

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

**October 10-12, 2012
Room 322, State Capitol
Santa Fe**

The fifth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, at 9:15 a.m. on Wednesday, October 10, 2012, in Room 322 of the State Capitol.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair
Sen. Gay G. Kernan
Rep. Dennis J. Kintigh
Sen. Linda M. Lopez (10/11)
Rep. Antonio Lujan
Sen. Gerald Ortiz y Pino

Absent

Rep. Nora Espinoza

Advisory Members

Sen. Sue Wilson Beffort
Rep. Ray Begaye (10/10)
Sen. Stephen H. Fischmann
Rep. Miguel P. Garcia (10/11 and 10/12)
Rep. James Roger Madalena
Sen. Cisco McSorley (10/11 and 10/12)
Rep. Bill B. O'Neill
Sen. Nancy Rodriguez
Sen. Sander Rue (10/11 and 10/12)
Sen. Bernadette M. Sanchez
Rep. Mimi Stewart (10/11 and 10/12)
Rep. James E. Smith (10/12)

Sen. Rod Adair
Rep. Eleanor Chavez
Sen. Mary Kay Papen
Sen. John C. Ryan

Guest Legislators

Rep. Patricia A. Lundstrom (10/10 and 10/12)

Rep. Dennis J. Roch (10/12)

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

Staff

Michael Hely, Legislative Council Service (LCS)

Shawn Mathis, LCS

Rebecca Griego, LCS

Guests

The guest list is in the meeting file.

Handouts

Handouts are in the meeting file and posted online.

Wednesday, October 10

Medicaid Innovations: Community Care of North Carolina (CCNC)

After welcome and introductions, Dr. L. Allen Dobson, Jr., president and chief executive officer of CCNC, made a presentation regarding health care delivery innovations made by CCNC, the nonprofit contractor that manages North Carolina's Medicaid program. (See handout.)

Dr. Dobson explained that he started as a rural primary care physician. He took part in over a decade's worth of work by the state and provider community to improve care and bend the rising health care cost curve in the state. Findings apply to fee-for-service (FFS) care delivery, as well as to capitated programs.

Medicaid tried various ways to achieve health care cost savings. Cutting provider reimbursement offered quick savings but reduced access through provider attrition. Lowering eligibility shifted the burden of care to the local community, as patients sought care through emergency rooms and visits to providers for which the providers could not collect.

North Carolina's Medicaid program has an \$11 billion annual budget and serves 1.6 million patients a year. CCNC realizes that primary care is "foundational", with care coordination crucial to cost-effective care. North Carolina's Medicaid program is currently among the 10 most highly rated in the country, having achieved a negative cost curve.

Timely access to claims data has been crucial. Data analysis reveals that a small group of aged, blind and disabled patients represents two-thirds of total patient care costs. As a result, CCNC focused on building systems around the highest-need patients. Now there is a statewide network of medical homes, and nearly all of North Carolina's primary care providers participate

in Medicaid.

North Carolina's Medicaid program manages the money and retains the savings. Solutions developed to manage high-need patients come from providers. This is a management, instead of regulatory, structure in which providers have ownership of improvement initiatives. Care is delivered through all willing provider community networks, which are compensated through an enhanced per-member, per-month payment. FFS is still in use. Communities drew their own regional network maps.

North Carolina also has a pharmacy home model to analyze and track patients on multiple medications. Providers "own" this database and upload data to it. The database has allowed providers to perform predictive modeling to identify patients needing attention and then advise the community on interventions.

The federal Office of the National Coordinator for Health Information Technology at the U.S. Department of Health and Human Services provides grant funding for North Carolina's community care structure.

Lessons learned:

- Data have to be available for each patient at the time and point of service.
- Community resources are necessary, in addition to FFS, to manage complex patients across silos. These resources are best located as close to the "ground", or community, as possible.
- Creating local collaboratives has been helpful. There needs to be a physician leader in a community. These physician leaders need to be identified and engaged. Dr. Dobson noted that it is very hard to put this in a contract. Contracts are inflexible, and flexibility is needed for local variations.
- Improvement is incremental by small steps over time.
- Physicians are the state's best fraud detectives. They report unusual claims activity.
- Risk-taking is not essential but shared accountability is. Doctors understand that poor outcomes negatively affect their fees.
- Medicaid planning needs to be done on four-year or six-year horizons. A decision may take six months to implement, and results are not apparent within one election cycle. Results come in the next biennium.
- Changing the health care delivery system on a budget cycle is problematic.

On questioning, Dr. Dobson and committee members addressed the following concerns and topics.

Managing Medicaid managed-care organizations (MCOs). A member noted that New Mexico has statutory provisions for medical homes, but there are potentially five or more MCOs that would manage them. The member inquired whether such a system is too complex. Dr. Dobson noted that it is "not inconceivable" to have well-run managed care programs, but requirements should be standardized, and the delivery system has to be uniform across all

MCOs. In addition, MCOs must be held accountable for contract deliverables. It was noted that no one from the Human Services Department (HSD) was in attendance.

The impact of reduced hospital admissions on hospital finances. A member noted that achieving reduced hospital admissions could affect hospital finances. Dr. Dobson explained that hospitals are part of the community provider network tasked with coordinating care; most hospitals do not complain about reduced Medicaid admissions because they do not depend on Medicaid as an income stream. Further, North Carolina has reduced only the growth rate of Medicaid, not fees. No hospitals have gone out of business.

Managing care for the disabled. A member noted that 80% of North Carolina's Medicaid expenditures are for disabled enrollees. Dr. Dobson advised that North Carolina is enrolling nursing homes in a medical home model. In his view, addressing the uninsured aging disabled population can yield savings by delaying their entry into Medicaid.

Managing transitions of care. North Carolina's Medicaid program has saved \$50 million through better management of care transitions. CCNC receives live communications twice a day regarding all discharged patients. A care manager is assigned to every patient who leaves the hospital. CCNC stratifies risk to determine which patients need more intensive transitional care. Some patients need home visits right away, others do not. The care managers do not work for home health care agencies.

The importance of claims data. North Carolina's CCNC claims database is a provider system that is used and kept current by providers. Enrolled providers have access to all of the data that are collected, including pharmacy data and feeds from hospitals. CCNC also asks providers to record delivery of care coordination services for which they cannot charge under a zero dollar billing code in order to track these services.

Building a system for those who need the most care saves the most money. Complex Medicaid patients and the frail elderly need the most care. Dr. Dobson advises building a system around these patients to realize the greatest savings. CCNC stratifies patients into 26 categories to identify those requiring additional care management. At least half of its complex patients co-present with behavioral health issues, and behavioral health is carved into the Medicaid program.

Holding physicians accountable for noncompliant patients. A member expressed concern about penalizing providers when patients are noncompliant. Dr. Dobson stated that current Medicaid regulations place limits on patient inducements. Noncompliant patients may be divided into three categories:

- those whose care is so complex that they "fall through the cracks";
- those with situational barriers for whom motivational interviewing techniques or having a good list of local community resources may help; and
- those who are stubborn (which Dr. Dobson stated is a smaller group than one might think).

CCNC reporting does not penalize doctors for noncompliant patients; the reports simply identify patients needing more focus.

Public Health Vision for New Mexico

Dr. Robert G. Frank, president, University of New Mexico (UNM), and Dr. Paul Roth, chancellor for health sciences and dean of the UNM School of Medicine, made a presentation about creating an accredited school of public health in New Mexico. While Dr. Frank proposed UNM as the hub, he envisions collaboration with New Mexico State University (NMSU) and other community colleges throughout the state. UNM has 57 faculty members with public health degrees. He estimates that it would take from four to seven years to achieve accreditation. (See handout.)

Dr. Frank, Dr. Roth and committee members addressed the following concerns and topics:

The need for statewide development of health services and programs. A member stated that for many New Mexicans, regional health centers in Texas are closer than Albuquerque. Dr. Frank noted that no single resource could serve the entire state. However, public health differs from acute care services in that it focuses on populations rather than on individuals. Dr. Roth added that faculty for the school of public health need not all be located in Albuquerque, but it would be important for the faculty to have an understanding of rural health needs and concerns. Another member observed that the UNM School of Medicine does not admit very many candidates from rural areas of New Mexico. There was also a request that UNM focus more on training Native Americans in the health fields.

The distinction between current public health degree offerings and those that would be offered by a school of public health. Dr. Frank explained that UNM currently offers a master of public health degree, but not a bachelor or doctoral degree. Though the Robert Wood Johnson Center for Public Policy does some work in the area of public health, it is a research center and does not offer degrees. When asked about the advantage of establishing a school of public health, Dr. Frank explained that universities with schools of public health have more expertise to apply to local public health challenges.

UNM Health Sciences Center (HSC) Update and Statewide Role and Mission in New Mexico

Dr. Roth advocated for a new UNM hospital with 96 beds to address a current shortage of inpatient beds, which is causing long waits for admitted patients and diversion of patients to other facilities. Unlike many states, New Mexico has a shortage of inpatient beds overall. The new hospital will specialize in elective surgery. Dr. Roth next reviewed the UNM HSC's funding requests for the 2013 legislative session (see handout). He noted that the UNM School of Medicine recently received a national award for public service.

Dr. Roth and committee members addressed the following concerns and topics.

The need for continuing support of Project Extension for Community Healthcare Outcomes (ECHO). Several members expressed support for Project ECHO as one strategy to address the health care work force shortage. A member expressed concern that the Department of Health (DOH) is not more supportive of funding for this program. Dr. Roth stated that he thinks that Project ECHO has only scratched the surface in terms of addressing the shortage of specialists in rural areas. Another member commented that she is sure that Project ECHO has saved lives in her community. Noting the value of Project ECHO for rural New Mexicans, Dr. Roth was asked why Project ECHO lost funding in recent years. He explained that "everyone" had their budgets cut. Project ECHO had a contract with the DOH that has since ended. He said that Project ECHO suffered as a result and has been forced to seek funding outside of the state. It has "only scratched the surface" of its potential to help in rural areas in delivering specialists' expertise. The U.S. Department of Veterans Affairs has adopted the Project ECHO model, as have other states. A member noted that the LHHS has already endorsed Project ECHO funding and that the DOH has told the Legislative Finance Committee that Project ECHO does not need funds. The member stated that the LHHS should educate the DOH on this point. One member commented that a hospital group doing business in the state has its own equivalent of Project ECHO at no cost to the taxpayers. It provides neurological services to 50 hospitals. The member stressed that Project ECHO is not the only "game in town" and that a government approach is not the only way.

The need to raise salaries to retain medical school faculty. Concern was expressed about the low pay for UNM faculty — with UNM faculty earning salaries in the lowest quartile among faculty nationwide. Dr. Roth noted the difficulty in recruiting, when new faculty must be brought in at the fiftieth percentile while older hires earn less. This is part of UNM's current budget request, so that faculty salaries may be modestly increased.

Using NMSU's agricultural extension framework for health extension rural offices (HERO). There was a discussion about UNM's search for someone to run the Hobbs HERO program and the difficulty for Medicaid patients in Hobbs to get to Albuquerque. In response to an inquiry, Dr. Roth stated that he does not know whether UNM would use HERO to apply for additional grant funding.

Other issues. A member expressed support for an appropriation to the Office of the Medical Investigator (OMI), housed at UNM, for the return of bodies from the OMI to families. Currently, families must bear that cost.

Dr. Roth noted that the combined degree BA/MD program is fully funded.

In response to a question about delays in building the new UNM hospital, Dr. Roth explained that the State Board of Finance tabled this project over concern in the community about the project.

A member expressed disappointment that funding for a waiver of primary care medical education tuition, as provided in statute but never funded, is not included in the UNM HSC's

requests for funding. Dr. Roth told the committee that he would look into the matter.

A member asked whether the UNM HSC supports a Medicaid expansion to cover "childless adults" with incomes below 238% of the federal poverty level (FPL) pursuant to the federal Patient Protection and Affordable Care Act (PPACA). Dr. Roth stated that UNM supports the Medicaid expansion.

New Mexico Health Connections

Dr. Nandini Kuehn, president of the board of directors for New Mexico Health Connections (NMHC), introduced the plan that the NMHC intends to offer on the state health insurance exchange or exchanges. It will be a nonprofit, consumer-operated and -oriented or "co-op" plan pursuant to PPACA provisions providing for the establishment of these plans and mandating their inclusion on state exchanges. The NMHC plan will reinvest any surplus generated into the plan, Dr. Kuehn explained. (See handout.)

Several members of the audience were introduced as members of the NMHC board, including Charlie Alfero; former Lieutenant Governor Diane Denish; Dr. Barbara McAneny; and Ken Carson. Dr. Kuehn explained that this board will step aside once NMHC is ready to sell insurance.

NMHC Chief Executive Officer Dr. Martin Hickey introduced himself to the committee and stated that he recommends the North Carolina approach to health care delivery that Dr. Dobson described to the committee earlier in the day. Dr. Hickey endorsed the idea of cutting health care costs by actively managing patients at high risk before risks materialize.

Dr. Hickey stated that the high cost of health care is driving people out of health care. Employers are dropping or limiting coverage. People are beginning to see deductibles of \$6,000 to \$7,000. This means that hospitals do not get paid, so the hospitals raise rates to cover uncompensated care. This, in turn, raises insurance premiums. He described this process as a "death spiral". The payment scheme is broken, he said; rational market behavior maximizes utilization under the FFS model. Studies have shown that medical practices with the latest medical diagnostic equipment order more tests than practices without such technology.

Dr. Hickey explained that co-ops such as the NMHC were formed under the PPACA, with the federal government making \$3.4 billion in grant funding available to all 50 states. Currently, there are 26 health insurance co-ops nationwide. In addition, there are many nonprofit co-op plans that have been operating for many years.

The NMHC's health insurance offerings will cover individuals and small businesses with fewer than 100 employees. The NMHC may eventually provide insurance to larger organizations as well. The co-op will focus on plans for individuals with incomes between 138% and 400% of the FPL. The NMHC will be licensed as any other insurance company by the state's Insurance Division of the Public Regulation Commission. It will seek certification as a qualified health plan to be offered on the state health insurance exchange or exchanges. The

superintendent of insurance has requested the co-op to offer health insurance statewide.

The NMHC's policy pricing will be transparent. As a nonprofit plan, it will not have to add a 9% profit into premium calculations. This should help to compete with other insurers. Profits will be put back into the organization either to improve benefits or to reduce the cost of the insurance. The operational board will be composed of members. There will not be any members representing health care institutions, thus eliminating potential conflicts of interest.

The NMHC is expected to reduce health care costs by 30% through elimination of unnecessary care and the use of system innovations such as the patient-centered medical home, a primary care physician "quarterbacking" a team that works with high-risk patients. The NMHC will place some of these teams into federally qualified health centers (FQHCs). These teams will be able to do high-risk complex care intervention like Project ECHO. Informatics now are so superior that they can analyze claims history and pharmaceutical history and project risk for the coming year.

The biggest savings are in improvements in transition of care that can reduce readmission rates by half. This reduction is significant over a large population. Physicians will review data to "drill down" on any disease, any individual or any provider to take the information and share it with the physicians to look at their outcomes in group reviews. If physicians analyze data and their time doing this is counted under the medical loss ratio, there will be reduced costs, better quality and sharing of surplus under quality parameters. The NMHC intends to share savings with primary care and behavioral health providers.

The NMHC will offer plans at five levels of coverage, with actuarial values tied to the level of enrollee copayment.

Dr. Hickey noted a "terrible shortage" of 400 to 600 primary care physicians in the state, which he explained is attributable to low compensation when compared to other areas of medical specialization. Returning savings to primary care physicians serves as an inducement to primary care physicians.

Dr. Hickey stated that small business is strongly supportive of the co-op given the large annual increases in premiums.

In the insurance business, the way one makes money is to insure healthier patients. The federal government has built in protection against adverse selection for all co-ops. Risk corridors and reinsurance will help co-ops that end up with sicker patients to succeed financially.

On questioning, the following topics were discussed.

Medicaid expansion. In response to a question on enrollment in the NMHC and in Medicaid under the expanded federal option, Dr. Hickey explained that individuals may enroll in the NMHC as of January 1, 2014. Shortly after that, there will be a process for members to be

nominated to sit on the board. This board has to be in place by the end of 2015.

As for Medicaid enrollment, 180,000 New Mexicans are expected to qualify for Medicaid under the expansion, and 200,000 would be eligible to purchase on the exchange. Individuals with incomes under 138% of the FPL will qualify for Medicaid. Subsidies for purchase of plans on the exchange will be available to those with incomes from 138% of the FPL to 400% of the FPL. The NMHC anticipates that there may be "churn", or movement back and forth between Medicaid and private plans, due to employment or family status.

Premiums and sustainability. A member asked how NMHC premiums would be priced. Dr. Hickey answered that an actuarial firm is pricing its plans, but pricing will also depend upon regulation. Estimates are expected in the spring of 2013. The NMHC has run proprietary projections for its business model and is confident that it is sustainable. The NMHC plans to offer Medicare supplemental coverage beginning in 2017, pursuant to federal regulations. The NMHC has just applied to join the New Mexico Health Insurance Alliance. Another member voiced "serious concerns" about the NMHC.

Medically unnecessary care and care coordination. Responding to an inquiry about cutting costs while increasing provider compensation, Dr. Hickey stated that the goal is to "do more at lower cost", identifying higher-risk patients earlier to avoid or delay costlier outcomes later. In response to a statement by a member that defensive medicine drives unnecessary care, Dr. Hickey informed the committee that defensive medicine is only responsible for 2% to 5% of unnecessary care. From his experience with the BlueCross BlueShield Association, physicians with diagnostic equipment in their offices perform more tests. The NMHC will be contracting with FQHCs, primary care providers and hospitals.

NMHC's management and board of directors. All executive compensation has been vetted by the federal Centers for Medicare and Medicaid Services and will be public. The NMHC board is a volunteer board whose members are not compensated. A committee member commented on the impressive slate of NMHC's board members.

A member asked whether legislative approval is required for the NMHC to operate. Dr. Hickey stated that it would not be needed and that the presentation was only informational.

All payer claims database and health information exchange. Dr. Hickey informed the committee of a trend in states establishing all-payer claims databases. He was involved in the formation of New Mexico's health information exchange. In his opinion, the exchange is now robust and has a capable information technology vendor. The cost of information storage is more affordable than ever. Whether through an all-payer claims database or the exchange, aggregated patient information can be an invaluable tool to compare care among physician peers.

Aging and Long-term Services Department (ALTSD) Update

Alzheimer's disease. Secretary of Aging and Long-Term Services Retta Ward first

addressed the status of the ALTSD's work on House Memorial 20 (2012), which requested the ALTSD to convene an Alzheimer's disease task force. The task force has been convened and expects to meet its 2013 reporting date. The task force is putting together a state plan to include recommendations for policy, legislation and funding. The task force is large and diverse. It includes the following working groups: public awareness; early detection and diagnosis; quality of care; needs of caregivers; research into brain health; and health care system capacity. The task force will look at available resources, methods of addressing the diverse population affected and the effects of poverty on individuals with Alzheimer's disease. At the same time, the National Alzheimer's Project is working on a national plan for Alzheimer's disease and related dementias.

Secretary Ward noted that 18% of all deaths in New Mexico in 2008 were attributable to Alzheimer's disease. At age 65, the odds are one in eight that a person will develop Alzheimer's; at age 80, the odds are 50/50. Recent research suggests that diabetes can drastically increase the incidence of Alzheimer's.

Elder abuse. Secretary Ward addressed the ALTSD's charge to investigate incidents of elder abuse and neglect. She noted that the Aging and Disability Resource Center's toll-free hotline, at 1-800-432-2080, receives reports of elder abuse and neglect and refers them to the ALTSD's Adult Protective Services Division (APSD). She stated that staff shortages have resulted in fewer investigations. Twenty-three percent of cases investigated were substantiated. A smaller percentage of cases requiring response in 24 hours were substantiated.

Many calls to the APSD involve self-neglect, for which the APSD may provide home care services. A typical report involves a woman in her late 70s or 80s, living alone with no family and unable to drive. Such elders are often so ill or frail that they cannot take out the trash, run errands, go shopping or get to medical services. They cannot afford paid help, as many have incomes of less than \$800 a month. Twenty percent of home care clients have even more severe limitations. These individuals are at a high risk of premature institutionalization. Secretary Ward noted that it is less expensive to keep these individuals in their homes. For this reason, the ALTSD is requesting more money for home care services in its budget.

Hunger. Secretary Ward informed the committee that 15% of the elderly go hungry, with New Mexico ranking second in the country for the number of adults facing food insecurity. Since the recession, the number of seniors experiencing the threat of hunger has increased by 34%. The ALTSD administers federal pass-through dollars that go to area agencies for senior meal programs.

Continuing Care Act rulemaking. Secretary Ward noted that there are nine continuing care communities in the state. In response to recent changes to the Continuing Care Act governing contractual relationships between continuing care community residents and operators, the ALTSD is conducting stakeholder meetings. The department expects to issue rules in the summer of 2013. Department staff are also drafting and updating Continuing Care Act consumer guides.

Prescription drug abuse. Rates of prescription drug overdose are higher for seniors in rural and poor areas. According to the secretary, those over 65 mostly misuse legal drugs, including alcohol and prescription drugs. In addition, Gino Rinaldi, deputy secretary of aging and long-term services, told the committee that older patients tend to keep their unused medicines in their homes, so they are good sources of drugs for diversion.

On questioning, the following topics were discussed.

Criminal prosecution for elder abuse. One member urged removing crimes against elders from the Hate Crimes Act because establishing the elements of a hate crime make it more difficult to successfully prosecute assaults against the elderly.

Investigating elder abuse. A member questioned why only 50% of 10,000 reports made were investigated. Secretary Ward explained that the Aging and Disability Resource Center screens these calls using established criteria to determine whether any investigation needs to take place. After intake, a field supervisor conducts a search for previous reports. A key factor is whether there is an allegation of neglect, abuse or exploitation. When it is clear that the elder has decisional capacity, the center does not investigate. Sometimes the reported information is not sufficient to locate the alleged victim. These factors are consistent with statistics reported nationwide. The member asked whether, for the 23% of substantiated cases, charges had been filed. Secretary Ward answered that if the case involves a crime, it is referred to law enforcement and to the Office of the Attorney General. Fifty percent of cases last year involved self-neglect and, thus, there was no one to prosecute. ***The member requested that the ALTSD supply the number of those who are convicted or who face penalties.** Note: In response to this request, on November 7, Secretary Ward sent the following answer:

Percent of Substantiated Abuse Cases Prosecuted: Adult Protective Services does not have this information. The Adult Protective Services Act is the civil law upon which Adult Protective Services is authorized to act. APS conducts investigations and substantiations based on a preponderance of the evidence. APS refers cases to law enforcement when there is an immediate safety issue or when APS case workers encounter evidence of a crime. In some cases, law enforcement is already involved when APS is referred in to conduct an investigation. Once a case is referred to law enforcement, APS does not receive additional information as to whether the case was successfully prosecuted. In cases in which there is a criminal conviction, it may take place several years after APS was involved. Prosecution may be based on 1) domestic violence statutes or 2) Resident Abuse and Neglect Act (30-47-1 NMSA 1978). APS cooperates fully with law enforcement, providing information to assist with investigations and prosecutions.

[Secretary Retta Ward, electronic mail of November 7, 2012.]

Public Comment

Ruth Hoffman of Lutheran Advocacy Ministry noted that New Mexico has a state general fund supplemental nutritional assistance program (SNAP, formerly known as "food stamps")

supplement for seniors. It is a minimum of \$25.00 a month. The federal SNAP allotment is very small. The HSD is asking for an increase in funding to keep that amount for the program. Ms. Hoffman supports an increase in the SNAP supplement to \$50.00 a month. This would cost \$1 million for 5,000 seniors. She noted that Governor Susana Martinez has been very supportive of this program.

Donna Higdon told the committee that she is concerned about the lack of prosecutions for elder abuse. She has made public records requests to the city police, county sheriff and state police requesting a breakdown of case statistics. The information she received showed that, for two years in which 51,000 cases were recorded, not one case of elder abuse was prosecuted. Ms. Higdon advocates giving out pamphlets that instruct those reporting elder abuse to contact the police, not the APSD. According to Ms. Higdon, response time is too slow for the APSD. ***A member suggested that elder abuse laws may need to be re-evaluated and that perhaps there should be an interim task force to study the issue, looking to laws of other states such as California.** A committee member noted problems in prosecuting the exploitation of elderly people by fraudulent telephone solicitations. Nearly all of these calls, the member stated, are from outside the U.S.

A motion was made, then withdrawn, on the matter of a committee letter to the State Board of Finance to encourage support for UNM's new hospital expansion.

Thursday, October 11

Hotspotting

Dr. Jeffery Brenner, director of the Institute for Urban Health at Cooper University Hospital and executive director of the Camden Coalition of Healthcare Providers, appeared before the committee via webcast. Dr. Brenner is known nationally as a pioneer of a different model of health care delivery, focused on "hotspots". Dr. Brenner framed the problem for the committee:

- the bulk of federal debt going forward is for health care;
- 85 million "baby boomers" are heading toward the most expensive health care system in the world;
- the U.S. does not have the best health care system in the world — just the most expensive;
- the health care industry is overbuilt with hospitals and specialty care;
- providers make money if they "cut, scan, zap or hospitalize" a patient;
- there is no financial incentive for a physician to spend time talking to a patient;
- hospital stays cost an average of \$10,000;
- emergency room visits cost an average of \$500;
- hospital stays are 40% of total health care spending; and
- health data are locked up in the hands of the state and private health insurers that do not want to share it.

Dr. Brenner recounted steps taken to reduce Medicaid spending in Camden, New Jersey. There, Medicaid was spending \$100 million annually on emergency room visits alone. Dr. Brenner asked the committee to imagine how much primary care one could buy for \$100 million.

The first step in Dr. Brenner's strategy to reduce Medicaid spending was to analyze available Medicaid health data to identify patients that were the highest users of services. Next, the home addresses of these patients were mapped against census blocks. This exercise revealed that most of the expensive Medicaid patients were clustered in two buildings populated by the elderly and disabled. Care coordination was then built around rank-ordered high-cost Medicaid beneficiaries, using nonprofit and church community resources. The goal of the strategy's clinical model is to "glue" a high-use patient to a primary care provider. Critical to care coordination are teams of health care workers, process workflow and real-time data feedback loops. According to Dr. Brenner, hotspot patients are identified by daily data feeds from hospitals and emergency rooms — not necessarily from referrals. Of note, the data system he uses for real-time tracking of patients is off-the-shelf, affordable software that can be run by a student intern. He told the committee that the barrier to this real-time tracking is not the technology, it is the unwillingness of insurance companies and state governments to share the data. (See handout.)

The following concerns and topics were discussed during questioning.

The impact of behavioral health and addiction on rates of utilization. Dr. Brenner dispelled the notion that mental health problems and addiction are the primary drivers of high hospital use. According to Dr. Brenner, poor patients have many life challenges. They live on \$660 per month, and one of their coping skills is to go to the hospital.

Community and local resources are key to reducing unnecessary utilization. Dr. Brenner believes that the community has to reconfigure the health care delivery system around high-cost Medicaid beneficiaries. He does not believe that there is a "federal fix" to reduce Medicaid spending; this is a local issue capable of a local solution.

Hospitals as legacy institutions. A member asked about the impact of reducing hospital admissions and emergency room use upon hospital finances. According to Dr. Brenner, hospital administrators know that the current hospital business model "is coming to an end". This is evidenced by consolidation in the hospital industry, through merger or closure. He compared the hospital industry to Blockbuster or Kodak. The new hospital business model will have to focus on delivering better, rather than more, care. As a result, hospital administrators are interested in reducing the amount of uncompensated or undercompensated care that hospitals provide to high-cost Medicaid beneficiaries.

The importance of a physician champion for new approaches to reduce health care costs. According to Dr. Brenner, a clinician and great project manager are needed to field a great team. He stated that clinicians need to "get out of the way". Dr. Brenner recognized Dr. Sanjeev

Arora, director of Project ECHO at the UNM HSC, as a world-class innovator in health care. In fact, Dr. Brenner has sent members of his staff to train with Project ECHO.

Steps that can be taken right now. Dr. Brenner stated that incremental improvements in care coordination and cost reduction can take place right now. According to Dr. Brenner, New Mexico's Medicaid program has the ability to identify the five most expensive Medicaid beneficiaries in each community. He suggests providing the cost data for those individuals to the community's business leaders, using a "governor's challenge" to ask local business leaders to develop a plan to address the health care needs of these high users. In response to a member's interest in an approach used by Maine, Dr. Brenner advised that Maine uses a waiver to set up a community outreach team. This is an immediate small project that can be done at very low cost. ***A committee member wondered whether the committee could challenge the state's Medicaid MCOs to identify the hotspotters to reduce costs. *A member wondered whether current health information collaboratives could identify hotspots. *Another member requested information on Maine's community outreach approach.**

Remote care coordination and case management. In his opinion, telephonic case management is an "utterly inadequate tool". There is no evidence-based data showing that telephonic case management works, absent an existing relationship. It is easier for a Medicaid MCO to hire 100 nurses to sit in a phone bank than to implement face-to-face care coordination because this is not its core business, and there is no way to ramp up for this. So in the state's contract, the MCO must be required to provide this service by purchasing locally.

Innovations in reimbursement. Dr. Brenner believes that it is difficult to manage a system that blends FFS and capitated rates. He advocates using one or the other, but not both. North Carolina's Medicaid program is FFS. Arizona's Medicaid is managed care. Dr. Brenner believes that to have a true integrated health care delivery system, all costs must be "in the same bucket".

The importance of data sharing. Pat Montoya, director of Aligning Forces for Quality with HealthInsight, emphasized the critical need for data that remain siloed. She urged policymakers to signal that data sharing is imperative and noted that UNM has the current capability to analyze such data. She suggested that a memorial discouraging the siloing of claims data might be in order. Jeff Dye, president and chief executive officer of the New Mexico Hospital Association, agreed that there needs to be collaboration, with the state taking a leadership role. According to Mr. Dye, hospitals are submitting discharge data to the New Mexico Health Policy Commission, but this is currently unfunded. Mr. Dye stated that an all payer claims database is needed. Maggie Gunter, president of LCF Research, the entity that runs the state's health information exchange, advised the committee that several states have passed all payer claims database legislation. According to Ms. Gunter, this is achieved through a mandate that health plans share data, with funding appropriated for the establishment and administration of the database. Ms. Montoya added that Colorado's all payer claims database has been established with grant funding. A representative from Project ECHO advised the committee that a new grant project is using data from four MCOs that have been sent to Tufts and New York

University for analysis, using certain Medicaid filtering, for predictive modeling of projected costs. ***A member asked whether legislation is needed to require the sharing of health data.** ***A member suggested legislation requiring the establishment of an all payer claims database.** Another member commented that health policy should be data-driven.

A member commented that "it is incredible" that no one from the state's Medicaid office was in attendance for Dr. Brenner's presentation.

Rural Care Coordination Innovations

Charlie Alfero, director of the Center for Health Innovation (CHI) of Hidalgo Medical Services, continued the morning's focus on local solutions to health care challenges. The CHI's approach is to use rural areas as a hub for training physicians. He emphasized that rural New Mexico wants to import, not export, health service providers. The strategy is to use local resources to take care of the local population. He indicated that the CHI already has a contract with UNM and Molina Healthcare to focus on the most expensive Medicaid beneficiaries. Already, the CHI has reduced the number of prescriptions, emergency room services and inpatient stays for this population. He advised the committee that Molina has hired UNM to build a curriculum for care coordination in nine states. (See handout.)

During questioning, the follow topics were discussed.

Caps on primary care training slots. According to Mr. Alfero, Las Cruces has the same number of primary care training slots as in 1997. The CHI wants to organize a consortium for family practice training. In response to a question from a member, Mr. Alfero stated that the cap on training positions was originally imposed to reduce health care costs.

Local data are available. Mr. Alfero believes that there is no need to wait upon the development of an all payer claims database; entities that possess health claims data could be required to share data now.

Tribal Consortium

Ileen Sylvester, vice president of executive and tribal services, Nuka Institute coordinator, Southcentral Foundation, made a presentation to the committee via webcast from Alaska. The Southcentral Foundation is composed of 55 tribes with seven different tribal leadership groups. Its board is composed entirely of Alaska natives who are also shareholders. In 1998, the foundation assumed responsibility for the entire primary care system through a 638 compact with the Indian Health Service. In 1999, the foundation assumed ownership of the Alaska Native Medical Center. The Nuka system of care was adopted in 2000 as part of a redesign of the system to incorporate customer choices and values. It is built upon shared responsibility, in which the customer is also an owner. In addition to operating various hospitals and other health care facilities, the foundation makes substantial use of health aides for village health care. Ms. Sylvester provided the following details about this highly successful health system:

- Last year's budget was \$200 million, with 1,600 employees and 64,000 customer-owners.
- The Nuka health system not only provides health care to Alaska natives, it also serves as an employer of Alaska natives. Over 50% of its employees are Alaska natives or Native American. Employee development is encouraged and supported. Every employee has a performance development plan with a clear understanding of how each employee supports the organization's vision.
- Services offered must be financially sustainable and viable. Employees from within the community are trained to take over.
- There is an internship program for young people from 14 years old to 18 years old. Each summer, 55 interns enter the program to develop tribal leaders of tomorrow. Those who go through the internship can step right into employment.
- Regional health centers are convenient for customer-owners with minimal stops to get all their needs addressed. The Anchorage campus serves as a gathering place for native peoples.
- Customer focus includes an annual gathering to get feedback on services. In addition, Nuka is piloting a real-time customer survey using iPads when the patient comes for an appointment. These surveys go to department managers and vice presidents as part of continuous improvement efforts.
- In 2011, the system won the Malcolm Baldrige National Quality Award for its unique relationship-based health delivery system, for obtaining the highest level of patient-centered medical home and for reducing staff turnover.

During questioning, the following topic was discussed.

Relations with state and federal governments. The Alaska Tribal Health Compact (1994) authorizes tribes and native health organizations to operate health and health-related programs. It is the umbrella agreement for the relationship between tribal governments and the United States. Alaska is the only state in which over 99% of health programs are managed by tribes and Alaska native organizations. According to Ms. Sylvester, under this compact, all tribes collaborate. They do not all agree, but as a whole, as a caucus, they negotiate with the federal government in one voice. Ms. Sylvester explained that 225 federally recognized tribes are parties to the compact. There is also an Alaska Native Health Board, which serves as the statewide voice on Alaska native health issues. It emphasizes the importance of self-determination in health care services. At its annual meeting, priorities are identified for consideration by state and federal legislators. Ms. Sylvester emphasized that, as a statewide health system, when an issue is identified, the tribes speak with one voice and carry the same message.

Statewide Expansion of Cancer Clinical Trials

Terri Stewart, executive director of the New Mexico Cancer Care Alliance (NMCCA), and NMCCA board co-chairs Dr. Cheryl Willman and Cal Ridgeway appeared before the committee to advocate for funding to enable rural physicians and patients to participate in cancer clinical trials. The NMCCA is a nonprofit organization outside of the UNM HSC that is a

statewide alliance of health care institutions and hospitals that makes cancer clinical trials available to patients throughout New Mexico. This model is being mandated elsewhere. There are rural cancer physicians who would like to join the NMCCA but lack the infrastructure or staff. The alliance is requesting \$200,000 to hire four employees to help rural physicians to participate in clinical trials through the alliance. This will permit patients in clinical trials to stay in their own communities. Dr. Willman highlighted that telemedicine now makes it possible to have cancer patients managed by their local physicians.

During questioning, the following issues were raised.

The shortage of chemotherapy drugs. In response to a question, Dr. Willman confirmed that there is a shortage of chemotherapy drugs in the United States as a consequence of the federal Medicare Modernization Act. She explained that pharmaceutical companies stop making a drug when the generic becomes available, because the generic is much less expensive and less profitable. This shortage has affected the opportunity for a patient to participate in clinical trials. Wealthy health care institutions are better able to compete for scarce drugs. ***A member requested that a letter be written to New Mexico's congressional delegation to support changes in the Medicare Modernization Act to alleviate the shortage of cancer treatment drugs.**

Funding for the NMCCA. Funding for the NMCCA must come through the DOH through a request for proposals. An appropriation to the DOH for a statewide alliance would be required.

New Mexico requires health insurers to offer coverage for cancer clinical trials.

Community Services Block Grant Update

Ted Roth, director of the Income Support Division of the HSD, appeared before the committee to report on the status of the block grant from the U.S. Department of Health and Human Services to the state. This grant is a flexible federal funding source to local communities through a network of community action agencies to reduce poverty. (See handout.)

During questioning, the following topics were discussed.

Whether the department's web site had a proper link for services available through the block grant.

The fate of individual development accounts.

Whether low participation in programs is an indicator of low outreach. Mr. Roth added that qualified low-income individuals may not be able to come up with their share of matching funds for programs that require this.

Other Matters

A member requested that the minutes reflect that the Las Vegas Rape Crisis Center provided the committee with the results of a financial audit.

Members discussed the governor's plans for a health insurance exchange and Medicaid expansion.

In response to a member's question, Mr. Hely reported that provisions of the PPACA will bring Medicaid reimbursement rates for primary care into alignment with Medicare reimbursement rates.

Friday, October 12

Dental Therapists and Access to Dental Care in Rural and Tribal Areas

New Mexico ranks forty-ninth among states in dental health, with 36% of third graders suffering from untreated dental decay, according to attorney Pamela Blackwell, project director for oral health access at Health Action New Mexico. Along with Ms. Blackwell, a panel of experts made the case for using dental therapists in areas where there is a shortage of dentists. According to the panelists, dental therapists can fill this gap with home-grown, culturally competent and high-quality dental care.

Dr. Todd Hartsfield, D.D.S., assistant professor of clinical dentistry at the Arizona School of Dentistry and Oral Health, has a long history of teaching dentists and others. He explained that he has trained and supervised dental therapists for 20 years, starting up a dental therapist program in Saskatchewan. In rural or remote village areas, dental therapists see more patients than fly-in dentists because they live in, and are from, the communities they serve. Their salaries contribute to the local economy. Dental therapists remain under the supervision of a dentist and are subject to frequent spot-checks; once licensed, a dentist's work is never inspected. Dental therapists prescreen patients and perform dental preparation so that when the dentist flies in, the dentist's time is used efficiently. According to Dr. Hartsfield, due to their limited scope of practice, dental therapists are more experienced at performing the procedures they are licensed to perform than most dentists. Further, no study has shown that care administered by dental therapists is inferior to that of dentists. Finally, there has not been a single complaint lodged against a dental therapist in Saskatchewan since the use of dental therapists began.

Daniel Kennedy, an Alaska native and dental therapist from Klawock, Alaska, told the committee how he was chosen by his village to receive training as a dental therapist. His education included course work in pathology, biology and anatomy through the University of Washington. His second year was spent in Bethel, Alaska, which is a hub for 58 Alaska native villages. There, he received clinical training Monday through Friday from 8:00 a.m. to 6:00 p.m. Next, he was in a preceptorship under a dentist for 400 hours (six months) of direct supervision. His total education and training took 3,000 hours over three years and nine months to complete. Now practicing in his hometown of Klawock, he told the committee that he is related to most of his patients. He treats patients at Head Start and the senior center, and he even makes house

calls. Mr. Kennedy stated that there are currently 33 dental therapists practicing in the interior of Alaska.

Dr. Ronald Romero, the former dental director for the DOH, is now retired and works with school-based programs. He has traveled to Alaska to assess its dental therapist program and to evaluate the training and curriculum. He stated that he was "very impressed" and observed "safe and technically appropriate care". He advocates using dental therapists in tribal dental health clinics, DOH programs, school-based programs, FQHCs and frontier and rural communities.

Michael Bird, M.S.W., M.P.H., public health consultant to the Pueblo of Kewa/Santo Domingo, told the committee how the American Dental Association (ADA) had attempted to block the use of dental therapists in Alaska but lost on the issue of tribal sovereignty. Mr. Bird advised the committee that following this loss in the courts, the ADA successfully lobbied for a provision in the PPACA that precludes tribes and the Indian Health Service from using dental therapists. He complained that this provision erodes self-determination and tribal sovereignty. According to Mr. Bird, this provision means that tribes must obtain authorization from the state in order to use dental therapists.

Don Weidemann, administrator for the Union County General Hospital in Clayton, New Mexico, explained how the shortage of dentists has affected his community. Currently, the closest dentists are in Dalhart or Amarillo, Texas. This means that his employees must take an entire day off to go to the dentist. Even with the promise of aid in recruiting a dentist from the president of the dental association, and two years after purchasing dental equipment, the community has been unable to attract a dentist. He supports legislation licensing dental therapists to ease the shortage of dental care in small rural communities.

Upon questioning, the follow topics and concerns were raised.

Dental hygienists are not filling the gap in dental care. The shortage of dentists affects the ability of dental hygienists to obtain employment and provide dental care. A representative of the New Mexico Dental Hygienist Association told the committee that schools are graduating twice the number of dental hygienists than there are available positions.

The need to "glue" dental therapists to a community. This involves recruiting dental therapists from the community in which they are expected to practice. A member suggested legislation requiring return to the community if training or education is state-funded.

Using existing higher education resources to provide dental therapist education and training programs. Members mentioned San Juan College, Eastern New Mexico University and Dona Ana Branch Community College as possible sites for such programs. Dr. Romero stated that UNM could train dental therapists. Dr. Charles Taver, a professor in the department of medicine at UNM, advised that UNM has an advanced dental education residency program and

could train dental therapists if directed to do so by the legislature. Funds may be available under the PPACA for dental demonstration pilots.

Legislation to allow Native American tribes and pueblos to use dental therapists. Two members expressed willingness to carry such legislation.

Other states considering licensing dental therapists. Minnesota and Kansas are closest to enacting dental therapist legislation. Twenty states are now considering licensing dental therapists. A member recalled the battle to enact legislation to license physician assistants. He stated that he could not imagine where health care would be today without physician assistants. He observed that, given the time lag to get dental therapists educated and trained, if legislation had been enacted two years ago, the state would be ahead of the game.

Audience members supporting the licensing of dental therapists. Audience members supporting dental therapists included: Lydia Pedley, president, Health Action New Mexico; Jerry Lujan, Seniors United; Dr. Howard Rhodes, dental director, Fort Sumner; and Dr. Jerry Harrison, director of New Mexico Health Resources, Inc.

Report from the Task Force on Work-Life Balance

Giovanna Rossi Pressley, president, Collective Action Strategies, and Lee Reynis, Ph.D., and director of the Bureau of Business and Economic Research at UNM, updated the committee on findings based on survey responses from New Mexico employers. Of note, the panel reported that 60% of children under six years old have parents who work outside the home during the day. They advised the committee that this phenomenon has caught the attention of the early childhood development community. The speakers requested the committee to fund further work of the task force to recognize family-friendly employers and to support a memorial encouraging more businesses to work with the task force in the future.

Physician Aid in Dying

A panel made up of patients, physicians, end-of-life advocates and an attorney for the American Civil Liberties Union of New Mexico advocated for greater patient choice in end-of-life care.

Dr. Katherine Morris, a surgical oncologist who now works at the UNM HSC, appeared in her capacity as a private citizen to explain how she came to be the center of Oregon's physician aid-in-dying legislation. She stated that, for those patients who want to die with dignity, the absence of an affirmative law puts physicians at risk of legal action. Dr. Morris is currently a plaintiff in a suit for declaratory and injunctive relief seeking a determination that New Mexico's assisted suicide statute does not criminalize the conduct of a physician providing aid in dying to a mentally competent, terminally ill patient who has requested such aid.

Barbara Lee, president of Compassion and Choices, explained that aid in dying is not suicide and that those patients choosing it are not suicidal. Such patients are terminally ill and wish to die at home at a time of their own choosing. Further, a large percentage of those opting

to receive medication do not terminate their own lives. Oregon, Washington and Montana permit mentally competent, terminally ill adult patients who are capable of self-administering lethal medications to obtain them legally from a physician, subject to stringent legal requirements.

Aja Riggs, a patient suffering from an aggressive uterine cancer, told the committee that she has gone through many courses of cancer treatment and has not tolerated it well. If she is going to die from this disease, she does not want to be in pain, or unconscious and surrounded by her distressed family. She would like the option and comfort of physician aid in dying to allow her to die a peaceful death. She has intervened in the lawsuit filed by Dr. Morris.

Upon questioning, the following topics and concerns were raised.

This is suicide, and suicide is wrong. A member of the committee scolded the presenters and audience members for "not calling a spade a spade". Another member questioned whether the state has the right to force people to live just because advances in medicine can extend the dying process.

Ways in which states have adopted physician aid-in-dying laws. Oregon and Washington have passed such laws through referendum. Montana's law is based upon a court ruling holding that physician aid-in-dying is not against public policy. A member asked whether any legislators in other states had lost their seats because they supported physician aid-in-dying laws. Ms. Lee replied that, to the contrary, several legislators had lost their seats for holding up this legislation. Ms. Lee stated that the political arm of the Catholic Church was the only organized opponent to physician aid-in-dying legislation. A member commented that "we should stay away from religion when we write our laws".

The distinction between physician aid-in-dying and advanced directives. Physician aid-in-dying statutes have stringent requirements to ensure that the patient is mentally competent to make end-of-life decisions and is not acting impulsively. Advanced directives come into play when a patient is no longer competent or capable of making decisions regarding medical care. According to Ms. Lee, one has nothing to do with the other.

Nurse Advice New Mexico (NANM) and Health Care Delivery Innovations

Presenters from NANM explained that it is a public-private partnership that provides statewide telephonic health advice. The organization operates under contract with the DOH to provide advice to consumers during outbreaks of disease and to assist the state in public health surveillance and reportable conditions. It also provides an after-hours health advice line for physician groups. NANM anticipates being a vendor for Medicaid MCOs that are required to hire local businesses for health hotlines. Calls are taken for both insured and uninsured patients. NANM is not compensated for approximately 12% of the calls it takes.

Greater Albuquerque Medical Association Pre-Hospital Navigation Program

This pilot program seeks to reduce the unnecessary use of the emergency room by patients who could appropriately be treated at primary care or urgent care centers. It is managed through 911 emergency dispatchers utilizing a computer to determine whether the patient is "low-acuity". While presenters hope that this medical assessment pilot will eventually have a sustainable funding stream, they are not seeking funds from the legislature at this time.

Essential Health Benefits

Superintendent of Insurance John Franchini concluded the meeting with an update on the selection of the state's essential health benefit benchmark plan. He advised the committee that the Lovelace Classic PPO had been chosen as the benchmark plan and that the next step would be to ensure that the plans on the proposed state health insurance exchange would have parity. He believes that nine to 10 health insurance companies will participate in the exchange and that this will increase competition.

Superintendent Franchini also advised the committee that the New Mexico Medical Insurance Pool (NMMIP) is running at a deficit of \$150 million. According to the superintendent, there are 9,000 insureds in this pool. He believes that the PPACA will result in the availability of health insurance coverage to these persons through the state health insurance exchange. Currently, health insurance companies receive a premium tax offset for contributions to the NMMIP. Once the pool is obsolete, the state will receive full premium taxes from health insurers.

Questioning from members focused on whether state-mandated benefits would be included in policies offered on the proposed health insurance exchange.