

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

**June 25, 2012
Room 307, State Capitol
Santa Fe**

The first meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, on June 25, 2012 at 9:41 a.m. in Room 307 of the State Capitol.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair
Rep. Dennis J. Kintigh
Sen. Linda M. Lopez
Sen. Gerald Ortiz y Pino

Absent

Rep. Nora Espinoza
Sen. Gay G. Kernan
Rep. Antonio Lujan

Advisory Members

Sen. Rod Adair
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Miguel P. Garcia
Rep. James Roger Madalena
Sen. Cisco McSorley
Rep. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. Bernadette M. Sanchez
Rep. James E. Smith
Rep. Mimi Stewart

Rep. Eleanor Chavez
Sen. Stephen H. Fischmann
Sen. Sander Rue
Sen. John C. Ryan

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)
Shawn Mathis, Staff Attorney, LCS
Rebecca Griego, Records Officer, LCS
Melissa Candelaria, Law School Intern, LCS

Handouts

Handouts are in the meeting file. They are listed at the back of the minutes.

Monday, June 25

Welcome and Introductions

The chair called the meeting to order and invited members of the committee and legislative staff to introduce themselves.

Review of 2012 Regular Session Health and Human Services Legislation

The meeting's first order of business was a review of the fate of health and human services bills introduced in the previous legislative session (listed in handouts 5 and 6) by Mr. Hely. Mr. Hely also reviewed memorials passed in the 2012 legislative session, including one requesting the New Mexico Legislative Council (LC) to establish a behavioral health committee, and another requesting creation of a committee to oversee the implementation of health reform in the state.

Several members of the committee expressed their desire that the LC establish an interim subcommittee on behavioral health in light of last year's keen public interest in state behavioral health programs and resources. A discussion between the members of the committee resulted in a motion, approved unanimously, to request the LC to establish a standing behavioral health committee.

Mr. Hely closed his presentation with a reminder that the U.S. Supreme Court decision on challenges to the federal Patient Protection and Affordable Care Act (PPACA) was expected within the week.

Fiscal Reports: Department of Health (DOH); Aging and Long-Term Services Department (ALTSD); Human Services Department (HSD); Children, Youth and Families Department (CYFD); Workforce Solutions Department (WSD)

Greg Geisler, senior fiscal analyst for the Legislative Finance Committee (LFC), provided the committee with a fiscal year (FY) 2013 fiscal overview and outlook of New Mexico health and human services programs (see handout 7). He advised the committee that appropriations from the general fund to the HSD were on the increase for FY 2013 due to loss of federal American Recovery and Reinvestment Act of 2009 (ARRA) funding and characterized FY 2013 as a "transition year" for the HSD.

According to Mr. Geisler, since the HSD reduced provider rates, there has not been a notable increase in Medicaid enrollment or utilization; nevertheless, the department's request for a budget increase of \$48.9 million is all attributable to Medicaid. In total, the department received \$4.7 billion in appropriations, an increase of 5.8 percent from last year. Total general fund revenue for the department was approximately \$1 billion, representing an increase of 4.1 percent over FY 2012. Total Medicaid enrollment is projected to approach 527,000 by the end of June 2013. Of concern, enrollment of children has declined to 336,000 from a peak of 338,000 in March 2011.

For FY 2014, Mr. Geisler called the committee's attention to the coming need to replace funds from the tobacco litigation settlement funds that were temporarily diverted for appropriations to various health programs. Mr. Geisler reminded the committee that the legislative authority to divert money from the tobacco litigation settlement funds is due to expire. Further, assuming that health reform moves forward, the department projects it will need an additional \$10.6 million to \$16.6 million in the first six months of FY 2014 to fund activities associated with the anticipated increase in Medicaid enrollment. The department projects an increase in enrollment of between 106,000 and 137,000 recipients from the Medicaid expansion called for under health reform.

Mr. Geisler closed his presentation with a review of appropriations under the Temporary Assistance for Needy Families (TANF) program. Of note, the FY 2013 appropriation for direct TANF programs is slightly less than the FY 2012 operating budget, primarily due to fewer projected TANF cash assistance cases. According to Mr. Geisler, there has been an approximately 10 percent decline in the number of TANF cases from January 2011 to January 2012. Mr. Geisler reported that the HSD speculates that the decline is attributable to increased employment, while advocates for the needy attribute the decrease to a 15 percent reduction in benefits and changes in eligibility criteria implemented in FY 2011.

Mimi Aledo-Sandoval, senior fiscal analyst for the LFC, informed the committee about trends in appropriations to the CYFD. Pre-kindergarten (Pre-K) funding has remained a priority, with many early childhood programs and interventions in place that focus on healthy development of children from the prenatal stage to age three. In fact, the LFC held a hearing on early childhood development on June 15, 2012. An appropriation of \$9.2 million from the general fund was made to CYFD Pre-K programs in FY 2013.

Ms. Aledo-Sandoval reported that, in 2010, of the 27,793 births in New Mexico, approximately 71 percent were covered by Medicaid. Accordingly, Medicaid plays a major role in the health outcomes for many New Mexico children. From birth to the age of 15 months, Medicaid pays for six well-child doctor visits. Ms. Aledo-Sandoval explained that these visits are crucial to track developmental progress and to aggressively treat any health issues that could impair a child's proper development. However, for FY 2012, only 29 percent of children who qualify for these visits are getting them.

Ms. Aledo-Sandoval also reviewed trends for the state's juvenile facilities population. While the average daily population declined from FY 2006 through FY 2010, there is an increase in FY 2011. Ms. Sandoval reported that the state's juvenile facilities are operating at capacity. The CYFD's FY 2013 budget reflects the realignment of probation and parole services into the juvenile justice program. The FY 2013 budget includes a \$250,000 contract for continued training and support for the Cambiar New Mexico model.

Ms. Aledo-Sandoval next briefly covered the WSD fiscal overview and outlook (see page 15 of handout 7). Increased funding has been appropriated for unemployment support planning. Since a high plateau from FY 2009 and FY 2010, unemployment benefits have been declining;

however, since FY 2007, benefits paid have exceeded revenue paid into the Unemployment Compensation Fund by employers. Ms. Aledo-Sandoval reported that an ad hoc unemployment advisory council has been meeting to review the state's unemployment insurance system.

Ruby Ann Esquibel, principal analyst for the LFC, covered the FY 2013 fiscal overview and outlook for the DOH. For FY 2013, the department's appropriation from the general fund is \$292 million, with an increase of \$3.3 million (1.1 percent) over FY 2012. Funding above that requested by the department was appropriated for rural primary care services contracts (\$818,000), sexual assault programs (\$200,000), health care work force training (\$100,000), as requested by the LHHS, and nurse advice (\$29,000).

Ms. Esquibel advised the committee that the governor vetoed the use of the following FY 2013 performance measures for the department:

- preventing HIV/AIDS;
- conducting health emergency exercises;
- analyzing public threat samples;
- substantiating cases of abuse, neglect and exploitation in state facilities; and
- conducting compliance surveys of the state's private adult residential care and daycare facilities.

For this reason, the LFC's FY 2013 report card for the DOH will be abbreviated.

Funding for DOH health facilities remains at FY 2012 levels. There is increased funding for personnel, but the department continues to experience problems in filling a large number of job vacancies. According to Ms. Esquibel, the LFC has not identified the reason that available jobs are going unfilled, but there are concerns that the DOH is using the funds appropriated for hiring for other purposes.

The total appropriation for FY 2013 provides sufficient funding for maintaining direct patient care staffing levels and programmatic health care services and for paying \$4 million to lease the Fort Bayard Medical Center.

Ms. Esquibel next reviewed the Medicaid developmental disabilities (DD) waiver program. Currently, there are approximately 3,600 individuals receiving DD waiver services and 5,600 individuals are on the waiting list. In addition, there are 227 individuals receiving medically fragile waiver services. The DD waiver program's FY 2013 budget is \$96 million, with a \$2.7 million increase in general fund revenue over FY 2012. With this increase, the program will be able to provide services to an additional 150 clients. Ms. Esquibel pointed out that the number of clients served by the program has remained constant from FY 2008 through FY 2012, with a corresponding dramatic increase in the number of persons placed on the waiting list (see handout 7, page 21). The DOH recently issued new rates and standards for the DD waiver program, but the LFC has not had sufficient time to analyze the impact of the new rates and standards.

Ms. Esquibel concluded the LFC's presentation with a report on the ALTSD. This department's FY 2013 total general fund appropriation is \$42.7 million, an increase of \$2 million over FY 2012. In addition, \$1.7 million was appropriated for home-delivered meals and other aging network programs, and \$537,000 was appropriated for the Aging and Disability Resource Center. Total FY 2013 general fund support for the aging network and area agencies is \$27.1 million, an increase of 6.6 percent over FY 2012. Ms. Esquibel informed the committee that the governor vetoed language in the appropriation to the aging network that directed the appropriation be used to expand home-delivered meals. Ms. Esquibel explained later that the governor had stated that she was not in favor of directing how these funds would be spent and preferred to give the agency flexibility in their use.

The LFC also provided the LHHS with handout 8, Third Quarter, Fiscal Year 2012 Performance Report Cards for the ALTSD, Interagency Behavioral Health Purchasing Collaborative (IBHPC), CYFD, DOH, HSD and WSD.

Questions and Requests from Committee Members

* A committee member requested an annual report on the IBHPC.

Another member asked why rates of participation in Medicaid home visitation and follow-up are so low. Participation in this program is voluntary. Of the more than 20,000 children on New Mexico's Medicaid rolls, only about 600 children are taking advantage of this initiative. According to LFC presenters, the program's budget is very small, with only \$3.1 million allocated to the program. Furthermore, the program is not limited to children.

The member also asked why the rate of participation in Medicaid's well-child doctor visit benefit was so low, with only 29 percent of eligible recipients participating. Mr. Geisler advised that there is a two-month lag in reporting the well-child doctor visit data. According to Mr. Geisler, the department's target is 65 percent participation by the third quarter of 2012. He stated that the HSD expects to meet this target.

* Several members requested further information regarding whether parents or providers are contributing to the failure to participate in the well-child doctor visits, or whether there are institutional barriers to participation.

* A member requested a breakdown of categories of juvenile offenders. In the adult offender system, there has been an increase in violent offenders. The member wanted to know whether this is also a trend with the state's juvenile system.

A member expressed concern about the state's liability for unemployment insurance for retired state employees who are laid off by a subsequent private employer. In the member's opinion, if an individual is already collecting a state pension, the state should not have to pay the same retired individual unemployment for loss of a post-retirement private sector job.

A member asked whether the DD waiver waiting list operated on a first in, first out (FIFO) basis. Ms. Esquibel confirmed that this is how the waiting list works, with exceptions for emergency cases. However, some people on the waiting list may receive some level of services while they are on the list. To obtain full benefits under the DD waiver, many people are waiting from eight to 10 years.

With regard to the 2014 expiration of authorization to divert a portion of the tobacco litigation settlement funds for health programs, a member asked whether there would be recurring replacement funding. David Abbey, director of the LFC, advised that replacement funding is included in the FY 2014 budget.

*A member requested better information on the level of outreach taking place to ensure that those eligible for Medicaid are enrolled.

A discussion on the health care work force shortage took place. Ms. Esquibel responded that whether there is a sufficient primary care work force is "an open question" and suggested that in order to maintain a primary care safety net, many other types of practitioners would need to be used and provider rates would need to be supported. *A member asked whether the LFC has any plans to analyze the health care work force as capacity is expanded. The discussion included mention of high school programs, the number of new medical schools and the use of programs to encourage medical school graduates to go into primary care.

Another member was curious about measures to reduce the DD waiver waiting list. The member questioned whether cost savings across the program could be achieved, thus enabling the DOH to increase enrollment. The member was also surprised that only 150 additional recipients could be added to the rolls as a result of the requested budget increase of \$2.7 million. * The member requested that the LFC provide more information about the impact of cost savings on reducing the number of people on the waiting list. She also requested more information about a new A through F "grading" system that is being used to allocate or reduce DD waiver benefits to individuals.

* A member requested information about the status of compliance with the Umbilical Cord Blood Banking Act and efforts required to educate pregnant women about the potential benefits of umbilical cord donations.

* A member requested information regarding the level of hospital compliance with requirements for newborn genetic screening and the screening of newborns for hearing sensitivity. Ms. Esquibel stated that in FY 2011, approximately 30,000 newborns were screened for hearing sensitivity, which indicates that all newborns are being tested.

There was a discussion among members who questioned the governor's veto of certain performance measures for the DOH. Several members agreed that it is critical to consistently measure performance indicators over time and that changing the indicators from administration to administration makes it difficult to track trends.

A member asked the LFC team whether they had information about problems with providing appropriate shelter to foster children. Ms. Aledo-Sandoval responded that the CYFD has a 19.7 percent job vacancy rate for mental health counselors and social workers. A 2011 hiring freeze put a lot of pressure on existing CYFD social workers, leading to burnout and resignations. The CYFD's current staff is composed of either long-term or brand new employees. As a result of these developments, it will take time for the department to ramp up its behavioral health work force. There is also an increase in repeat maltreatment of foster kids. According to Ms. Aledo-Sandoval, the CYFD is presently more focused on children who have problems than on providing support to foster parents.

A member reported a rumor that foster kids in Bernalillo are staying in CYFD offices and asked that this be looked into. A member of the audience, Renada Galen, announced that she works for the CYFD and that this report is not correct. However, according to Ms. Galen, recruitment of foster families is a constant issue for the department.

A member questioned the \$4 million annual lease payment from the DOH to Grant County for the Fort Bayard Medical Center. Mr. Abbey stated that the deputy secretary of the DOH has been asked to explore restructuring the debt. Mr. Abbey stated that the New Mexico Finance Authority has taken the position that the debt cannot be restructured. While this facility was financed with bonds issued by Grant County, it was "a unique arrangement", according to Mr. Abbey.

One member questioned the LFC staff about the cost to New Mexico of new enrollees from 2014 through 2020 under the PPACA Medicaid expansion, referring to differing financial projections by the Lewin Group and by The Hilltop Institute. Mr. Geisler reported that the HSD is aware of these. He added that the HSD's calculations assume an increase of 162,000 recipients from the Medicaid expansion.

Another member commented on Item 8 on the IBHPC report card (handout 8) showing a target of only 37 percent of hospital inpatients to receive follow-up within seven days post-discharge. The member questioned whether this target was too low and whether it would lead to costly readmissions.

Presentation of Phil Lynch Legislative Award

After the close of the period for questions, Senator Ortiz y Pino requested audience member Barack Wolff to step forward, whereupon Mr. Wolff announced that Senator Feldman is the 2012 recipient of the Phil Lynch Legislative Award given by the New Mexico Public Health Association and University of New Mexico National Health Disparities Center. This award is given to a policymaker, advocate or legislator in any branch of government who has actively worked with communities to improve public health. According to Mr. Wolff, Senator Feldman received this award in recognition of her legislative record (350 bills introduced, 51 of which were signed into law, including the creation of the Brain Injury Services Fund in 1997) and of her "openness and inclusiveness" in the way she conducts the committees upon which she serves. This announcement was met with a standing ovation from all present.

Review of Work Plan and Meeting Schedule

Mr. Hely reviewed the 2012 proposed work plan and meeting schedule for the committee (see handout 12). Mr. Hely called the members' attention to the absence of meetings on the work plan for the Behavioral Health Services Subcommittee, as the LC has yet to meet.

* A member commented upon the ambitious work plan and suggested limiting time for presentations to ensure sufficient time for questions from the committee members. Presenters should be requested to streamline presentations to address areas of specific interest to the LHHS. It was suggested that the use of more detailed handouts be encouraged, and that these be emailed to committee members in advance of the meetings.

* A member requested including autism coverage for state employees on the work plan. Another member suggested that this be included in the Behavioral Health Services Subcommittee's work plan. According to the member, there is already a work group on this topic, and he would like a report from it.

* A member requested more information on medical schools and programs to increase providers.

* Several members were opposed to having the Disabilities Concerns Subcommittee (DCS) meet concurrently with the October 9-12, 2012 Southwest Conference on Disability in Albuquerque. Last year, subcommittee members were not able to attend the conference because of the subcommittee meeting. In addition, conference attendees had to choose between attending the conference and attending the subcommittee meeting. Members would prefer to have the DCS meeting on a different day. A member also requested that the DCS meet an additional day.

* Several members urged greater strategic focus to champion LHHS initiatives before the legislature. A member requested copies of fiscal impact reports (FIRs) for bills that did or did not pass in the last legislative session. The member wants to address concerns raised in the FIRs to improve the chance that future legislation recommended by the LHHS will pass muster with the LFC. Another member suggested that, since budgets are key, the LHHS needs to focus its efforts on programs for which budget requirements are known, taking into account start-up costs.

* With regard to topics for the Behavioral Health Services Subcommittee, a member suggested narrowing down the work plan. The member is interested in plans for the Los Lunas facility and would like to tour it. The member would also like to hear from the New Mexico Medical Society and New Mexico Medical Board regarding prescription drug abuse and overdose issues that the LHHS has been following. The member also requested review of mental health services for children in foster care if they are medicated. Committee members agreed that the Behavioral Health Services Subcommittee should meet a minimum of three days.

* A member requested the LHHS to look into the impact of non-compete clauses in health care professional services contracts on the number of physicians who practice in health

care work force shortage or rural areas. This is included in the LHHS's review of health care work force issues included in the LHHS work plan.

Incorporating the requests and suggestions of members listed above, the work plan was approved without opposition.

Medicaid Redesign: Centennial Care

Sidonie Squier, secretary of human services, gave a presentation on the HSD's redesign of Medicaid, which the department has coined "Centennial Care", and on the Section 1115 Centennial Care waiver request.

Secretary Squier began her presentation with an explanation of recent events regarding the Section 1115 waiver request that the HSD submitted to the Centers for Medicare and Medicaid Services (CMS) on April 25, 2012. [The waiver request was withdrawn on May 29, 2012.] According to Secretary Squier, the HSD completed all "necessary" public hearings and Native American consultations required for the waiver. However, the department did not provide the Indian Health Service (IHS) with 30 days' notice and a 30-day comment period before submitting the waiver request to CMS, as provided for by New Mexico's state plan tribal consultation process. While the secretary believes that the IHS had actual notice of the HSD's plans for the waiver through meetings with the department, formal notice has now been given. As a result, there is now a 60-day delay before the waiver may be resubmitted, during which time the department is accepting public comments.

Next, the secretary proceeded to cover information set forth in handout 10, "Centennial Care". As of FY 2013, the HSD projects that Medicaid will make up 20 percent of the state budget. Further, if the Medicaid expansion called for in the PPACA is upheld, the department anticipates greater enrollment, at a greater cost. Secretary Squier gave examples of both federal and state measures to trim Medicaid budgets, a goal of Centennial Care. The secretary next explained the four principles of Centennial Care:

- comprehensive service delivery system;
- personal responsibility;
- payment reform; and
- administrative simplicity.

According to Secretary Squier, two-thirds of Centennial Care is "care coordination". Centennial Care is centered around care coordination "from newborn to nursing home". Care coordination is also the reason behind the department's decision to include behavioral health services in Centennial Care.

Next, Julie Weinberg, director, Medical Assistance Division, HSD, explained the mechanics of "care coordination". A managed care organization under contract with the state receives an enrollment file, completes a health risk assessment in 10 days and assigns the Medicaid recipient a care coordination designation of Level 1, 2 or 3. A Level 1 recipient needs the least amount of care coordination and will be reassessed at least quarterly, with health risk

assessments performed annually. A typical Level 2 recipient has chronic diseases such as obesity and uncontrolled diabetes. A Level 2 recipient would receive care coordination that enlists a team of health care providers who each receive a copy of the care plan. A Level 2 recipient will have ongoing face-to-face contact with the care coordinator, who provides "education and advocacy". A Level 3 recipient requires care at the level of a nursing facility. A determination of needs for home- and community-based services is made. Next, a care plan is developed and reviewed with the recipient. This care plan will be provided to a team of health care providers, and the Level 3 recipient will have ongoing face-to-face contact with the care coordinator, who provides "education and advocacy".

Ms. Weinberg gave an example of behavioral health Level 3 care coordination. Here, the managed care organization completes a health risk assessment in 10 days. If the recipient is identified as a schizophrenic who is not receiving psychiatric care and lacks permanent housing, the recipient is evaluated for referral to a core service agency or health home. If this option is viable, a referral is made. Face-to-face contact takes place and a comprehensive level of care assessment is made. The recipient selects a primary care provider within 30 days of the health risk assessment. Information is obtained from all members of the recipient's care planning team. A care plan is completed with the recipient and, if approved by the managed care organization, is provided to all care plan team members. Services are initiated, with ongoing contact accompanied by "education and advocacy". Ms. Weinberg characterized this as a "high touch process". Secretary Squier interjected that she has issued a directive that Medicaid behavioral health decisions will be made jointly by Ms. Weinberg and the chief executive officer of the IBHPC.

With regard to Native American participation in Centennial Care, Secretary Squier acknowledged that there is apprehension in the Native American community over managed care. She stated that the HSD wants to promote and encourage greater involvement by and with the Native American community. To this end, the department is requiring managed care organizations to contract with tribes to provide on-reservation case management. Her directive is not to interfere with measures that are working on reservations. Further, the department is requiring providers to offer culturally appropriate services. The department wants to have government-to-government collaboration with the Native American communities. For example, the department would support a Native American community that wants to contract directly with the federal government for mini-block grants to provide services to their members. The department will require managed care organizations to offer contracts to tribal health care entities at federal Office of Management and Budget (OMB) rates, to pay clean claims from IHS providers and to pay OMB rates to out-of-network IHS providers who do not want to contract with managed care organizations. Department contracts will require preferential hiring of Native American care coordinators and cultural diversity training for all care coordination staff. Further, each managed care organization is required to have at least two tribal representatives in its management structure.

With respect to "personal responsibility", the second core principle of Centennial Care, the secretary explained that co-pays (also referred to as "cost sharing") are important to make both

the patient and provider mindful of the cost of care. Patients who present at the emergency room for non-emergent conditions will be advised by the hospital that there will be a co-pay for non-emergent care. According to Secretary Squier, the hospital is supposed to refer the patient to available non-emergent services. In addition to this financial disincentive to use the emergency room for non-emergent care, recipients will be rewarded for engaging in healthy behaviors with gift and debit cards.

With respect to payment reform, the third core principle of Centennial Care, the HSD will reward plans and providers that practice cost-effective medicine, "targeted at outcomes rather than process". The HSD plans to establish pilot programs on adult diabetes and pediatric asthma to improved patient outcomes. Bundled payments will be made for inpatient hospital care for pneumonia and congestive heart failure. Under this rate structure, a hospital will not be paid if the patient is readmitted for the same condition within 30 days. Payment reform will also use peer-to-peer physician effectiveness reporting.

Secretary Squier explained the fourth core principle of Centennial Care — administrative simplicity. Currently, New Mexico has 12 Medicaid waivers. Except for the DD waiver, the HSD proposes to combine all current waivers into a single Section 1115 waiver. According to Secretary Squier, this would give New Mexico the flexibility to fashion "programs that work here". In addition, the HSD hopes that reducing the number of managed care organizations with which the state contracts will reduce costs and simplify oversight by the HSD. The updated Section 1115 waiver will be submitted by August 2012. From September through December, the HSD will be going through its procurement and award process. The HSD will use calendar year 2013 to transition to Centennial Care, with the goal of "going live" in 2014. Secretary Squier closed her presentation with assurances that program eligibility and provider payments would not be cut. She also announced additional public meetings on the Section 1115 waiver to be held in Albuquerque on June 26, in Las Vegas on June 27 and in Las Cruces on July 16.

Questions and Requests from Committee Members

When pressed by a member of the committee, Secretary Squier confirmed that scheduled public meetings meet the public notice and comment requirements under current federal regulations for changes to state Medicaid waiver programs.

Another member questioned a statement made by Secretary Squier that it would cost the state an additional \$320 million to \$500 million for the Medicaid expansion as a result of the PPACA. The secretary was asked how this estimate squared with projections by The Hilltop Institute (estimated net increase of \$40 million between 2012 and 2020) and The Lewin Group (estimated increase of 0.4 percent for 2014 through 2019). Brent Earnest, deputy secretary, HSD, clarified that the figures given by the secretary referred to the aggregate cost of the state's Medicaid program (the existing program and as expanded by the PPACA). Responding to further questioning, Deputy Secretary Earnest advised that, controlling for baseline costs (i.e., the cost of the existing program), "there is not much difference" between The Hilltop Institute's estimate and that of the HSD. He also clarified that statements about a dramatic rise in the state's

Medicaid bills referred to the number of enrollees and estimated cost per person. To "bend the cost curve" will require a systemic change, according to Deputy Secretary Earnest.

Ms. Weinberg was asked to explain what "needed services" mean within the context of care coordination. She defined "needed services" as "those needed to support or maintain health". She was asked whether this means "least expensive and most convenient". According to Ms. Weinberg, coordinated care focuses on "most effective" and "best outcomes". She stated, "managed care organizations will not be telling physicians what pills to prescribe". When asked who would measure a physician's success, Ms. Weinberg indicated that physicians would be measured by standard quality performance measures, such as hospital readmissions within 30 days of discharge. Ms. Weinberg was also asked about the role a patient's family would play in treatment decisions. Ms. Weinberg indicated that part of the care coordinator's job is to involve the recipient's support system.

Another member asked whether there are any changes in eligibility for any of the waivers (see handout 9). Ms. Weinberg explained that the waiver proposal was developed assuming that the PPACA would be upheld, which means that some of those on the Medicaid waiver rolls would qualify for health insurance through the insurance exchange required by the PPACA. This change in policy would only affect persons applying for Medicaid for the first time; it would not apply to persons who have applied for disability and have had to wait for a determination (which can take years) or to persons whose eligibility has lapsed and who are "re-certifying".

* A member requested information regarding the way the HSD generated its estimated increased enrollment, since it appears that there is a disparity between the LFC's estimates and those of the HSD. The LFC predicts between 106,000 and 137,000 new enrollees while the HSD predicts 162,000 additional enrollees.

* A member wanted to know the cause of limited Medicaid enrollment for children. Ms. Weinberg stated that the HSD believes the cause is out-migration. She added that the HSD was surprised that growth in Medicaid enrollment of children did not increase during the recession.

A member asked whether the proposed waiver would affect the current practice of providing retroactive coverage for first-time enrollees; otherwise, service providers may not get paid for services rendered. According to Ms. Weinberg, there would be no change; however, by 2014, patients will be able to apply for Medicaid when they present at a hospital emergency department. The HSD anticipates that Medicaid eligibility determinations will be made quickly and will not result in cost shifting to the providers.

A member asked why, in light of the withdrawal of the 1115 waiver submission for failing to conduct required tribal consultation, the three additional public hearings do not include any to be held on tribal lands. Secretary Squier replied that the department did conduct tribal consultation but that the glitch was a technicality about notice to the IHS. According to the secretary, Ms. Weinberg personally visited reservations.

A member asked how medical records would be shared across providers. Ms. Weinberg indicated that sharing of medical records would be governed by medical confidentiality laws.

Another member applauded the department's attempt to design an innovative program. The member confirmed that the HSD had conducted meetings at which many legislators were invited, and the member took issue with those who allege that the HSD made an end-run around stakeholders and the public.

A member requested clarification about the way the capitated rate paid to a managed care organization would be determined. The member asked whether capitation rates would be based on different segments of the covered population. The member also asked whether incorporating behavioral health services into care coordination would increase costs. Ms. Weinberg replied that capitation rates will be risk-adjusted. Currently, the HSD does not pay the same rate for each recipient, e.g., those in nursing homes, children and women in childbearing years.

A member expressed concern that, by utilizing outcomes measures, the HSD would penalize providers if recipients do not take care of themselves. The member used the example of a diabetic who goes home and eats an entire birthday cake, or of a patient with substance abuse problems. Secretary Squier replied that she expects physicians will be compensated, for the most part, for the care they provide.

A member asked whether the HSD would be able to work with what has already been implemented as part of health care reform at great cost, regardless of the outcome of the U.S. Supreme Court decision on the PPACA. Secretary Squier gave her opinion that the decision would not interfere with measures that are working. Further, she believes that Centennial Care "is a good idea regardless" of the outcome of the court decision; care coordination makes sense and many insurance companies have announced that they will continue certain initiatives that were mandated by the PPACA.

Next, a member questioned the transparency of the HSD's tribal consultation process. * The member asked for specifics on the number of tribes consulted. The secretary reiterated that Ms. Weinberg met with many tribal representatives face-to-face. *Following up on the secretary's response, the member asked whether Secretary Squier was aware of SB 196 requirements for tribal consultation and asked whether this law was followed. Secretary Squier insisted that even small one-to-one meetings constitute tribal consultation.

Another member asked whether care coordination will cut behavioral health patients off from their current providers. Linda Roebuck-Homer, chief executive officer of the IBHPC, answered that patients can choose their providers. Next, the member asked about alternatives to core services agencies in rural areas that are not served by these organizations. Ms. Roebuck-Homer acknowledged that some mechanics of the waiver have not yet been sorted out. For example, there are plans to utilize telehealth and three services for behavioral health in rural areas: peer-to-peer support, respite and family support for seriously disturbed children. In using

telehealth to expand mental health services, she anticipates greater use of allied health professionals such as psychiatric nurses.

A member of the committee responded to statements by the HSD about the anticipated increase in Medicaid enrollment in the next few years, urging that the rate of increase "should not be driving panic". The member expressed concern about changing eligibility for long-term care services from 250 percent to 138 percent of the federal poverty level. According to the member, reducing eligibility of some recipients merely results in cost-shifting. His constituents have called to complain that Centennial Care's changes to the state's Medicaid program will be "devastating".

Some Tribal Perspectives on Centennial Care

The Honorable Rex Lee Jim, vice president of the Navajo Nation, gave the Navajo Nation's formal comments on the Section 1115 research and demonstration waiver request for Centennial Care (handout 13). Vice President Jim prefaced these with a brief overview of the Navajo Nation, the largest federally recognized Indian tribe in the United States.

The Navajo Nation encompasses a land base of nearly 27,000 square miles of mostly rural and geographically remote terrain, incorporating parts of 13 contiguous counties in northeast Arizona, northwest New Mexico and southeast Utah. In 2010, approximately 10 percent of New Mexico's total state population was Navajo. Unemployment among the Navajo is over 50 percent, a rate 10 times higher than that of New Mexico as a whole. In 2007, approximately 37 percent of Navajos were living below the poverty level, compared to 18 percent for New Mexico as a whole. A factor that may contribute to difficulty in accessing health care is the language barrier, as Navajo is widely spoken by tribal members in their homes.

Vice President Jim next described the Navajo health care system. The system includes the Navajo Nation's Divisions of Health, Social Services and Public Safety, the IHS, 638 tribal organizations and Native American traditional healing. In conjunction with several of the 638 tribal organizations located in the tribal area, the Navajo Area IHS provides primary care services to 246,000 individuals, with 16,000 hospital admissions and over one million outpatient visits annually. The IHS spends \$1,600 per person per year for health services, approximately 50 percent less per person than private and public health insurance plans. The Navajo Area IHS receives federal funding that meets only 55 percent of the health care needs of the tribal population served; due to severe underfunding, the IHS must rely on third-party revenues to support its system.

Vice President Jim gave statistics comparing the much higher rates of illness and injury of American Indians and Alaska Natives to those of other Americans to illustrate the "daunting" challenge of providing health care services to tribal members.

Vice President Jim also stated that, in preparation for the Navajo Nation's input on the Centennial Care plan, Medical Assistance Division officials were invited to meet in Window Rock, Arizona, on March 13, 2012.

The Navajo Nation's formal comments on Centennial Care are as follows.

- The Navajo Nation requests that the state do no harm to Native American Medicaid beneficiaries.
- The Section 1115 waiver request proposes mandatory enrollment of Native Americans in Medicaid managed care, while guaranteeing Native Americans the right to choose an Indian health care provider. However, the proposal does not define "Indian health care provider". The Navajo Nation requests New Mexico to include the IHS, tribal operated facilities pursuant to the Indian Self-Determination and Education Assistance Act and urban Indian organizations in the definition of "Indian health care provider".
- The Navajo Nation requests New Mexico to explicitly require the Medicaid managed care organizations to contract with Indian health care providers as a provider network and to reimburse these providers at the Medicaid all inclusive rate or OMB rate.
- Consulting with the IHS is not collaboration with tribes. The Centennial Care plan had been finalized by the time it was presented to the Navajo Nation, with limited opportunity for additional input into the development of the plan. Additional tribal consultation in accordance with the State-Tribal Collaboration Act (SB 196) is requested before the waiver proposal is resubmitted to the CMS.
- The Navajo Nation requests the HSD to include a tribal representative on the RFP Finalization Team and Proposal Review Team as a voting member in the selection of managed care organizations.
- Native American culturally relevant holistic care is missing from the waiver request. The Navajo Nation requests establishment of a system of care that includes culturally appropriate comprehensive behavioral health services that comports with requirements of the Indian Health Care Improvement Act of 2010 and the Tribal Law and Order Act.
- The Navajo Nation has had problems with the managed care organizations administering the state's coordination of long-term services program. The managed care organizations have required "outrageous justification" for claims submitted for payment, failed to reimburse the IHS and other Native American providers in a timely manner and failed to coordinate care. The Navajo Nation urges the HSD not to repeat past managed care mistakes.
- With regard to proposed payment reform, the Navajo Nation is concerned about ensuring that compensation will be paid to providers who provide services to chronically ill patients residing in rural or geographically remote areas who may require readmission for the same diagnosis in 30 days.
- The Navajo Nation would like to contract directly with the state for a pilot chronic disease health home project.
- The Navajo Nation supports provisions of Centennial Care that exempt Native Americans from co-pays.

The next speaker was the Honorable Joshua Madalena, governor of the Pueblo of Jemez. Governor Madalena started his presentation by questioning information provided by the HSD regarding the health status of tribal members. According to the governor, the Pueblo of Jemez has an accredited ambulatory care facility that services a population of over 2,600 tribal members, 28 percent of whom are Medicaid eligible. Accordingly, Medicaid revenue constitutes

70 percent of the facility's total revenues. Further, the facility meets or exceeds several clinical standards under the federal Government Performance and Results Act of 1993 (GPRA). The GPRA is the tool used by the IHS to report to Congress on the quality of care provided to Native American patients. The GPRA measures include clinical, quality of care and infrastructure standards. In addition, as part of the facility's recent accreditation survey, the facility was commended as a rural community medical home model.

Governor Madalena takes issue with the state's assertion that tribal consultation took place as Centennial Care was developed. He referred to the State-Tribal Collaboration Act and stated that tribal consultation is not a "technicality" but a federal mandate. Furthermore, consultation is of paramount importance in this case, because the Pueblo of Jemez has exercised its right under federal law to contract for health care funds that would have been spent by the IHS to provide health care for the pueblo's population. Without consultation, the state has decided to pull the pueblo's large Medicaid population into a managed care organization that is not a part of the pueblo's sovereign health system. To add insult to injury, according to the governor, the state plans to pay these managed care organizations a robust capitated rate for assuming the risk of caring for Native Americans.

Governor Madelena maintained that the state has a bad track record with managed care organizations. There continue to be large waiting lists for services. Managed care outreach and education in rural areas have been insufficient and ineffective, with access to managed care providers in rural and tribal communities a continuing concern. Existing managed care organizations have failed to coordinate care, such that the brunt of care coordination and associated costs falls upon the tribes. Nevertheless, the managed care organization receives a capitated rate for Native Americans while failing to take care of them. The governor was also critical of the state's lack of oversight of managed care organizations.

According to the governor, Centennial Care will also affect the economy of the pueblo. The Pueblo of Jemez is a rurally located non-gaming tribe. The pueblo relies upon Medicaid and other third-party reimbursement to supplement the cost of care for its tribal patients. An interruption or reduction in this revenue stream would negatively impact the pueblo's health system and its ability to maintain current levels of service. Health care on the pueblo is also a job creator.

The governor concluded his remarks by saying that the Pueblo of Jemez has no confidence in the state to properly take care of its Native American population. Further, based on tribal sovereignty, the PPACA and other provisions of law, Native Americans cannot be compelled to enroll in managed care, nor will they suffer a penalty if they do not purchase health insurance.

On behalf of the pueblo and other tribes, the governor requests:

- direct communication with Governor Martinez to discuss the waiver and Native American concerns;
- a joint meeting with the CMS and the Medical Assistance Division of the HSD to discuss the waiver and its impact on the Native American Medicaid population;

- that the waiver expressly state that fee-for-service reimbursement for tribal health care services will be maintained and that cost-sharing will not be imposed;
- tribal consultation as required by federal and state law;
- disclosure of tribal health outcomes data under existing managed care organizations, including fee-for-service data from managed care providers; and
- retention of retroactive coverage to avoid increasing uncompensated care for Native Americans and very low-income individuals who are exempt from the individual mandate.

Shelly Chimoni, executive director of the All Indian Pueblo Council, provided additional information about the Centennial Care tribal consultation process. She indicated that the All Indian Pueblo Council serves as a single point of contact and that she is currently working with Ms. Weinberg's office. According to Ms. Chimoni, the appendix to the Centennial Care waiver request only reflects "consultation" with six of the 22 tribes. The 2009 State-Tribal Collaboration Act defined what tribal consultation is. The tribes have since given feedback on Centennial Care at an event attended by a representative of the CMS. She requested that a process to document tribal consultation be utilized, requiring the signature of each tribal governor. Ms. Chimoni also acknowledged that Native American tribes and pueblos could do a better job of publicizing their accomplishments in health care. She noted that many tribes have health care pilot projects under way and should be looked to as mentors for other tribes. She pointed out that revenues from these projects expand existing facilities and invest in tribal lands.

Joseph Ray, executive director of Native American Independent Living from the Pueblo of Laguna, spoke next. His organization works to improve the quality of life of pueblo people with disabilities by empowering them with attitudes, knowledge, skills and practices to live independently. The organization empowers its "consumers" to go on with their lives. Among the services the organization provides are home- and community-based services that allow aging at home in the community. Mr. Ray urged that any new fees or co-payments under Centennial Care should be waived for people with disabilities. He explained that people with disabilities do not have primary care options available after hours or on the weekend and that, often, the hospital emergency department is their only alternative. Many people do not even have access to a vehicle, with the nearest provider an hour away. He also encouraged the HSD to retain retroactive coverage, as cutting this feature would put more families in debt.

Governor Phillip A. Perez from the Pueblo of Nambe and First Lieutenant Governor Harry Antonio, Jr., from the Pueblo of Laguna were in the audience and recognized by the committee.

Questions and Requests from Committee Members

At the conclusion of this portion of the program, a member requested confirmation from the secretary of human services that there will be no co-payments for Native Americans. Secretary Squier so stated.

* A member also requested further information regarding the problems reported regarding existing managed care organizations, such as "unreasonable" demands for claims documentation and the extra burden on Native American care coordinators.

Public Comment

Nat Dean identified herself as a survivor of traumatic brain injury who lives in Santa Fe. She requested greater legislative action to mandate access for assistance dogs in public facilities.

Linda Milanese identified herself as the executive director of Assistance Dogs of the West. She supports greater access for assistance dogs in public facilities and expressed concern that dogs were being taken from a shelter by the U.S. Army to be trained as service dogs without being properly evaluated for temperament.

Ken Collins, who stated that he is a member of the Governor's State Independent Living Council, spoke regarding the Mi Via self-directed waiver. He is concerned that independent living centers have been left out of any planning processes. According to Mr. Collins, the managed care organizations are not doing a good job, and independent living centers have to do a lot of work that the managed care organizations are supposed to be doing.

Jim Jackson from Disability Rights of New Mexico complained about the lack of consultation in the development of the Section 1115 waiver. He asked the committee to serve as a "Board of Directors" to exert as much oversight as possible over changes proposed in Centennial Care. He noted that changes in eligibility would penalize and discourage persons with disabilities who make an effort to seek gainful employment.

Dr. Harris Silver, a retired surgeon, drug policy advocate and patient, weighed in on the HSD's plan to establish a pilot program for pediatric asthma. According to Dr. Silver, 40 percent of children with asthma live in homes infested with cockroaches. Dr. Silver stated that there is no proposed HSD intervention that will address the core issue of poverty. He believes that these asthmatic children need to be seen by a physician. He believes that co-payments are a disincentive for parents getting asthmatic children to the emergency room. He also volunteered that most adult Medicaid patients need pain management and that a better way to manage pain needs to be found.

Dick Mason, with the New Mexico Alliance of Health Councils, testified that cuts in funding to health councils have had serious health effects and have cost more than they have saved. He indicated that national organizations are impressed with the unique structure of health councils in New Mexico and that the state alliance is in final negotiations for a national source of funding. Mr. Mason also requested that presentations on health councils be added to the committee's work plan.

Sharon Argenbright identified herself as a nurse speaking on behalf of 1,199 New Mexico health care workers. They support House Memorial 51, which calls for a study showing the relationship between staffing levels and outcomes. According to Ms. Argenbright, inconsistent

staffing impacts patient care, causing falls, urinary tract infections and bedsores. These preventable conditions would be addressed by proper staffing.

Brenda Parker, the executive director of the San Juan Center for Independent Living, testified that her clients are located in areas so rural that even the use of telehealth is not workable. She questioned giving incentives to Medicaid recipients to get care when there is a shortage of physicians available to some Medicaid patients. Her agency has a primary care office program that is self-directed. This organization handles all the paperwork for self-directed care. Centennial Care would eliminate this type of agency, and her patients would end up in nursing homes.

Ellen Pinnes, with the Disability Coalition, echoed Mr. Jackson's observations that there are both good and bad provisions in Centennial Care, but she complained about the lack of opportunity to review it in advance. She disputes Secretary Squier's characterization of the federal Medicaid program as "one size fits all". Beyond some basic requirements, the federal Medicaid program provides considerable flexibility to states. In fact, every state has a unique Medicaid plan. In its Centennial Care waiver request, New Mexico is requesting an exemption from basic minimum federal requirements.

Dave Schmidt, from the Drug Policy Alliance of New Mexico, requested that the work plan on substance abuse be expanded and indicated that he would like to present a study regarding the impact of appropriate legal sanctions for possession of specified quantities of controlled substances.

Quela Robinson, with the New Mexico Center on Law and Poverty, requested a 12-month continuation of eligibility for Medicaid. Centennial Care proposes to reduce Medicaid eligibility for the working disabled and for those needing family planning and pregnancy services on the assumption that they will be covered through an insurance exchange. She added that Indian Country is not the only place where access to medical services is limited. Further, she advocated in favor of legislation providing for the discharge of debts for past medical care in bankruptcy. She also urged further tribal consultation.

Penelope Foran testified about the intersection between poverty and health care. She stated that she has become poor since becoming disabled and is an example of the working disabled. If she is removed from Medicaid eligibility, it means a loss of \$1,300 a year to her. Mi Via is impacted by the proposed Centennial Care waiver. She wanted to know who would police the managed care organizations, stating that delays in receiving authorization for needed care are common.

Stevie Bath identified herself as the parent of an adult daughter who has been in the Mi Via program for five years. She likes this program, testifying that self-direction works. But the Centennial Care proposal appears to do away with self-direction. Family support does not appear to be incorporated into the managed care template. She reminded members of the

committee that services of friends and family are free contributions to the state. She urged that the Mi Via waiver be kept.

Mary Vivian identified herself as the parent of an adult daughter who participates in Mi Via. She opposes including the self-directed waiver in the Centennial Care waiver. Mi Via works for her daughter: she does not get sick, has not been hospitalized and decides who her caregivers will be. The Mi Via waiver is working well and should not be changed.

Saskia van Hecke works for the Center for Health Innovation in Silver City. She is critical of Centennial Care because it fails to specify who will be coordinating care. If the care coordinators will be managed care organization employees, it will not work. Care coordination has to be done locally. Local care coordinators must be developed and integrated into the care team. There is also a lack of information regarding behavioral health homes. There are already many such centers that should be integrated into Centennial Care. Ms. van Hecke opposes co-payments and supports keeping retroactive payments.

Dr. Michael Prudhomme is a chiropractor from Albuquerque. He advocates including chiropractic care in Medicaid for pain management. This is a benefit in every private insurance policy in New Mexico. There are evidence-based studies showing positive outcomes.

Yvonne Hart is an independent consultant for community support. She is a former director of the Office of Disability and Health at the DOH. She has read the Centennial Care waiver application and concept paper and has great concerns. Centennial Care evidences no appreciation of what it means to be a disabled person who works in the community. The focus on outcome measures is not appropriate for evaluating care for the disabled community. For a disabled person, a positive outcome is not getting worse, or being able to function on a daily basis. She also noted the greater use of medications by the disabled. She requested leave to submit a copy of her testimony to the committee.

Nick Estes, from New Mexico Voices for Children, also spoke on behalf of the New Mexico Academy of Family Physicians. This group urges greater efforts to enroll eligible children in Medicaid. (See written public comments.) At present, the HSD requires children to be re-enrolled in Medicaid at age one, and as a result, many drop off the Medicaid rolls. There is no reason to require this re-enrollment. Mr. Estes also pointed out that differences in the estimated cost of the Medicaid expansion depend on whether they reflect savings from discontinuing the SCI program.

Ed Keller stated that he was "blown away" by Secretary Squier's cavalier attitude about the impact of Centennial Care on some recipients. He has two traumatic brain injuries. He is in Mi Via and suffers from severe pain. His physicians have considered institutional nursing care for him, but this means the loss of all daily decisions if he is institutionalized. The best outcome for him is the ability to live independently and interact with his community.

Gay Findlayson spoke on behalf of the autism community. There were 285 children born with autism in 2011. Funding for autism is insufficient. She hopes that in the updates for the Section 1115 waiver, an innovative health home for autism will be included.

Sandy Skaar spoke on behalf of a Mi Via participant. Under Centennial Care, rural residents need adjustments for higher costs. For example, a cell phone costs \$600 per year in rural New Mexico. Rural health clinics are only open on Tuesdays and Thursdays. It takes one-and-a-half-hours to drive to the nearest hospital if a recipient is ill on other days. She helps people on Mi Via get out of nursing homes. As of last fall, she had assisted 112 people with developmental disabilities. One of those was just discharged.

Rebecca Shuman, a Mi Via consultant, said that CMS rules and guidelines for self-directed waiver programs have specific requirements such as plans and budgeting. None of these requirements is found in the Centennial Care waiver application because the state does not plan to follow the CMS self-direction process. She believes that the state will call whatever it decides to do "self-direction". She urged either excluding the Mi Via waiver from the Centennial Care waiver or ensuring that the state follows CMS self-directed guidelines.

Jill Kennan is a Mi Via participant. She has a brain injury. To reconnect with life, she has used some unique services to help her. Medicaid does pay for chiropractic care if one is in Mi Via. This is an important aspect of self-direction.

David Murley, an AAA participant and Mi Via consultant, wants to see continuation of self-directed services. He doubts that Centennial Care will improve on existing self-directed services and urges greater stakeholder input.

Nannie Sanchez was recently given a "B" level assessment and therefore no longer receives services through a waiver. She cannot live independently and is now expected to move out of her mother's house. She stated that inmates in prison receive better treatment than the disabled. She also complained that she has been separated from her friends with Down syndrome.

Tess Velasquez is a family living provider within the DD waiver. She has problems with proposed changes to the waiver. She is a caregiver for her son who is 41 years old. Long-term services will be capped and the state has not said what the cap will be.

Bruce Evans is the former co-chair of the IBHPC and is familiar with funding, implementation, coordination of care, management and oversight of managed care organizations. He cited a history of high turnover at OptumHealth. While he finds that Centennial Care has some good provisions, some are questionable or "not good at all". He stated that the local collaborative met earlier in the day. There are many open questions regarding the Medicaid redesign, and there has not been enough public input. The other ongoing concern is underenrollment, primarily in urban areas.

Clarissa Hoover, a parent and patient advocate, weighed in on home-based versus managed care organization care coordination. Her daughter has had a health home for the last seven years. Relationships are very important. Communication and trust between the health care providers are essential to the medical health home. A care coordinator who is not part of a team, or who becomes a rationer, is not helpful.

Hank Hughes, New Mexico Coalition to End Homelessness, cautioned that co-payments for emergency room visits may discourage people from going for care when they really need it.

Doris Husted, ARC of New Mexico, is also the parent of a daughter with a disability. She also questioned whether the family as caregiver is included in the Centennial Care plan. Furthermore, she does not want managed care organizations arranging care for the disabled population as part of Centennial Care.

* At the conclusion of public comment, a committee member requested that the health planning councils be included in the committee's work plan.

Adjournment

There being no further business, the committee adjourned.

Handouts

1. Meeting Notice (May 24, 2012)
2. Memorandum from Raúl E. Burciaga re: Interim Committee Reminders — 2012 (June 5, 2012)
3. Draft Calendar for Legislative Committee Meetings (rev. 6/15/2012)
4. Tentative Agenda for the First Meeting of the Legislative Health and Human Services Committee (rev. June 21, 2012)
5. 2012 Health & Human Services Legislation (6/22/2012)
6. Legislative Health and Human Services Committee — Status of Endorsed Bills
7. NM Health and Human Services Programs: FY13 Fiscal Overview and Outlook (June 25, 2012)
8. Third Quarter, Fiscal Year 2012 Performance Report Cards for:
 - Aging and Long-Term Services Department;
 - New Mexico Behavioral Health Collaborative;
 - Children, Youth & Families Department;
 - Department of Health;
 - Human Services Department; and
 - Workforce Solutions Department.
9. Excerpt from Section 1115 Centennial Care Waiver Request (submission to CMS April 25, 2012)
10. Centennial Care, Human Services Department (June 25, 2012)
11. Money Follows the Person in New Mexico Act Fact Sheet (June 2012)
12. 2012 Proposed Work Plan and Meeting Schedule for the Legislative Health and Human Services Committee
13. Prepared Statement for Vice President Rex Lee Jim
14. Pueblo of Jemez State of New Mexico Centennial Care Position Statement (May 2012)
15. Pueblo of Jemez Position Statement Presented by Governor Joshua Madalena to the Legislative Health and Human Services Committee (June 25, 2012)
16. Navajo Nation Comments to New Mexico Human Services Department on the Centennial Care: Ensuring Care for New Mexicans for the Next 100 Years and Beyond (April 2012)
17. Certificate of Recognition for Pug Burge, Chief Administrator of the University of New Mexico Health Sciences Center

Written Public Comment

- Statement of Nat Dean, Advocate for Public Assistance Dogs (June 25, 2012)
- Resolution of the Board of Directors of the New Mexico Academy of Family Physicians (April 21, 2012)
- Statement of Laurence Shandler, MD, FAAP (June 25, 2012)
- Statement of Ken Collins and Attachments
- Email Correspondence from Jill Kennan
- Statement of Tess Velasquez (6/25/2012)
- Statement of Ernestine Morales (6/25/2012)
- Handwritten Statement of "Monique's Mother"
- Statement of Art Tarro