

**MINUTES**  
**of the**  
**FOURTH MEETING**  
**of the**  
**LEGISLATIVE HEALTH AND HUMAN SERVICES COMMITTEE**  
**September 16, 2009**  
**Santa Ana Star Civic Center, Rio Rancho**

**September 17-18, 2009**  
**University of New Mexico Health Sciences Center**  
**Family Practice Center, Albuquerque**

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Representative Danice Picraux, chair on September 16, 2009 at 8:55 a.m. A voting quorum was present.

**Present**

Rep. Danice Picraux, Chair  
Sen. Dede Feldman, Vice Chair  
Sen. Rod Adair  
Rep. Nora Espinoza  
Rep. Joni Marie Gutierrez  
Sen. Linda M. Lopez (9/18)  
Rep. Antonio Lujan  
Sen. Gerald Ortiz y Pino

**Absent**

**Advisory Members**

Rep. Ray Begaye  
Rep. Jose A. Campos (9/17, 9/18)  
Rep. Eleanor Chavez  
Rep. Nathan P. Cote  
Rep. Miguel P. Garcia  
Rep. Keith J. Gardner (9/16)  
Sen. Clinton D. Harden, Jr.  
Rep. Dennis J. Kintigh  
Rep. James Roger Madalena  
Sen. Cisco McSorley  
Rep. Bill B. O'Neill  
Sen. Mary Kay Papen  
Sen. Nancy Rodriguez (9/17, 9/18)  
Sen. Sander Rue  
Rep. Mimi Stewart  
Sen. David Ulibarri (9/16, 9/18)  
Rep. Gloria C. Vaughn

Sen. Sue Wilson Beffort  
Rep. John A. Heaton  
Sen. Gay G. Kernan  
Rep. Rodolfo "Rudy" S. Martinez  
Rep. Jeff Steinborn

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

### **Staff**

Michael Hely, Staff Attorney, Legislative Council Service (LCS)  
Karen Wells, Researcher, LCS  
Jennie Lusk, Staff Attorney, LCS  
Josh Sanchez, Intern, LCS

### **Guests**

The guest list is in the meeting file.

### **Handouts**

Handouts are in the meeting file.

## **Wednesday, September 16**

### **Welcome and Introductions**

Representative Picraux welcomed everyone. Committee members and staff introduced themselves. Kathleen Colley, deputy mayor, Rio Rancho, and James Jimenez, City Manager, Rio Rancho, welcomed the committee on behalf of Mayor Swisstack, who was unable to be present. Mr. Jimenez provided information about plans for future growth for the City of Rio Rancho.

### **Medicaid Cost Containment: What Other States Are Doing**

Laura Tobler, program director, Health Programs, National Conference of State Legislatures identified actions taken by other states to save money in their Medicaid programs. She noted that Medicaid costs cannot be separated from general health care spending and provided statistics about national health expenditures. A graph demonstrated the growth in Medicaid acute care spending between 2002 and 2006 and the impact of federal Medicaid spending that is attributable to the federal American Recovery and Reinvestment Act of 2009 (ARRA). To date, state budgets have reported a funding gap of \$348.3 billion through federal fiscal year 2012. Ms. Tobler identified actions and strategies under way in other states to improve Medicaid quality and lower costs, such as quality improvement measures and care management for individuals with high, chronic care costs that may not save money in the short run, but are valuable strategies to manage the program in the long run. Examples of short-term strategies were provided, including provider rate cuts, which have been implemented in California, Louisiana, Florida and Ohio. Pharmacy utilization and cost control initiatives, such as prior authorization, preferred drug lists and bulk purchasing arrangements, are under way in 31 states. She will provide much more detailed information about pharmacy cost control initiatives and which of these measures are the most effective. Ms. Tobler discussed benefit reductions and restrictions or eliminations of optional services. The most common services under consideration for reduction, restriction or elimination are dental benefits for adults and chiropractic, podiatric and optometric services. Eligibility reductions are not permitted under the provisions of ARRA through 12/31/10; however, several states are taking measures to slow

Medicaid enrollment growth. New or higher co-payments are being implemented in Illinois, Massachusetts, Mississippi and Nevada. New York, South Carolina and Indiana are strengthening fraud and abuse detection efforts. Ms. Tobler highlighted New Mexico for its efforts in long-term care cost containment with the implementation of the CoLTS program. Ohio is working to shift 2,000 people from nursing homes to home and community-based care. A request was made to identify the impact of cuts and potential cuts on Native Americans. Several states are investing in programs and systems that ensure that Medicaid is always the payer of last resort. Washington State has a program that connects veterans with services to which they are entitled. Steps for reducing Medicaid expenditures were identified in the order of difficulty of implementation. The simplest cost-containment measure identified was across-the-board provider cuts, followed by elimination of optional services and capping enrollment. Chronic disease management and outcome-based pay for performance were highlighted as measures that should improve quality as well as reduce costs. Other more desperate measures are anticipated to emerge as states continue to face serious budget constraints. Ms. Tobler described some strategies that show great promise for Medicaid reform and cost containment, such as targeting high-risk, high-cost members for care management activities. The body of evidence is growing to support the effectiveness of enhanced care management and coordination of the needs of clients with chronic and complex conditions. Several states are implementing payment reform initiatives, such as pay for performance, payment for episodes of care and global budgeting. Minnesota has expanded the payment reform effort beyond Medicaid with bundled payments for what they call "baskets of care".

Questions and comments from committee members were offered regarding the following topics:

- the most costly and the most frequently prescribed medications;
- the impact of provider cuts on provider participation in the program;
- the experience of states in promoting personal responsibility for health care;
- the budget impact of very high-cost individuals and the potential for developing systems of care to address this;
- whether states' efforts to implement medical home models of care are reducing Medicaid costs;
- whether any states are taking steps to enhance revenues to deal with Medicaid;
- requests for updated and enhanced data; and
- the potential for cost savings in end-of-life care and counseling.

### **New Mexico Cost-Containment Issues**

Pamela S. Hyde, secretary, Human Services Department (HSD), outlined future projections for the Medicaid program, which is growing beyond appropriated amounts due to enrollment growth, increases in utilization and loss of federal ARRA funds. The HSD expects a general fund shortfall of between \$53 million and \$58 million in the current fiscal year, close to \$300 million in fiscal year 2011 and another \$140 million in fiscal year 2012. Significant cost-containment efforts will be necessary, and some, such as administrative changes and steps to slow enrollment growth, are already under way. The HSD will consider benefit elimination and reductions and provider rate reductions. Specific examples of each of these areas were provided.

The HSD is currently planning fundamental restructuring of the Medicaid program, and possible eligibility changes to deal with the loss of ARRA funds in fiscal year 2012. Secretary Hyde identified future cost-containment measures for which the department is seeking input from the legislature and the public. She emphasized that all these efforts are time-consuming and resource-intensive. She drew the committee's attention to a list of possible cuts and changes and the estimated amount that would be saved if implemented. Also provided to committee members was a list of the services and populations that are mandatory and which services are optional. Prescription drugs, for example, are optional, while nursing home coverage is mandatory.

The total cost for the Medicaid program is projected to be close to \$890 million in general fund dollars if no cost-containment measures were implemented; the current fiscal year budget is \$575 million in general fund dollars. Many of the approaches being taken by other states that were presented by Ms. Tobler have already been taken in New Mexico, leaving few and difficult choices for the future. Secretary Hyde acknowledged that none of the cuts will be well-received by those affected. She identified two options for fundamental restructuring of Medicaid: (1) eliminate whole programs that have high costs; and (2) eliminate all but mandatory services for mandatory populations. Opportunities for restructuring that could increase Medicaid coverage were described, including limiting traditional Medicaid to mandatory services only, while enhancing the state coverage insurance (SCI) program and offering "buy-in" to Medicaid for optional benefits and non-eligible populations. Medicaid waiver programs could be consolidated into one waiver.

Secretary Hyde described implications of cuts in fiscal years 2010, 2011 and 2012, noting the possible impact of federal reform efforts, the impact of cuts on other state agencies and the anticipated growth of waiting lists for waiver services. Public meetings are scheduled to gather input. All hospitals and most community-based providers will be affected. The economy will be affected and the growth of the uninsured population is likely.

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

- clarification regarding the income levels of various covered eligibility groups;
- areas of the biggest cost growth; it is long-term care and disability services;
- the highest-cost maintenance prescription drugs; asthma, behavioral health and hypertension account for the highest costs of drugs in New Mexico;
- whether federal funding may be lost in the future if the program is reduced now, especially in the children's health insurance program (CHIP);
- recognition that short-term cuts will result in long-term problems;
- the difference between state administrative costs, managed care organization (MCO) administrative costs and provider administrative costs;
- variations in managed care administrative costs in Salud, CoLTS and behavioral health managed care;
- the amount of MCO payments of premium taxes and assessments for the high-risk pools; the total profit of managed care companies, as reported to the Insurance Division of the Public Regulation Commission, is in the range of 2.4%;
- a request for the breakdown of administrative amounts in writing;

- ways in which auto-assignments take place;
- how the governor's request for an additional 3% reduction in state agency budgets affects the Medicaid deficit and whether there are alternative ways of achieving an overall 3% reduction without harming Medicaid;
- the negative impact of vacancies at the HSD on the administration of the Medicaid program;
- how New Mexico compares to other states regarding the provision of optional services;
- the optional services that could be eliminated and could achieve the biggest savings with the least disruption;
- whether a redefinition of the poverty level is under discussion at any level;
- how the MCOs cap on profits compares with other states;
- the total number of individuals on Medicaid today and in the past;
- a request for a breakdown regarding the most costly Medicaid recipients;
- the potential for revenue enhancements that could be dedicated to Medicaid;
- clarification regarding plans for the SCI program;
- clarification regarding restructuring possibilities, including "buy-in" to various parts of the Medicaid program, and whether such restructuring would require legislation;
- a request for the HSD to present a formal plan, when developed, to this committee; Secretary Hyde indicated willingness to work with staff and hold a special meeting with interested LHHS members;
- ways in which federal reform efforts may affect Medicaid restructuring;
- possibilities for renegotiating MCO contracts mid-year; and
- how rate negotiations with providers occur, and under what circumstances those rates might be changed by the MCOs.

### **Report from Health Reform Subcommittee**

Senator Feldman and Representative Picraux reviewed the outcome of the LHHS subcommittee for health in which subcommittee members attended the "health reform day" held by the Legislative Finance Committee (LFC). The subcommittee heard the same presentation that was presented today by Secretary Hyde. Additionally, presentations were offered on medical homes, quality initiatives, federal health reform and a study conducted by Dartmouth University researchers regarding variations in health spending around the nation. Dr. Paul Roth, dean of the School of Medicine at the University of New Mexico (UNM), gave an update on the BA/MD program. Several items covered in the LFC hearing will be covered in great detail before the LHHS. Senator Feldman provided a current update on federal health reform, highlighting the bill introduced by Senator Max Baucus, chair of the Senate Finance Committee. The bill does not include a public option, but does include expansion of Medicaid and measures to increase the number of primary care providers, insurance reforms and mandates for coverage. According to Senator Baucus, the bill will be voted on next week. In the house, the tri-committee bill, as amended, will go to the floor of the House of Representatives.

### **The Economic Impact of Medicaid Cost Containment**

Lee Reynis, Ph.D., director, Bureau of Business and Economic Research, UNM, talked about the economic impact of Medicaid cost containment. She began by discussing the effect of the national recession on local and state economies. She described the importance of the energy sector in terms of New Mexico revenues and economies, noting that while the price of oil has been rising, the price of natural gas has been declining. Statistics regarding non-agricultural jobs reflect that New Mexico is not recession-proof. Employment and personal income dropped to record lows this year; a continuing six-quarter recession is anticipated. The sector of health care and social assistance is currently one of the only sectors that has experienced employment growth. The ARRA has been important to maintaining strength in this sector by providing enhanced Medicaid federal matching funds that, unfortunately, will come to an end before the recession is over. Dr. Reynis identified Medicaid as a critical factor in maintaining economic strength around the state. The estimated impact of spending \$100 million in Medicaid, combined with the generous federal match, results in a job multiplier of five. The Medicaid caseload has increased dramatically since the recession began, mostly among children in low-income families and SCI enrollment. The loss of ARRA funds and the additional general fund money that would be needed to keep the program whole must be considered should Medicaid be determined to be a priority for funding in the state budget. Dr. Reynis noted that New Mexico has a heavy reliance on Medicaid in achieving access to needed health care services but also has a fragile infrastructure of providers to meet the needs.

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

- how veterans and military personnel are affected by the economic downturn;
- why farm and agricultural jobs are not considered in these economic projections;
- whether and how Native Americans, many of whom are on Medicaid, are built into these economic projections;
- the validity of the data, given these omissions;
- clarification of the actual number of jobs that would be lost if Medicaid cuts were made to the extent previously described by Secretary Hyde; an estimated 20,000 jobs could be lost; and
- clarification regarding the employment experience of the construction industry.

A motion was made and seconded to accept the July and August minutes as distributed. The motion was unanimously adopted.

### **Medicaid Coalition Perspective**

Kim Posich, executive director, New Mexico Center on Law and Poverty (CLP), stated that all the members of the panel have a bias that Medicaid should not be cut. Sireesha Manne, staff attorney, CLP, presented information regarding the number of people served by Medicaid and the economic impact of the program to New Mexico. She reviewed eligibility criteria to qualify for Medicaid, discussed the critical nature of Medicaid services and contended that without these services costs of health care will increase for all New Mexicans. The services being suggested for cuts are essential to the health and welfare of clients. Mr. Posich briefly identified ways in which cuts to Medicaid will impact the New Mexico economy; a \$1.00 cut out of Medicaid takes between \$6.00 and \$7.00 from the New Mexico economy. Cutting Medicaid will mean a loss of

jobs, particularly in the health care sector. He demonstrated ways in which cuts to Medicaid will negatively affect wages and salaries and result in lost business activity. He detailed the specific ways in which health care providers such as hospitals and rural primary care clinics would be harmed by cuts to Medicaid of this magnitude. Those who lose health care coverage due to these anticipated cuts will sometimes defer getting needed health care services and seek care when they are much sicker. He contended that cuts to the Medicaid program will damage the health care system and are basically unfair.

Ruth Hoffman, Lutheran Advocacy Ministry, described the nature of her advocacy work. She reiterated a point made earlier in the day by Ms. Tobler that Medicaid costs are driven by health care costs and should not be viewed separately. She emphasized that Medicaid is unlike other social services programs in that Medicaid payments go directly into the health care system, thus benefiting the economy. She called the state budget and the Medicaid budget moral documents that reflect the values of the legislature, the executive and New Mexicans. She believes that revenues should be raised rather than considering the catastrophic kinds of cuts that would be needed to balance the budget. She drew the committee's attention to two documents that make the case for raising revenues rather than implementing cuts and that identify possible avenues to do so. States that have raised taxes in previous recessions were presented.

Committee members had questions and concerns in the following areas:

- whether data is available about the number of children on Medicaid who are also in the custody of the Children, Youth and Families Department;
- the option of imposing co-payments and other incentives or disincentives on those who make poor lifestyle choices;
- a request by Representative Begaye for a bill to be drafted for introduction in the special session to reform the corporate income tax law, roll back personal income tax and other cuts and impose "sin" taxes;
- whether any research has been conducted regarding who benefited from the cut to the food gross receipts tax; the gross receipts taxes for all other services were raised to offset the loss of revenue from gross receipts taxes on food;
- the lack of progressivity of the current tax structure; and
- a call for a political strategy to repeal the cuts to personal income taxes and the important role of the governor in developing that strategy.

### **Public Comment**

Vicente Vargas, New Mexico State University (NMSU), introduced the committee to the new dean of the College of Health and Social Services, Tilahun Adera. Mr. Adera described his background and training and spoke about the college, identifying priorities for the School of Nursing, the School of Social Work, and the School of Public Health and Social Services. The School of Nursing is currently training 300 undergraduate students in three separate units training B.S.N., M.S.N. and Ph.D. nurses, and including nurse practitioner training. The college is actively engaged in addressing the nursing shortage in New Mexico and the nation. He would like the opportunity to testify before the committee at greater length.

Lisa Patterson, program manager, New Mexico Alliance for School-Based Health Care, spoke about the importance of maintaining funding for these centers, as well as school based services, such as school nurses.

Shelley Chimoni, council member, Pueblo of Zuni, addressed the importance of continuing consultation with the tribes and requested that cost-containment options be presented to the tribes for consideration. She recommends that the committee ask the HSD for a flow chart of the proposed cuts and the impact that they will have, as well as a list of the principles that are guiding decisions for cuts. She noted that at UNM Hospital, there is a sign that no Native American can receive services without prior authorization. This results in potentially deadly situations and should not continue. Finally, she urged the committee to support the continued operation of the New Mexico Cancer Center in Gallup. Inequities still exist in providing access to services and care for Native Americans.

Regina Roanhorse, New Mexico Voices for Children (NMVC), identified herself as a Navajo. She noted that enrollment of Native American children in Medicaid has dropped by 250 children in the last five months. McKinley County has the highest percentage of Medicaid clients, largely because of the large Native American population there. She, too, urged continued consultation with the tribes. Navajos have experienced budget cuts to vital programs dealing with teen suicide and alcoholism.

Anna Otero Hatanaka, Association for Developmental Disabilities Community Providers (ADDCCP), reminded the committee of several very important programs that the ADDCCP members provide. She testified that the providers are very over-regulated due to the *Jackson* lawsuit. She commented that although provider rate reductions may be easy to implement, they have devastating effects that result in fewer services and poorer quality services to the developmentally delayed. This would make it harder for the state to get out of the *Jackson* lawsuit. The ADDCCP supports revenue enhancement approaches and adequate opportunities for stakeholders to decide what cuts to impose.

Roxanne Spruce Bly spoke representing the Pueblo of Laguna. She echoed the comments of Ms. Chimoni and Ms. Roanhorse. She noted that providers to tribes and pueblos are increasingly dependent on Medicaid reimbursement. She also noted that Native American women have a very high rate of late or no prenatal care.

Nick Estes, NMVC, assured the committee that the NMVC fully intends to do everything in its power to influence the governor about recommendations for revenue enhancements. He emphasized that in order to achieve the magnitude of cuts outlined by the cabinet secretary this morning, devastating cuts would have to be made, affecting up to one-third of the services and beneficiaries of the program.

Alicia Corral introduced the committee to her daughter who is developmentally delayed, and though an adult, has the mental age of a five-year-old child. Cuts to the Medicaid program

would severely limit her care options and quality of life. She urged the committee to maintain the developmental disabilities (DD) waiver program.

Amanda Gillespie identified herself as the mother of a 23-year-old son with Down syndrome and other chronic care needs. He requires 24-hour supervision and is a recipient of the DD waiver. She asked for a continuation of the team care plan development process.

Erin Marshall with Health Action New Mexico read a statement from one of its physicians, Dr. Anthony Flegg. The letter emphasized his first-hand experience with the fallout of the lack of access to health care services that would be exacerbated with cuts to Medicaid. She also read a statement from Joni Kay Rose, a citizen with facial damage, who expressed frustration in trying to access Medicaid services. She feels that Medicaid needs more funding, not less.

Richard Mason, chair of the action committee of the League of Women Voters, presented the league's position on this issue. It supports an approach of enhanced revenues to sustain the program. He presented a written statement of its position.

Lacey Keene, Family Voices, spoke in support of avoiding cuts to Medicaid. She presented a petition that will go to the governor and lieutenant governor in support of full funding of Medicaid.

Jim Jackson re-emphasized many of the points previously made and added that the shortfall should not be borne entirely by the Medicaid program but should be spread to the full budget. He delineated some total program costs for the CoLTS program the DD waiver and the behavioral health program, which together account for about 40% of the full cost of Medicaid and which represent critical services. Cuts, if necessary, should be evenly spread across all budget areas. His organization also supports revenue enhancements as a partial or full solution. He disagreed with Ms. Otero Hatanaka regarding the quick resolution of the *Jackson* lawsuit, contending that the goals of the case are close to being met, and are important, and should not be curtailed prematurely.

Eric Lujan, a personal care option (PCO) coordinator in the Socorro area, pointed out that the PCO not only affects the consumer, but small businesses and caregivers also benefit from the program with employment by raising people out of poverty. He provided written comments for the record.

The committee recessed for the day at 6:05 p.m.

### **Thursday, September 17**

The second meeting day of the LHHS was reconvened at 8:50 a.m. by the chair.

### **Welcome and Remarks**

Representative Picraux welcomed everyone and introduced the staff. Members of the committee introduced themselves. Dr. Roth welcomed the committee to UNM. He remarked on

the importance of this committee and the importance of the HSC as health reform unfolds. He noted that challenges and opportunities face the university and the nation, and they are looking forward to facing them. Diane Snyder, Greater Albuquerque Medical Association, also welcomed committee members and reminded them that the Greater Albuquerque Medical Association is sponsoring a reception for them at Los Poblanos.

### **Overview of Medical Homes, Accountable Care Organizations and Payment Reform Issues**

Dr. Justina Trott, a practicing family practice physician and Robert Wood Johnson health policy fellow in Washington, D.C., gave an overview of her presentation regarding medical homes that was intended to set the stage for the rest of the presentations to come before the committee that day. She noted that the health care environment is far more complicated and segmented than it was in the days of Marcus Welby, M.D., with extensive vertical and horizontal integration of care. She identified payment reform as an essential element of health reform and identified steps that will be necessary to achieving it; without payment reform, physicians are slated to receive a 20% cut to reimbursement under Medicare in the near future. Dr. Trott highlighted the rising costs of health care, especially in entitlement programs, that are predicted to eclipse historical tax levels by 2052. Implementation of medical home models of care may provide part of the solution to these issues.

She described a general framework for the medical home concept, noting that there are numerous iterations of the model that the committee will be hearing about as the day unfolds. All medical homes involve primary care case management, a formal quality insurance program, 24-hour patient access, maintenance of advance directives and complex coordination of care. Accountable care organizations (ACOs), consisting of local networks of providers, are an emerging concept that can incorporate medical homes along with hospitals and other providers under one umbrella. Demonstration projects have been under way since 2004. Noted researchers (Fisher and McClellan) have advocated for a payment system that reinforces integration and accountability and rewards quality; an ACO is a model to do that. Policy considerations with ACOs include ways to include small practices, whether this model will actually save money and how to avoid a medical monopoly.

Committee members had questions and concerns in the following areas:

- whether true efficiency can be achieved in a medical home with the duplicative requirements from insurers and multiple regulations;
- reasons for the increase in health care costs; research shows rising costs are primarily due to new procedures, very expensive biologics and over-utilization;
- whether evidence-based medical research is reliable;
- an observation that the system of payment and the system of care are different issues with different solutions;
- the potential role of mid-level providers in a medical home model;
- whether dental care is included in a medical home model; it could be;
- ways in which a medical home compares to the Veterans Administration system of health care delivery;

- recognition that many community health centers have been using a medical home model for decades;
- how advertising contributes to over-treatment of patients;
- whether ACOs are more efficient; they are generally thought to provide better quality, but it is unknown if they will save money;
- whether ACOs and medical homes have features that promote or allow competition in the marketplace;
- clarification about how medical homes enhance treatment of chronic disease; research shows major improvements in outcomes with better coordination of care;
- the potential for cost savings by serving patients with high-use or complex needs in medical homes;
- an observation that care in the Mayo Clinic is very well-coordinated and efficient and could serve as a model for the system of health care delivery in the nation;
- recognition of barriers that prevent widespread implementation of this model: aligning incentives, reforming reimbursement and preparing practitioners to change their style of practice are needed;
- whether New Mexico's electronic medical record statute will permit implementation of the medical home model; a request was made to have a review of this as a future agenda item for the committee; and
- whether the medical society has any projections about the cost of implementing a medical records system in a physician's practice.

### **Alternative Models of Medical Home**

Jeff Thomas, M.S.W., executive vice president, Southwest Care Center, described the patient-centered model of care the center provides to patients with HIV/AIDS. Primary medical care, comprehensive case management and mental health services are all provided at the clinic. Support services are part of the array of services offered. This year, the center is opening a pharmacy on site. A nutritionist is also available on site. Dr. Trevor Hawkins, the founder of the center, has published his research conducted at the center. The center has a major focus on wellness and prevention and is able to address barriers to care such as transportation, housing and utility support. The center offers a "one-stop shop" for care.

Anita Ralston, nurse practitioner, described the scope of practice of nurse practitioners, which, in New Mexico, includes their ability to be in independent practice. Examples were provided of nurse practitioners in the state who operate medical home practices. She contended that not all medical homes are primary-care based. In her case, she feels she is providing that kind of coordinated care at the New Mexico Heart Institute for specialty patients. Support exists in Congress and in the Centers for Medicare and Medicaid Services for inclusion of nurse practitioners in a medical home model of care. Ms. Ralston asserted that nurse practitioners should be included in any legislation directing the development of medical homes. She thanked the committee for its support of education of nurse practitioners.

Kristen Ostrem, representing the New Mexico Primary Care and Midwifery Association, testified that the association provides holistic, cradle-to-grave care for women. The association

feels it is meeting nearly all of the criteria for medical homes identified in congressional legislation establishing medical home pilot projects. Keys to the services are case management and coordination of care, even after hours.

Representative Picraux drew the committee's attention to New Mexico's statute regarding medical homes, which includes a definition of medical homes. She noted that through this statute, New Mexico has already taken the first step in establishing medical homes in the state.

Committee members had questions and comments in the following areas:

- whether the statute creates barriers or opportunities for practitioners to implement medical homes;
- whether a medical home promotes family participation in the care of an individual;
- whether the cost of malpractice insurance is a barrier to providing care in this model and whether this insurance is available to nurse practitioners and midwives;
- a request that the current statute come before the committee for debate at a different time;
- the potential impact of Medicaid and other cuts on access to care;
- clarification regarding the difference between nurse practitioners and physician assistants;
- the currently excessive costs to receive emergency care;
- the extent to which malpractice insurance affects the cost of health care; and
- the extent to which nurse practitioners practice in rural areas.

### **UNM Medical Home Model**

Dr. Carolyn Voss, executive director, ambulatory services, UNM Hospital, and Jamie Silva-Steele, R.N. administrator, ambulatory services, UNM Hospital, presented information on how the hospital is working to implement a medical home model of care. Statistics were provided on health spending in the nation as a percentage of the gross domestic product and per capita spending. UNM Hospital is convinced that developing a medical home model is a foundation for achieving a reduction in spending. Dr. Voss gave background information that supports the need for medical homes, particularly with regard to the level of chronic care in the country and in New Mexico. Information was provided demonstrating the disparity between the number of physician residents who choose specialty areas of practice versus primary care, in large part due to the higher salaries of specialists. That being said, she contends that primary care must rely on specialists to achieve the goals of medical homes. The model, called "Care One", is a system of care that is integrated and patient-centered. Ms. Silva-Steele described the historical development of medical homes at UNM Hospital, through several staged models of care. Early research shows that emergency utilization has declined since the implementation of Care One. Elements of the model include care coordination, intensive disease management and chronic care management. The program focuses on five top conditions that are most frequently seen at the center and that often occur in combination. Physicians and nurses work as a team, anticipating patient needs and fostering patient self-sufficiency. UNM Hospital has a structural framework, including advanced information technology, that allows optimal administration of a medical home. The hospital

continues to take steps to improve and further develop the program and is seeking recognition by the National Committee on Quality Assurance (NCQA) as a medical home.

Committee members had questions and comments as follows:

- a request that the program track savings and outcomes to be able to demonstrate future success;
- a request for specifics about the budget to operate this model;
- appreciation for the inclusion of cultural competency in the model;
- efforts that may be underway to improve the accessibility of the actual site of this program;
- clarification regarding the Colorado collaborative and how it resembles this program;
- whether the program addresses the mental health needs of its clients;
- whether some high-risk, high-user Medicaid clients in the Albuquerque area could be entered into a pilot project using this model;
- coordination between this model and care received in the emergency department of UNM Hospital; and
- ways in which advisory councils are used to gain public input to guide future development of the model.

### **Molina Healthcare: Coordination of Care: Quality Improvement and Cost Savings Through Integration and Disease Management**

Dr. Eugene Sun, medical director, Molina Healthcare, presented information about Molina and its efforts to develop models of coordination of care. He identified himself as a primary care physician and a native of New Mexico. Molina Healthcare has a mission of providing health care to financially vulnerable families and individuals covered by government programs. It is the second largest Hispanic-owned business in the nation. Molina's basic business model involves helping its members to navigate the health care system. Dr. Sun spoke about the lack of sufficient numbers of primary care providers in the nation and reiterated the income disparity previously mentioned. This insufficiency is reflected by the number of office visits that now are far eclipsed by lab tests and procedures in the Medicare program. Molina's goal is to manage care through coordination of care at all times and in all settings. He described four models of coordinated care, beginning with patient-centered primary care. The NCQA has a physician recognition program that measures superior care against evidence-based parameters. Molina has been working with the HSD and the NCQA to incentivize physician practices to become recognized as medical homes. Once recognized, Molina pays physicians a monthly incentive of up to \$20.00 per patient. The Hidalgo Optimal Health Plan is an example of a medical home model. Molina funded its initiative to support responsible and coordinated care. Community Care of North Carolina is nationally recognized for the partnerships it has fostered with physicians, hospitals, the health department and social services organizations. It has demonstrated impressive improvements in outcomes, including a 17% decrease in emergency department visits. Molina also is supporting initiatives involving community health workers (*promotoras*) and their role in care coordination. Another initiative is called "Motherhood Matters" that seeks to identify high-risk pregnancies through incentive payments to obstetricians.

Committee members had comments and questions in the following areas:

- the impact of shortages of specialty physicians in rural areas and how to best address these shortages;
- the need for all types of practitioners of primary care medicine, including physicians, physician assistants and nurse practitioners;
- clarification regarding the other MCOs besides Molina in New Mexico;
- the extent to which Molina serves Native Americans, and how it coordinates with the Indian Health Service;
- the percentage of Molina members enrolled in Medicaid; approximately 85%;
- a request for written information regarding whether Molina will be able to survive \$300 million cuts in the Medicaid budget;
- a request for the number of physician practices in its network that have electronic medical record systems;
- whether there are any national standards against which Molina can compare its success in quality management; HEDIS measures are used by Molina and by all the MCOs in the state;
- whether Molina has a publicly stated position regarding taxes on alcohol and cigarettes;
- the adequacy of a provider network to serve children with autism;
- variations in communication and coordination between health plans that own hospitals, those that do not and staff model health plans;
- a request that the HSD be asked to project the impact of cuts to Medicaid on the health plans and the potential for the MCOs to absorb the costs rather than cutting services;
- a request for information about the administrative overhead costs of Molina in the Medicaid program;
- the ability of members to go out of network for medical care with Molina and the other health plans; and
- the percentage of Medicaid penetration in Molina; 24%.

Charlie Alfero was invited at that time to give a brief presentation to the committee about the Hidalgo Medical Services (HMS). He described the services provided and how they are organized. Over the years, the HMS board of directors has supported efforts to train primary care practitioners and steps to increase access to care, improve outcomes and reduce costs. HMS has received numerous federal grants to pursue its goals. Mr. Alfero noted that the current reimbursement system rewards treatment of procedures and visits but does not reward prevention or disease management. This focus results in new innovations in medicine targeted to diagnosis and treatment rather than care management and leads to the most expensive health care system in the world; yet, it cannot demonstrate good outcomes. Outcomes are not a priority as they are not reimbursable. HMS wants to redesign its system to reward outcomes of care. HMS is pursuing demonstration grants from the MCOs to redesign the system with reimbursement based on patient health outcomes, reduction in costs, societal improvements and community priorities. HMS is prepared to be accountable to these goals by agreeing to bear risk in its reimbursement. HMS proposes a per person, per month payment tied to key improvements in outcomes based on best practices and research. HMS has a contract with Molina to conduct field-based case

management. Mr. Alfero gave an example of a patient who was homeless and a frequent visitor to the emergency department. With its interventions, HMS assisted the gentleman to get a job, find a home and stabilize his medications. The patient is no longer frequenting the emergency department.

Committee members expressed interest in and support for Mr. Alfero's concepts. Clarification was requested regarding the specifics of what he is proposing. Elaboration was requested regarding the contract with Molina; it chooses the patients and refers them to HMS, which coordinates care using community health workers. For that activity, HMS receives a per person, per month payment. Molina has told HMS that this intervention is saving 62% of the previous cost of care for these patients. HMS has recently signed a similar contract with Lovelace Health Plan. The model appears promising for reducing costs in Medicaid for high-cost clients; however, the model is not currently available to residents of other parts of the state.

Questions were asked about the patient population currently served by HMS; it serves 75% of the residents of Hidalgo County and 50% of the population in Grant County.

### **Medical Home Implementation (HB 710)**

Dr. Lowell Gordon, medical director, Medical Assistance Division, HSD, spoke about the efforts of the HSD to implement HB 710, which includes requiring the MCOs serving Medicaid clients to work with the New Mexico Medical Society to determine a process for implementation. Pilot projects are anticipated. He emphasized that the ability to track patients electronically is the key to the success of the project.

Dr. Michael Kaufman, a primary care physician in Taos, identified himself as the chair of the committee that is determining how to implement the medical home model. He raised issues about the difficulties physicians are facing in becoming recognized as primary care medical homes (PCMHs). Early research shows that implementation of a medical home model will fail if the implementation is under the control of the insurers rather than the physicians. The committee has discussed the need for a uniform application and one set of standards for physician practices that agree to participate in the project. Additionally, physicians need to know how much they will be reimbursed for participating. He strongly recommends studying the method in which North Carolina set up a successful medical home model.

Comments and questions from committee members covered the following areas:

- dissimilarities between North Carolina and New Mexico that may make a comparison with them difficult;
- what constitutes a reasonable incentive for a physician to participate;
- a request to present updated information and a proposal regarding the project later on in the interim;
- clarification that revisions to the managed care contracts required funding pilot implementation of the medical home model;
- a request that someone from North Carolina be invited to testify at a future meeting;
- whether the medical home would cover all patients or just Medicaid patients;

- a request to have a copy of the primary care network study that was the precursor to Medicaid managed care;
- clarification regarding the SALUD contracts and the "set-aside" amounts that are being used to fund medical homes;
- the need to identify and focus on specific high-cost conditions for the medical home model in the Medicaid program; this can be done through contract negotiations and does not require legislation;
- the need for flexibility in implementing the model to accommodate the variety of practice models and providers around the state;
- the importance of the UNM School of Medicine working more intensively to encourage medical students to choose primary care versus a specialty; without enough primary care physicians, there will be no ability to broadly implement medical homes;
- the potential for this model to result in real cost savings if implemented proactively for high-risk patients, and whether legislation is needed to put this in place;
- the potential for great savings by reducing poly-pharmacy use; and
- the costs of prescription drugs and emergency department visits for treating depression and psychoses.

### **Further Options for Implementation of the Medical Home**

A panel of providers presented alternative approaches to implementing medical home models of care. Nikki Katalanos, Ph.D., director of the physician assistant (PA) Program, UNM HSC, and Tom White, J.D., academic coordinator, PA Program, School of Medicine, UNM HSC, discussed the role of PAs in medical homes. Dr. Katalanos presented background information about the nature of the practice of PAs and statistics about the number and location of PAs in the state. She spoke about the value of PAs in addressing the shortage of primary care practitioners. She provided details about the program to train PAs at UNM; 80% of the graduates remain in New Mexico and 37% are in rural areas.

Committee members asked for clarification about the program at UNM, practice limitations of PAs, the average starting and ongoing salaries and characteristics that make a good PA. Interest was expressed in expansion of the program at UNM; however, financial and space constraints limit that possibility. Incentives to remain in practice were discussed. The number of PAs serving in the military and the VA system was discussed. The excellent practice environment for PAs in New Mexico was described.

Ralph McLish, executive director, New Mexico Osteopathic Medical Association, noted that there are 248 licensed osteopaths practicing in New Mexico, most of whom are practicing in primary care. Though their school graduated more osteopaths than UNM graduated physicians, the funding for the program was shut down. He noted that osteopaths were not included as providers in the medical home statute. He presented a letter from Secretary Hyde stating her belief that osteopaths could be included in the implementation of the model in Medicaid. He urged the committee to consider amending the bill in the upcoming session to specifically include osteopaths in HB 710. It was noted that the bill might not be germane during the upcoming session unless accompanied by a message from the governor. Senator Feldman made a motion

that the committee write a letter to Secretary Hyde, with a copy to the governor, to state that the original legislative intent was to include osteopaths in the medical home model. The motion was seconded by Representative Gutierrez. The motion passed unanimously. A suggestion was made for the osteopathic association to request that the governor send a message to permit the bill to be amended in the next legislative session.

The chair recognized Brent Earnest, analyst, LFC, to explain some highlights regarding the Medicaid budget shortfall. He stated that in 2010 the program is projected to grow to \$4.4 billion; to get there, \$300 million in new money would be needed. The LFC will be working very closely with the HSD to ensure that projections of shortfalls are current and accurate. It was noted that there are no projected cuts to the current Medicaid program; rather, cuts are anticipated to the growth in the Medicaid program. Clarification was sought regarding the impact of the loss of ARRA funds and the amount of projected growth that is due to enrollment growth. It was acknowledged that the recession in the nation is having a profound impact, and many more people are likely to need services such as Medicaid. Mr. Earnest agreed that cuts to services and provider rates are likely; he was merely trying to put into perspective from where the \$300 million projection came. Committee members requested that Mr. Earnest's remarks be sent to all by email.

#### **Public Comment**

Dr. Bill Wiese stated that rising health care costs, including Medicaid, are unsustainable. He noted, however, that cuts are not the only answer, and that system changes are needed. There are real examples of both the right and the wrong way of managing systems of care. The medical home models presented by Dr. Kaufman and HMS represent successful examples of ways to do that. He urged the committee to find a way to support the HMS option presented by Mr. Alfero. The committee has the opportunity to make a very strong statement regarding system reform versus merely talking about cuts. A suggestion was made to look closely at the contractual set-aside funds and see whether they could be dedicated to funding the HMS program.

There being no further business, the committee recessed at 6:15 p.m.

#### **Friday, September 18**

The meeting was reconvened at 8:45 a.m. by the chair.

#### **Advance Practice Oral Health Provider: A Kellogg Foundation Initiative**

Albert Yee, M.D., program director, W. K. Kellogg Foundation (Kellogg), and Dolores Roybal, executive director, Con Alma Foundation (Con Alma), described an initiative to increase access to oral health services in New Mexico with the training and use of dental health therapists. Dr. Yee identified the goals of Kellogg to focus on community involvement and children, especially uninsured children in minority families. It has identified three priority states, including New Mexico, being identified as states with poor access to dental health services. Dr. Yee described a program in Alaska with which Kellogg is involved that trains and utilizes dental health therapists. Dental health therapists are widely used in over 50 countries around the world

but have only been introduced in this country since 2005 through the Alaska project. The program owes part of its success to the use of local individuals who return to the communities in which they grew up after their training. Kellogg became involved in this program at the request of Alaska tribal officials who wanted to implement the model as it has been implemented in New Zealand. In the program, high school graduates are trained as dental therapists over a two-year period to provide preventive oral health care and who perform under general supervision as part of a team. After the two-year initial training, dental therapists spend 400 hours in an internship with a dentist. The Alaska model could be replicated in New Mexico or modified to meet New Mexico's needs and circumstances. Kellogg supports the model as one viable option to increase access to oral health services for children and underserved populations. Interest in this initiative is growing in this country. Kellogg has partnered with Con Alma to gauge the interest and feasibility of implementing the model in New Mexico. A brief video was shown about the Alaska experience.

Ms. Roybal identified Con Alma as the largest foundation in New Mexico dedicated entirely to health. The foundation has a special focus on rural communities and people of color. Con Alma has discovered that Hispanics suffer the greatest health disparities of any population, and that New Mexico has the highest health professional shortages of any state in the nation. New Mexico ranks forty-ninth in the nation for dentists per capita. Four counties in New Mexico have no dentists at all. Con Alma feels that New Mexico shares some similarities with Alaska that may make the state a good candidate for implementation of this program. Con Alma intends to begin by convening all stakeholders and encouraging them to determine the feasibility of implementing this program. It would like the support of this committee to introduce a memorial in support of this effort.

Committee members were very interested in the concept and asked questions and made comments in the following areas:

- whether an advanced level of dental practice is being considered;
- the interest in ensuring that a dental health therapist requires licensure;
- recognition that dentists may oppose this model;
- an observation that Con Alma is not a prescriptive foundation but rather one that brings people together to identify viable solutions to known problems;
- opportunities for a program such as this to serve as a career ladder for more advanced positions in dentistry;
- clarification regarding where such training might occur;
- oral health disparities among Native American children;
- whether the proposed training curriculum has been modified from the New Zealand model;
- clarification regarding the nature of the work that dental therapists provide;
- what kinds of oral health programs are already in place around the state;
- whether two years is a sufficient amount of training for this role; research shows that this level of therapist provides high-quality services;
- clarification of the goals of the feasibility study and the convening of stakeholders;

- recognition that a program like this could help preserve dental services under Medicaid;
- whether dental therapists will know the limits of their training; this is included not only in the training but in the internship; and
- whether telehealth has a role in this program.

### **UNM: Primary Care Work force: Update and Future Projections on BA/MD Program: Nursing Program Update**

Dr. Roth provided an update to the committee, starting with information about the HSC and its statewide community involvement. He reminded the committee of statistics about New Mexico, including that the state is thirtieth in the nation for health determinants and twenty-third in the U.S. for health outcomes, and that trends seem to be declining. Studies from the Centers for Disease Control and Prevention (CDC) show that if tobacco use and the lack of exercise were eliminated as problems, the incidence of heart disease and diabetes could be reduced by up to 80% and cancer incidence reduced by 40%. Dr. Roth reviewed the purpose and strategic plan of the UNM HSC, which desires to be known as an institution that helps New Mexico make more progress than any other state by 2020. He reviewed areas in which the legislature has supported UNM HSC in the past and identified priorities for the future. Topping the list will be efforts to expand the programs that enhance the health professional work force in the state. Goals also include expansion of the clinic and hospital sites and research that is targeted toward the greatest community impact. UNM is involved statewide in community activities. He described the distribution of funding through its system, noting that state funding accounts for approximately 9.5% of its revenues. More than 50% of its revenues come from patient revenues.

Dr. Roth described in detail how the university selects medical school students, all of whom are residents of New Mexico and 85% of whom have graduated from high school in the state. Of most recent graduating class, over 50% remained in New Mexico for their residency, with 48% choosing primary care as a specialty. He noted that, unfortunately, this percentage is dropping as a national trend. The UNM School of Medicine (UNM/SOM) compares favorably in many national benchmarks, including its experience in graduating primary care physicians. Graduates from UNM/SOM account for 37% of all the physicians practicing in New Mexico. He briefly spoke about the nursing shortage and efforts to develop a plan to address this at UNM. He noted that the current efforts to reform the health care system have the potential to exacerbate health professional work force shortages, as people with insurance coverage will seek medical care sooner. The result will be a growing crisis in access to care. He noted that estimates of shortages reflect a need for 400 primary care physicians, 400 non-physician clinicians, 556 specialty physicians, 600 dentists and 600 dental hygienists. A plan must be developed to address these priority needs. Dr. Roth then gave updated information regarding the BA/MD program, which is the only legislative request it will make this year. Students are already enrolled in the program and are critical to addressing the growing physician shortage in New Mexico. The program is an eight-year long program; four years for an undergraduate degree and four years of medical school. As the current class members complete their undergraduate degrees, there is the potential to expand the SOM class from 75 to 103 students. The legislature provided \$200,000 in funding in fiscal year 2009, allowing the university to fund the first year of medical school for

this program. The UNM HSC request for fiscal year 2011 is \$853,400 to fund the second year of medical school. Demographics were provided regarding the students enrolled in the BA/MD program.

Dr. Nancy Ridenauer, dean, College of Nursing, UNM HSC, discussed issues regarding the nursing work force. A shortage of nursing faculty still exists, with a vacancy rate of 10% to 13.5%. New Mexico ranks forty-ninth in the nation of R.N.s per 100,000 population. Currently, 326 students are enrolled in nursing school at UNM. The current nursing shortage will lead to an unsustainable situation as the aging of the work force is combined with the aging of the population. UNM HSC is collaborating with the Center for Nursing Excellence on a statewide plan for nursing education. UNM HSC also works collaboratively with NMSU and several community colleges to share resources and planning for seamless education and transition of nurses from AND to BSN status. Advance practice faculty will soon be running clinics and seeing patients in two locations. Dr. Ridenauer noted the role that nurse practitioners play in addressing the shortages of primary care practitioners. Additionally, acute care nurse practitioners are filling critical gaps in hospitals, and certified nurse midwives are delivering 40% of the babies in New Mexico. She concluded by identifying policy implications of the work being done.

Committee members had questions and comments on the following topics:

- recognition that work is being done in various ways to expand the health professional work force;
- a need to permit anesthesiologist assistants to practice statewide;
- whether there is a program whereby nurse practitioners or PAs at UNM can apply to the UNM/SOM;
- whether there is data regarding the number of primary care physicians who remain in that specialty;
- identification of obstacles for admission to nursing school, including waiting lists and a burdensome application process;
- clarification regarding ways in which the School of Nursing is involved in altering the nature of the work of nursing, especially in hospitals;
- clarification regarding the difference between a resident and an intern;
- what the School of Nursing is doing to address the problem of nurses leaving the profession;
- whether there is coordinated planning for standardized nursing education;
- reasons why physicians and nurses leave practice to enter academia;
- whether current residency programs adequately prepare physicians for the rigors of practice;
- the need for more outreach to high school students in rural areas regarding the BA/MD program;
- the competitive nature of the application process and acceptance into the nursing program;
- clarification regarding methods of billing for services by residents and how that benefits the UNM/SOM;

- whether patient encounters can be segmented by zip code in all UNM HSC practice areas;
- whether there is any coordinated planning regarding the need for new hospital facilities; currently, data show there is enough need for more hospital beds than are being planned;
- what the university plans to do to address a growing aging population;
- the importance of a continuing focus on cultural competence in all health profession training efforts;
- clarification regarding the screening process for applicants to the UNM/SOM and the School of Nursing;
- clarification regarding the nature of the relationship between the pharmaceutical industry and the UNM/SOM; the school has a rigorous policy restricting influence in clinical settings; and
- encouragement for UNM HSC to emulate the Mayo Clinic.

### **Use of Telehealth to Extend the Primary Care Work Force in New Mexico: Update on Community Health**

Dr. Sanjeev Aurora, director, Project ECHO, described the project. ECHO stands for extension for health care outcomes. He noted that with the financial support of the New Mexico Legislature, the project has been able to leverage \$14 million in funding from additional sources. He spoke about the problem of hepatitis C, which currently affects more than 28,000 in the state. Project ECHO utilizes telehealth to foster collaboration between the UNM HSC, the Department of Health, physicians in private practice and community health centers to educate practitioners and provide case consultation for hepatitis C and other diseases such as diabetes, asthma, substance abuse and chronic obstructive pulmonary disease. The project now utilizes community health workers (CHWs) to enhance patient compliance with recommended treatments. Dr. Aurora described the training conducted through Project ECHO and the incorporation of CHWs into the treatment team. He made the case for expanding the pool of trained CHWs as a means of augmenting the primary care team in rural communities. Dr. Aurora described a pilot project in which prisoners were trained as CHWs and taught methods of preventing and treating hepatitis C. Future plans for expansion of Project ECHO were identified, as were current benefits of the project to clinicians around New Mexico. Project ECHO has received national and international recognition and acclaim.

Committee members had questions and comments in the following areas:

- expressions of commendation for the cross-training Project ECHO conducts with CHWs; and
- clarification regarding the certification program for CHWs; they have worked with the secretary of health and are collaborating with 14 other organizations to develop a formal program.

Dr. Arthur Kaufman, vice president for community health, discussed some projects UNM HSC has conducted to improve community health through health extension programs. It is partnering with NMSU. Starting next year, all medical students will be trained in public health in

addition to curative medicine. UNM/SOM is the only medical school in the nation to take this step. It is going through a process to align research with identified community priorities. UNM HSC has established health extension rural offices (HEROs) to promote all these goals. Volunteers across the state are working regionally to monitor the program's effectiveness. HEROs are working to develop telepharmacy, rural residency programs, food distribution systems, health professional recruitment, housing support for health professional students in community colleges and integration of HSC programs in rural areas. In the eastern Navajo Nation, HEROs have encouraged high school students to stay in school and pursue health careers. The HERO model is now written into a section of proposed federal legislation called the Affordable Health Choices Act.

Questions and comments included:

- what is being done to improve math and science curricula in high schools;
- whether the Mesa program is connected to the HERO program in any way;
- appreciation for the work being done at the community level; and
- clarification of the work being done with the tribes and pueblos.

### **Working Lunch: Guardianship Update: Oversight of Developmental Disabilities Planning Council**

Nonnie Sanchez provided personal testimony alleging poor treatment by the Developmental Disabilities Planning Council (DDPC). Rosemary Sanchez, Nonnie's mother, provided a written statement alleging incompetency of the staff of the DDPC. Janice Ladnier spoke about the issue of guardianship. She is a master guardian and has experience as a mental health provider and as an ombudsman with the Aging and Long-term Services Department. She has been an active member of the board of the Guardianship Task Force that developed recommendations for legislation that were passed by the legislature this year. She created an organization called Guardian Angels that has developed training modules for guardians. She contends that the Office of Guardianship has no oversight, has hired unqualified people and has compromised its integrity in the legislative process. She claimed the office has breached court orders. She has approached the office to ask for its support to promote her training modules, to no avail. She recommends that the Office of Guardianship be moved to a larger agency that has the resources to conduct training and properly monitor the guardians. Ms. Otero Hatanaka testified that many of her member agencies interface with guardians regularly. She stated that guardians have exercised undue authority in removing clients from providers' care against their wishes. She provided documents that support her contention that she and others have been excluded from important work, despite the fact that they are members of the guardianship committee. She referred to an investigation by the HSD that was critical of the DDPC and its management of the Office of Guardianship. She reported that the DDPC has engaged in legislative efforts to permit itself to investigate complaints against itself and to remove the HSD from that activity. She noted that she and the Guardian Angels organization have been notified that they have been removed from the council, and that now the council membership is biased and not properly representative.

Pat Putnam, director, DDPC, countered the information provided by the previous speakers and introduced many advocates, staff and council members. He stated that the Center for Self-Advocacy is developing and conducting training and is composed entirely of people with disabilities. He commended Ms. Sanchez and her mother for their work. He offered to meet with a small group of this committee to resolve differences.

Representative Picraux suggested that this debate not continue right now but that she confer with the parties after the hearing to identify what, if any, further activity should occur. Other members expressed a belief that those who desired to bring the issues before this committee should be allowed a forum to speak, and that the proper location of the Office of Guardianship has long been a point of contention. Other committee members stated that a legislative hearing is not the appropriate forum for resolution of conflicts between opposing parties. Representative Picraux suggested that Mr. Putnam work to create a memorial to resolve these long-standing issues. Committee members acknowledged that this is an area where it is very difficult to achieve agreement, but that collaboration needs to occur between all sides to reach a consensus.

Mr. Putnam stated his opinion that the committee might benefit from hearing from some of the people served, and that he will be glad to work with members of the committee at their direction. Liz Thomson, a parent of a son with autism, stated her feeling that supporters of the DDPC have not had the opportunity to be fully heard, and she urged the committee to understand that many people disagree with the statements previously made. Another parent offered positive feedback about the DDPC and the Center for Self-Advocacy. An employee of the center urged committee members to visit the center to see for themselves the good work that is being done there.

### **High School Pipeline Programs to Health Careers: Dream Makers Program and Health Careers Academy**

Valerie Romero-Leggott, M.D. director, Office of Diversity, UNM HSC; Bob Sorenson, director, Santa Fe Capital High School Health Care Careers Pathway; and Matt Probst, PA-C, Chief Programs Officer, El Centro Family Health Semillas de Salud, spoke about pipeline programs they each operate to encourage students in high school to consider health careers.

Dr. Romero-Leggott described projects in the Office of Diversity that are aimed at students in middle school, high school and college. The Dream Maker program is an after-school program that provides hands-on, health-related activities and instructional interaction with health professionals. It works to improve math, science and writing skills. The program has multiple sites in schools throughout the state. She described the curricula and activities and identified costs associated with the program. Dr. Romero-Leggott then described the Health Careers Academy, which is a six-week long nonresidential summer program for high school students. It is designed to prepare students for entry into college and to expose them to health careers. The program is designed to increase the number of ethnically diverse health care providers and is funded in part by grants from the Robert Wood Johnson Foundation and Con Alma. Costs to

operate the program were identified. Success of both programs is attributable to key partners with leadership from within the HSC and financial support from the legislature.

Mr. Sorenson described a program that is a partnership between Capital High School and Christus St. Vincent. It is a dual credit class that gives students exposure to many different health professions and real world experiences. The program has the support of many members of the community. Students begin by learning basic vital sounds and progress to learning normal and abnormal heart and lung sounds. They are required to keep charts. The program is designed to let the students feel as close to medical professionals as possible. The course includes an introduction to forensics, which creates a mock murder as a teaching tool. Students learn how to administer and read EKGs and perform invasive procedures such as finger sticks and phlebotomies. The program includes experiential lessons in logical thinking and anatomy and physiology. At the end of the year, the students choose the health profession they think they want to pursue and spend a week shadowing a person in that profession. The program has quadrupled in size since its inception. The program has been funded with private grants and donations, but in order to continue, it is requesting support from the legislature.

Mr. Probst described the clinic-based program, which he founded to encourage high school students to pursue medical careers and to use personal stories of health care providers to carry the message. He has developed a statewide pipeline system to support and mentor students by encouraging students at all levels with the question, "What do you want to be?". Students who express an interest in any health profession are linked up with a practicing health professional. His program is developing a network of interested schools to partner with clinics in the area, including school-based health centers. He is exploring partnering with Dr. Kaufman to collaborate with HEROs and with Dr. Aurora to utilize Project ECHO to get the program into clinics and schools statewide.

Committee members made comments and observations as follows:

- recognition about the potential of high schools to generate interest in health professions;
- the shortage of available funding and resources;
- the number of students touched by these programs who end up in a medical profession;
- the exceptional nature of these programs that could serve as national models;
- the difficulty in reaching Native Americans in programs like these;
- the role of the UNM HSC in supporting promising programs such as these; and
- whether trained high school students could be used to take vital signs and support school nurses.

The chair of the New Mexico Health Policy Commission (HPC), Dr. Frank Hesse, commented on the status of the HPC. With cuts in funding, it has had to limit its efforts, and it has decided that health professional work force issues are the most important area on which to focus. He believes it will be imperative to increase graduation of more mid-level practitioners. The HPC desires to work with the LHHS on projects such as this.

## **Workforce Solutions Department and Workforce Development Boards: Focus on Health Care Professions**

The final panel of the day was composed of representatives of regional workforce development boards, and Ken Ortiz, the Secretary-designate of the Workforce Solutions Department (DWS), introduced the other members of the panel. He briefly discussed the federal Workforce Investment Act (WIA). A little over \$12.2 million is allocated to New Mexico, which is divided among the regional boards. The funding is intended to streamline services, empower businesses and job seekers, provide universal access to services, increase accountability and ensure a strong role for local partners. The WSD is responsible for oversight of these funds and policy development to allow the local boards the flexibility they need to do their work. He described the responsibilities of the local regional workforce boards. He touched on the state strategic plan for work force investment using a business-driven strategy. The WSD is aware of the high demand for health care occupations, and funds will be made available to local workforce boards to support these jobs. Statistics were provided about projections of jobs in the health care industry, as well as a picture of major health sectors from 2006 through 2016.

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

- clarification regarding funds that will be made available to local boards for innovative projects to support health care and green job industries;
- whether the WIA is fully federally funded; yes, it is;
- whether any federal funds reverted in the last fiscal year; no, they did not;
- a request for the WSD to be more responsive and helpful to job seekers;
- whether the WSD has given any money to UNM in support of the work force development programs just described;
- the type of training that the WSD is providing;
- how the WSD has used the \$29 million received in ARRA funds;
- the challenges of meeting the enormous new demand for unemployment support due to the declining economy; and
- clarification regarding the local regional boards and how they are appointed.

Beth Elias, director, monitoring and integration, Eastern Area Workforce Development Board, testified that it is attempting to work with community colleges to create training labs that will put people into the work force quickly and that will allow them to attend classes online or during alternative hours.

Pat Newman stated that the Central Area Workforce Board has been studying the health care area, which is considered a top priority area, to determine how best to distribute resources. He provided a list of the prioritized occupations within the health care industry and the training providers and programs that it is able to offer. Unfortunately, UNM has opted out as a service provider in the central area. Additionally, the central board has had difficulty identifying instructors to conduct the training. It formed a Central Health Care Alliance in 2008, the chair of which is Dr. Barbara McAneny. This alliance has identified the need for a fast-track or alternative path to education for nurses, a pilot program for veterans transitioning back into

civilian life and a faster path to train certified nurse assistants and phlebotomists. He provided statistics regarding future projections for health care jobs.

Dr. Emily Salazar, Albuquerque Job Corps, Northern Area Local Workforce Development Board, noted a lack of instructors to train people in all the health care jobs that are needed. Additionally, the certification and/or licensure process for these critical positions is intense. There is currently a four-year wait to get into an R.N. program. Support is needed for the schools to expand their capacity.

Steve Duran, administrator, Southwestern Area Workforce Development Board, identified health care as a top priority industry. It is focusing on R.N., radiology, sonography and CNA training. Of all the training they provided using WIA and ARRA funding, 24% was spent on health care training. It is not able to train all the people who need to be trained due to limited funding, and it currently has waiting lists for programs. It has partnered with local community colleges; however, the schools lack the faculty to meet the demand.

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

- the requirement for faculty at accredited nursing schools to be at least master's-level educated, and the inability to pay them what they can make in the private market;
- the potential for developing a program that pays nursing education for nurses in exchange for a commitment to teach for five years; and
- whether data exists to reflect the number of students who have come to UNM under the WIA, where they came from and where they ended up once UNM stopped being a service provider.

### **Public Comment**

Joyce Horne, president, New Mexico Dental Hygiene Association, and Robert Duarte, president, New Mexico Dental Association, presented their combined statement on access to oral health services in New Mexico. They have been meeting regularly and provided a written statement of the areas of agreement, which include the development of a collaborative dental hygiene practice, a new career pathway of community dental health coordinator, expanded training opportunities, particularly in high schools, and combined oral health advocacy. They hope to seek private support and plan to work with Con Alma on the initiative. At the request of a member, Dr. Duarte agreed to ask the dental association if it would be willing to publicly support an increased tax on sugar products. A question was asked about the impact on the dental profession of insurance companies dropping dental insurance.

Carol Anda and Dr. Anjadi Taneja, Community Coalition for Healthcare Access, stated their feeling that UNM Hospital should be held accountable to its mission to serve all people regardless of their ability to pay. There are many people in New Mexico suffering from medical debt imposed by the hospital. A committee member asked the presenters to write a letter to the committee asking support for a policy that no one below a certain poverty level be sent to collections.

There being no further business, the committee was adjourned at 6:00 p.m.

- 27 -