Mexico" RFP. The member stated that he is "astounded" by the secretary's response to the question about the RFP. Secretary Squier responded that Dr. Derksen "had no experience working on an exchange and Leavitt does".

A member commented that it is disingenuous for the administration to continue to take the position that the federal government had not provided sufficient information about the exchange to go forward. According to the member, this same proposal was heard two years ago, so it is apparent that the administration will continue to drag its feet. The state was prepared to advance to level 2 in the establishment of the exchange months ago.

Secretary Squier was also questioned at length by committee members about the department's decision not to include any legislators on the New Mexico Health Insurance Exchange Task Force and the fact that the department has not engaged in any consultation with the legislature regarding the exchange. The observation was made that the legislature had spent a year studying the exchange with input from stakeholders as well as from the administration. Secretary Squier was specifically requested to give legislators a formal role in the task force. A member commented that the failure to consult with the legislature on the exchange could present a constitutional problem. Another member noted that if any legislation is necessary to implement the exchange, there would have to be a special session to pass it if the exchange must be up and running on January 1, 2014.

In response to questions, Secretary Squier stated that she thought that legislation would be necessary to establish the exchange. However, she had no details as to what that legislation

should entail and had not discussed this matter with the governor's office. *A request was made by the committee that the administration provide an answer as to its position on the question of legislation.

When asked how the administration would meet the November 2012 deadline for an exchange "blueprint" or readiness plan as required by federal regulations, Secretary Squier stated that "we will meet it". When asked how requisite legislation to create an exchange would be achieved before November, Secretary Squier stated that while legislation may not be achieved by November, there might be consultation with legislators before November.

A member inquired whether the state exchange would provide plans on both the individual and small-group markets. Mr. Schuyler replied that the exchange would first establish the small-group or "SHOP" exchange because it is "low-hanging fruit". Less technology would be needed to implement this component because the subsidy and individual eligibility and Medicaid interface systems would not need to be in place for the SHOP to operate. The individual market would be established "months later" than the SHOP, according to Mr. Schuyler.

A member asked the panel how much the state would have to pay to operate the exchange. Mr. Schuyler stated that the federal Consumer Information and Insurance Oversight Agency could not provide the state with an answer to that question.

A member asked what role the Insurance Division of the Public Regulation Commission (PRC) is playing in the exchange. Mr. Schuyler indicated that the department is working in partnership with the Insurance Division.

Review of New Mexico Broadband Program and Health-Related Applications

Gar Clarke, New Mexico Geospatial Program manager, New Mexico Broadband Program manager and agency tribal liaison for the Department of Information Technology, reported on the status of the state's broadband strategy. According to Mr. Clarke, the goal of the program is broadband availability and adoption for every New Mexican. This is achieved through: defining service areas and technologies; identifying barriers to adoption such as socioeconomic factors, education and markets; and implementation of steps to increase adoption. The department is in the process of mapping broadband availability and has several maps available on its web site. Building capacity for health care is one of the department's areas of focus. For health care, community anchor sites include health facilities and schools. Currently, there are 57 hospitals, eight nursing homes, 39 urgent care centers, 53 school-based health care centers and 150 federally qualified health centers with broadband in the state.

To enhance telehealth services throughout the state, Mr. Clarke recommends a collaborative quasi-governmental entity to serve as a trusted intermediary between the government and the private sector. This approach has been adopted by other states. This entity would function as a central hub and clearinghouse for technology grants and would track grant funding. The projected date for completion of the state's broadband initiative is February 2014, but the health care portion of the system should be complete in December 2012.

Questions and Requests from Committee Members

A member asked about broadband progress in tribal areas. Mr. Clarke stated that the department is interviewing stakeholders in pueblo and tribal areas before expanding into those areas. This survey should be complete by the end of July 2012, with a report published in August 2012.

Health Information Exchange Network

Craig Hewitt, chief information officer for LCF Research and the New Mexico Health Information Collaborative (NMHIC), and Dale Alverson, M.D., NMHIC information technology director, reported on the status of the New Mexico Health Information Exchange (HIE). This exchange links patient records for 1.3 million New Mexico patients. All patient data are encrypted in motion and at rest. Every provider that participates in the HIE is required to sign a network subscription agreement that addresses security and privacy protections. Access to the patient data requires user authorization and is password protected. Furthermore, the NMHIC keeps audit logs of all access transactions.

Mr. Hewitt and Dr. Alverson explained that a patient must give written consent to give specific providers access to the patient's records and has the right to opt out. The only exception to the requirement that a patient consent to give a specific provider access to the patient's medical records would be in case of emergency; in such a case, an emergency department physician would be able to "break the glass" and access the patient's records linked through the HIE. The DOH has access to patient data, but only for public health conditions that must be reported by statute and for the state immunization registry. With patient authorization, the NMHIC also provides patient health data to the federal Social Security Administration to facilitate, and shorten the time for, disability determinations.

The presenters stated that, perhaps more than anyone, University of New Mexico emergency department physicians appreciate and are enthusiastic about the benefits of central access to patient records through the HIE because it: 1) improves care coordination; 2) provides for superior triage and evaluation in emergencies; 3) provides more comprehensive data for diagnosis and patient management; 4) reduces unnecessary duplication of tests; and 5) avoids unnecessary admissions and reduces readmissions.

Dr. Alverson, a noted telehealth expert, stated that telehealth and the HIE should be closely linked as a means to improve access to care, to achieve the best health outcomes and to reduce costs. He explained that the convergence of technology could address "the perfect storm" created by health care reform, an aging population, a critical shortage of health care providers and disparities in access to health care. With respect to rural New Mexico, gaps in access to health services exist for hepatitis C, behavioral health, diabetes, asthma, cancer, oral health and cardiac and stroke care. According to Dr. Alverson, only three out of 33 counties exceed the national average of physicians per 100,000 population. Sixty-four percent of New Mexico's physicians practice in three counties. These same three counties are home to only 39% of New Mexico's population.

Dr. Alverson identified three entities working to broaden the use of telehealth to meet the state's health needs:

- the Center for Telehealth and Cybermedicine Research at the University of New Mexico Health Sciences Center develops new programs and provides technical, operational, business and evaluation planning;
- the Southwest Telehealth Access Grid is a "network of networks" that can support both telehealth and the HIE. It connects 11 New Mexico hospital and health system telehealth providers, Arizona's Telemed Program, providers in Phoenix and Tucson and the Navajo Nation with three regional "backbone" providers building-out broadband networks for health care; and
- the New Mexico Telehealth Alliance is a 501(c)(3) consortium of public and private health care stakeholders.

Dr. Alverson reminded the committee that various telehealth programs are funded by grants and do not have sustainable funding.

Dr. Alverson requested the committee's support for the following:

1. maintaining the NMHIC as the state's designated HIE entity;
2. legislation that allows point-of-service patient consent and authorization to disclose patient medical records;
3. funding for the NMHIC to demonstrate the effectiveness of the HIE and to establish a sustainable funding model;
4. legislation to provide reimbursement for telehealth encounters (reintroduction of House Bill 591 from 2011); and
5. legislation establishing the New Mexico Telehealth Alliance as the state's designated telehealth resource center.

Questions and Requests from Committee Members

A member asked about coordination with health care providers in West Texas, specifically El Paso, Lubbock and Midland. The member stated an interest in a less Albuquerque-centric approach to regional health care. The member brought up an incident in which testing at the M.D. Anderson Cancer Center had to be repeated in New Mexico because of an impediment to the exchange of patient medical records. The member stated that patients cross state boundaries for medical care all the time and that there needs to be a national HIE. The member added that he would be glad to support funding for access to out-of-state patient records. Maggie Gunter, the president and executive director of LCF Research, responded that

the NMHIC is in contact with West Texas providers, and she added that the HIE is part of a nationwide network.

Several members asked questions about the consent and authorization process and about protections for confidential and private patient medical information. Dr. Alverson clarified that a patient would have to present to a physician for treatment and then consent to the disclosure of medical records to that physician before the physician would be granted access to the patient's medical records. A member was concerned about correctly matching medical records to the patient. The presenters explained that the HIE system is designed to provide each patient with a unique patient identifier. According to Dr. Alverson, hospitals use sophisticated systems for patient verification, but no system is perfect. He added that locating the correct record digitally takes less time than finding the right paper record. A member was concerned about DOH access to records through the HIE. Dr. Alverson explained that for reportable conditions, the DOH has access to patient medical records (whether electronic or hardcopy) by law. *The member requested a list of reportable conditions.

Another member asked whether the HIE system is linked with the Board of Pharmacy's prescription database. Ms. Gunther stated that the NMHIC would be interested in this. Dr. Alverson commented that this demonstrated the need for a central body to coordinate the information-gathering technology. *The member requested that the NMHIC contact the Board of Pharmacy about its prescription drug monitoring database and link it to the HIE. *Another member requested that the HIE include adverse drug events in its database.

A member questioned Dr. Alverson about the availability of broadband in rural areas. Dr. Alverson confirmed that there are "gaps" and that the HIE for Native Americans is just beginning. The main barrier is the lack of adequate high-speed connectivity.

A member asked how long it would be before a physician in any emergency room in the state could access a patient's medical records. Mr. Hewitt analogized HIE access to the use of automated teller machines (ATMs). According to Mr. Hewitt, expanding the use of ATMs was a standards issue. He estimates that it could take two to three years to achieve universal access to HIE. In Dr. Alverson's opinion, much progress could be made in two to three years, but it may take five years for the HIE to be ubiquitous in New Mexico. He observed that, if the public perceives value, adoption of technology takes place more rapidly. He pointed to the spread of the use of cellphones, and now tablets, as examples of this phenomenon.

A committee member asked whether a patient could refuse to consent to the disclosure of medical information. Dr. Alverson confirmed that no patient can be compelled to consent to the disclosure of confidential medical information and that there is no penalty for this.

The NMHIC presenters were asked about the exchange of patient medical information with the Social Security Administration. *A member was interested in seeing a copy of the agreement between the NMHIC and the Social Security Administration.

Molina Medicaid Managed Care Telehealth and Innovations in Coordinated Care

Irene Krokos, M.D., chief medical officer for Molina Healthcare of New Mexico, spoke to the committee about a changing paradigm in the delivery of health services. She explained that Molina was founded by an emergency room physician who saw too many patients in the emergency room for non-emergent conditions. These patients were low-income and had low health literacy. As a result, he decided to open primary care clinics in California. Molina is now a managed care organization operating across the country. This organization is now a "medical home" that reduces unnecessary use of the emergency room. In New Mexico, Molina participates in the Salud! and State Coverage Insurance (SCI) programs, and is a third-party administrator for Personal Care Option and the Mi Via self-directed waiver.

Dr. Krokos explained that, as a practitioner, she treats patients with several factors that impact health status: chronic disease, behavioral health and mental illness and social determinants such as early childhood development, lifestyle and working conditions. In addition, one-half of the adult population in the United States has difficulty understanding and acting upon health information. Integrated health management addresses physical, behavioral and social factors.

Molina is leveraging technology, such as Project ECHO, to promote quality and best practice care in rural and underserved areas through telemedicine. As Dr. Krokos explained, there are patients who cannot be served in a 15-minute appointment and who require a more intensive treatment approach for chronic conditions. The Project ECHO model provides an "outpatient ICU". Project ECHO is the hub that supports primary practices around it, with outpatient intensive care unit (ICU) teams embedded in the primary care clinic. The goal of the model is same-day triage by the team. This is a transformation in the model of care.

Questions and Requests from Committee Members

Several members were surprised by the incidence of mental illness cited by Dr. Krokos in her materials. According to the Centers for Disease Control and Prevention, 25% of all U.S. adults have a mental illness, and nearly 50% of U.S. adults will develop at least one mental illness during their lifetime. Dr. Krokos explained that "mental illness" was defined using clinical definitions according to DSM IV criteria.

Another member asked Dr. Krokos about the role of electronic medical records in the outpatient ICU model. Dr. Krokos replied that access to electronic medical records is vital to track a patient after discharge and to follow care over time.

Tuesday, July 10

The meeting reconvened at 8:57 a.m.

Status of the PPACA

Mr. Hely briefed the committee on the recent United States Supreme Court decision on the PPACA. First, the Court upheld the PPACA's individual mandate requiring certain

uninsured individuals to obtain health insurance or be subject to a monetary penalty. Second, the Court held that Congress cannot penalize states for not participating in the PPACA's Medicaid expansion. However, Congress may provide incentives to states that choose to expand their Medicaid programs. Finally, the Court upheld the other parts of the PPACA, including the insurance coverage provisions, innovation grants and programs and the health insurance exchange.

Committee members inquired about the positive and negative economic impacts of the PPACA on the state. The members expressed concern about the penalty to be imposed on New Mexicans without health insurance by 2014. Committee members asked whether uninsured residents and businesses can qualify for tax credits or subsidies to purchase health insurance. It was noted that New Mexico's uninsured rate is the second highest in the country.

Committee members requested information on the amount of federal grant funding received by the state since 2010 to implement the PPACA, including grants for the development of a health insurance exchange. According to the Human Services Department's web site, the amount received is more than \$120 million. Mr. Hely mentioned that the Legislative Finance Committee will be studying the tax implications of the PPACA at its August meeting and may provide a list of total funding received to date.

Consumer Perspectives on Health Care Reform

Pamelya P. Herndon, executive director, Southwest Women's Law Center (SWLC), provided an overview of some of the new benefits to women under the PPACA. She stated that more than 50% of the New Mexico population are women. Women and children can now receive preventative services without cost-sharing under the PPACA. Some of these preventative services include cancer screening, immunizations, domestic violence screening and counseling. Ms. Herndon explained that the PPACA also establishes women's health coordinating centers and a network of supportive services to help mothers and pregnant women to complete secondary education. She emphasized that the PPACA allows the extension of parents' health insurance coverage to children under the age of 26. Ms. Herndon said that older women will benefit from the PPACA provision that eliminates co-pays for prescription drugs.

Kyle Marie Stock, staff attorney, SWLC, focused on consumer protections for insured New Mexicans under the PPACA. She highlighted five key points: 1) New Mexicans with health insurance already meet the PPACA's individual mandate requirement; 2) consumers stay healthy because they can access preventative health services without cost-sharing; 3) consumers have access to more health care services when they need them; 4) consumers can get health insurance even if they have pre-existing conditions; and 5) the law creates more transparency and helps to control costs for consumers. Ms. Stock pointed out that the new health care law affords consumers an appeals process when they are denied coverage for a treatment or service and ensures that health insurance premium rates are fair according to the rate review and medical loss ratios.

Kelsey McCowan Heilman, staff attorney, New Mexico Center on Law and Poverty, views the PPACA as an opportunity to reduce the state's uninsured rate from 25% to 5%. She underscored that expanding Medicaid is critical to provide health care to low-income working families and adults under 138% of the federal poverty level. She said expanding Medicaid to 200,000 more New Mexicans will save hundreds of millions of dollars each year in uncompensated care costs. She explained that the state will leverage significantly more federal dollars from its small investment in expanding Medicaid, thus providing a major boost to New Mexico's economy and jobs. Ms. Heilman pointed out that even if New Mexico does not expand its Medicaid program, New Mexico's federal tax dollars will nonetheless go to other states that do participate in the Medicaid expansion. She recommended that the committee ask the governor to make a public commitment to implementing the Medicaid expansion under the PPACA and that the committee introduce legislation and appropriate funds to that end.

Committee members asked what the new eligibility requirements would be under a Medicaid expansion. The panel answered that it would be up to each state to determine its eligibility requirements. The committee requested information regarding long-term cost savings associated with expanded coverage, what extra money would come to the state and what a Medicaid expansion would mean for urban and rural hospitals under the PPACA. Committee members inquired as to which states have requested waivers to establish a single-payer system similar to Vermont's proposal. It was noted that states can submit waivers beginning in 2017.

Katie Faith Martinez Patient Bill of Rights

Tyler Atkins, an attorney with McGinn, Carpenter, Montoya and Love, P.A., who represents the parents of Katie Faith Martinez, explained that House Memorial 80 from the 2011 regular legislative session requested the creation of a task force to study the rights of health care patients and the manner in which state health care facilities consider patients' rights in the delivery of health care, among other purposes. The New Mexico Health Policy Commission was charged with convening the task force; however, the commission was de-funded and the task force was not established. Mr. Atkins asked that the committee endorse the legislation in the upcoming 60-day session.

Deborah and Melvin Martinez, Katie's parents, shared the story of how their daughter had been misdiagnosed by hospital staff who were not doctors. Katie was eventually admitted to the hospital with pneumonia. The last physician to treat her was a locum tenens "substitute" physician from a temporary agency who was unable to resuscitate Katie after complications from a procedure due to his lack of familiarity with the hospital facility. Mr. and Mrs. Martinez said their proposed legislation would make hospitals fully accountable for any physicians they provide onsite to treat patients who present at the hospital. The proposed legislation is based on a Vermont statute that requires each hospital to have a policy that protects the patients' rights to receive information about their health care that will allow them to make informed decisions about their care.

Committee members asked whether the family had taken any action against the doctor or the hospital. Mr. and Mrs. Martinez stated that their case was settled without a trial. Committee

members were interested in whether hospitals frequently use temporary agencies to hire physicians. The committee said it will look at the proposed patient bill of rights legislation at its final meeting when it considers bills to endorse.

Tour of Appletree Educational Center (AEC)

Rebecca Dow, chief executive officer, AEC, gave a tour of the educational facility serving children and youth from pre-kindergarten through ninth grade. She complained of what she characterized as too much regulation by the Children, Youth and Families Department (CYFD). She alleged that the CYFD retaliated when she complained of CYFD rules and enforcement.

Tour of the Sierra Vista Hospital

Domenica "D" Rush, chief executive officer, Sierra Vista Hospital, gave a tour of the community-operated, 25-bed critical access hospital.

Meaningful Use of Health Information Technology

Lindy Dittmer-Perry, program director, New Mexico Health Information Technology Regional Extension Center (NM HITREC), explained that the NM HITREC is a consortium of three nonprofit organizations — LCF Research, HealthInsight New Mexico and the New Mexico Primary Care Association — working together with the goal of assisting primary care providers to reach "meaningful use" of electronic health records to improve patient care. Eligible providers that achieve meaningful use of electronic health records can obtain Medicare and Medicaid incentives. For example, Medicare provides up to \$44,000 over five years in incentive payments, and Medicaid pays up to \$63,750 over six years, including assistance to providers in the first year to adopt, implement or upgrade electronic health records.

NM HITREC's service areas include: Albuquerque, Santa Fe, Farmington, Gallup, Zuni, Clovis, Roswell, Las Cruces and Carlsbad. Of the 1,500 eligible primary care providers within these service areas, NM HITREC hopes to reach 1,035 providers, including doctors, osteopathic physicians, physician assistants and nurse practitioners, among others. Ms. Dittmer-Perry further stated that primary care providers have the unprecedented opportunity to update their electronic health records, as exemplified by Sierra Vista Hospital. This hospital was nominated and selected to attend a White House meeting to share its experience in implementing electronic medical records.

Ms. Rush detailed Sierra Vista Hospital's efforts to upgrade and implement an electronic records system, including the challenges of using electronic health records. Some of these challenges involve the ongoing need for staff orientation and training and the high cost to fully implement, maintain and troubleshoot the software system. Ms. Rush emphasized the administrative burden on the hospital to meet all federal standards regarding the sharing of protected patient health information. She thanked the NM HITREC for helping to modernize Sierra Vista Hospital with the electronic medical records and believes her hospital will achieve Medicaid meaningful use status in the near future. Ms. Rush's recommendations to other hospitals interested in upgrading their electronic medical systems are to apply for grants and

loans, to hire a good team to train facility personnel to use the system and to work with a reputable and responsive electronic records system vendor.

Committee members were interested to learn that Midland College in Midland, Texas, received a grant to provide online training to New Mexico's primary care providers in using electronic records technology. Committee members agreed that it is important that physicians and medical staff understand the electronic medical records and data collection technology. The committee inquired about the costs for purchase, implementation and training to use the technology.

Status Update: The Insurance Division and the PPACA

John Franchini, superintendent of insurance, Insurance Division, PRC, reviewed the procedures that the division has implemented pursuant to legislation (SB 208 from the 2011 regular legislative session) intended to improve the health insurance rate review process. The rate review law mandates that specific factors be considered when reviewing proposed rate increases from health insurance companies.

Superintendent Franchini mentioned that Blue Cross Blue Shield of New Mexico (BCBS) requested a 9.9% rate increase, which was approved prior to SB 208 becoming effective. Subsequently, the Insurance Division reexamined the 9.9% rate increase under the parameters of the new law and decided that it was too high. BCBS sued the Insurance Division and eventually accepted a 6.9% rate increase that accounted for medical inflation and BCBS's rural service area. Presbyterian was approved for a 4.7% increase, and Lovelace received a 6.9% increase. Superintendent Franchini stated that this is the first time that health insurance companies have not received double-digit increases, partly due to the new rate review requirements under SB 208 and mandates under the PPACA.

Superintendent Franchini reported that the Insurance Division received a federal grant to hire a new actuarial firm to audit the division and hire new staff to join the rate review team, resulting in better overall performance of the division. He added that in 2011, the division's Life and Health Bureau and the Managed Care Bureau conducted external rate reviews as required under the PPACA and closed 3,212 claims. Superintendent Franchini announced that the division has received several grants totaling more than \$4.2 million, and he hopes to receive a grant from the SWLC to conduct outreach to rural communities.

Superintendent Franchini said that SB 290 (introduced in the 2012 regular legislative session) requires an amendment to make the New Mexico Insurance Code compliant with the PPACA. Superintendent Franchini explained that the amendment would cover medical loss ratios, children and gender rating, among other provisions. He ended his presentation by announcing that New Mexico has been recognized in a national article as one of 10 successful states in implementing health insurance reform under the PPACA.

Committee members asked how many New Mexicans are covered by insurance plans and the number of health insurance companies under the division's purview. Superintendent

Franchini answered that 400,000 New Mexicans are covered by some type of health insurance. The division handles seven companies that write individual health plans. Additionally, there are other limited medical plans, accident plans and small group plans under the division's purview. The committee asked whether the insurance companies can appeal the division's rate increase decisions. Superintendent Franchini explained that SB 208 allows an appeals process with the PRC and that the new approved rate increases for BCBS, Presbyterian and Lovelace have not been appealed. According to Superintendent Franchini, Presbyterian has the highest number of enrollees. BCBS is the biggest rural provider and enrolls the second-highest number of people. Lovelace has the fewest enrollees — 75,000.

The committee questioned whether existing insurance companies are committed to serving rural areas of the state and, if they are not, how the state plans to fill the void. Superintendent Franchini believes that none of the state's existing insurance companies will pull out of the state. He also said that there is a new nonprofit health insurance co-op interested in serving rural New Mexico. Committee members would like a presentation on the new co-op at a future committee meeting.

Committee members wondered whether the division is involved in setting up the health care exchange under the PPACA and requested information regarding the exchange's potential impact on the division's workload. Superintendent Franchini replied that the division already has in place the medical loss ratio, external review, web site and a federal team to assist with outreach. He also stated that with his team of financial examiners, actuaries and ombudsmen and support from the PRC commissioners, the Insurance Division is prepared for any increased workload resulting from the PPACA. He added that the division will focus on outreach to people currently without health insurance. He confirmed that he was recently asked by the Human Services Department to join the advisory board working on the exchange and that he had offered the assistance of his staff as well.

Committee members wanted to know what progress has been made on defining an essential benefits package to be offered under the exchange. Superintendent Franchini responded that at the end of last year, his division requested insurance companies to send in their health benefit plans. Of the plans submitted, the division picked the three most common plans, which were different from the federal government's chosen plan. He said the issue of the conflicting plans should be resolved in the near future before the implementation of the exchange.

Public Comment

Jim Jackson, executive director, Disability Rights New Mexico, explained that under the PPACA, insurance companies cannot deny coverage based on disability or pre-existing conditions. The PPACA also requires that the essential benefits package include mental health, behavioral health, rehabilitation and habilitation services, which are important needs of people with disabilities. Mr. Jackson detailed the ways a Medicaid expansion will help cover adults with disabilities who do not qualify for Supplemental Security Income. He disagreed with the

Human Services Department that a Medicaid expansion would be challenging or unsustainable and urged the committee to support Medicaid expansion.

Ellen Pinnes, health policy consultant with the Disabilities Coalition, added that it makes moral sense for New Mexico to participate in the Medicaid expansion and urged legislators to support the expansion. She said that without the expansion, the most vulnerable population will be without health care.

Adjournment

Committee members thanked the mayor and the City of Truth or Consequences for hosting the meeting. There being no further business, the committee adjourned at 3:27 p.m.