

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

**August 17-18, 2011
Western New Mexico University, Silver City**

The third meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, at 9:10 a.m. on Wednesday, August 17, 2011, at Western New Mexico University (WNMU) in Silver City.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair
Rep. Nora Espinoza
Rep. Dennis J. Kintigh
Rep. Antonio Lujan

Absent

Sen. Gay G. Kernan
Sen. Linda M. Lopez
Sen. Gerald Ortiz y Pino

Advisory Members

Rep. Ray Begaye (8/18)
Sen. Stephen H. Fischmann
Rep. Miguel P. Garcia
Sen. Cisco McSorley
Sen. Sander Rue

Sen. Rod Adair
Sen. Sue Wilson Beffort
Rep. Eleanor Chavez
Rep. James Roger Madalena
Rep. Bill B. O'Neill
Sen. Mary Kay Papen
Sen. Nancy Rodriguez
Sen. John C. Ryan
Sen. Bernadette M. Sanchez
Rep. James E. Smith
Rep. Mimi Stewart

Guest Legislators

Rep. Rodolpho "Rudy" S. Martinez
Sen. Howie C. Morales

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

Staff

Michael Hely, Staff Attorney, Legislative Council Service (LCS)

Lisa Sullivan, Staff Attorney, LCS

Rebecca Griego, Records Officer, LCS

Abenicio Baldonado, Intern, LCS

Greg Geisler, Analyst, Legislative Finance Committee (LFC)

RubyAnn Esquibel, Principal Analyst, LFC

Wednesday, August 17

At Senator Feldman's request, Senator Morales welcomed the committee, speakers and audience to Silver City and thanked them for coming.

Tony Trujillo, president of the Grant County Prospectors Civil Organization, welcomed the committee.

Joseph Shepard, Ph.D., president of WNMU, welcomed committee members and informed them that there are 3,600 students attending WNMU, where the schools of nursing and occupational therapy are vital to meeting the health care work force needs of southwestern New Mexico.

James Marshall, mayor of Silver City, also welcomed the committee to Silver City.

Representative Martinez welcomed the committee and stated that it is necessary to recognize the needs of rural communities and the huge needs of the health care system and to figure out what it will take to provide health care services to those with the greatest need, including the underprivileged. He added that the Department of Health (DOH) is running a 200-bed long-term nursing facility that will need financial support as the population of Grant County ages.

Committee members asked Dr. Shepard how many WNMU graduates are residents of Silver City and how many received jobs in Silver City upon graduation. Dr. Shepard indicated that he would get back to the committee with that information. Dr. Shepard said that WNMU wishes to expand its health care program, as the many aging baby boomers will be living far longer than previous generations and will need many health care services.

Reinventing Medicaid Through the Medical Home

Mary Takach, M.P.H., R.N., program director of the National Academy for State Health Policy, presented on the medical home model as applied to Medicaid. She distributed a handout titled "Reinventing Medicaid Through Medical Homes". She told the committee that the United States has the best health care system to care for the sick yet the worst system to keep people from getting sick. She stated that the decades-old research on primary care indicates that resources must be shifted to primary care. Ms. Takach stated that the U.S. rates low on primary care infrastructure and the ability to provide primary care yet rates high on health care spending.

Ms. Takach stated that medical homes are a way to integrate care and improve communication among providers. Committee members asked Ms. Takach to distinguish between the medical home model and health care homes. She referred the committee to page 14 of her handout, and stated that sometimes the terms are used interchangeably.

Ms. Takach said that several states tie Medicaid payments to objective medical home evaluation criteria. States such as Iowa, Maine, Maryland, Massachusetts, Michigan, New York, North Carolina, Pennsylvania, Rhode Island, Vermont and West Virginia have adopted National Committee for Quality Assurance (NCQA) medical home standards, which broadly include:

1. enhanced access to and continuity of care;
2. identifying and managing patient populations;
3. planning and managing care;
4. providing self-care support and community resources;
5. tracking and coordinating care; and
6. measuring and improving performance.

Ms. Takach stated that seven other states have developed their own standards for tying Medicaid payments to objective medical home criteria outside of the NCQA criteria, which include Colorado, Minnesota, Nebraska, Oklahoma, Oregon and Washington. She stated that bringing the care coordinator to the patient produces better outcomes.

Ms. Takach reported that the average age of these programs is two years, but some states' Medicaid surveys show that modest bumps in fee payments to primary care providers pursuant to the medical home model have resulted in dramatic reductions in overall health care costs that derive from emergency room visits and other high-need services. In most states, these programs are implemented on a budget-neutral basis. For example, Oklahoma saw a decline in per-member, per-month costs of Medicaid even though the medical home model was implemented on a budget-neutral basis. In addition, Oklahoma had a drop in patient complaints about same-day/next-day appointment availability from 1,670 to 13 in one year.

In response to committee members' inquiries, Ms. Takach stated that she could not serve as a consultant for the state or the committee, as her organization does not give feedback about whether a state's policy is good or bad. Her organization simply gathers and compares states' data, and she stated that she would be happy to be a resource to the committee.

Ms. Takach suggested that the medical home model should be much more cost-effective because many of the primary health care services would be delivered by non-physicians such as nurses and behavioral health care specialists. In response to committee members' questions, Ms. Takach stated that medical home models will require primary care providers to: (1) provide patient-centered care and inquire about whether patients' needs are being met; (2) follow whether patients' health outcomes are being improved; (3) determine if patients' behavioral health needs also are being met; and (4) have strong relationships with other care providers to provide auxiliary medical services so that patients receive complete medical services. If providers lack

such relationships, Ms. Takach continued, then it would be hard to provide continuous care for patients. She emphasized that strong relationships in the medical community must be established before the medical home model can be attempted. The provider groups must be sufficiently high functioning and organized before becoming accountable care organizations (ACOs) with integrated delivery systems, she insisted.

Committee members asked whether a bureaucracy will have to be in place to monitor outcome-based care. Ms. Takach stated that she has observed a continuum of monitoring in the various states. Some states, such as many following the NCQA standards, have no bureaucracy or oversight and use the NCQA's judgment as to the quality of a medical home program. Other states not following NCQA standards, such as Minnesota, or those with standards above and beyond the NCQA standards, such as Vermont, employ more oversight and even perform Medicaid audits. Ms. Takach stated that some states such as Vermont and Minnesota do not use managed care to manage Medicaid.

Committee members suggested that Ms. Takach's data indicate that most providers are not following evidence-based guidelines for the practice of medicine and outcomes. Ms. Takach said that some states require providers to use a guidelines checklist to make sure that appropriate screenings and effective alternative health care options are considered.

Committee members pointed out that the Kaiser Family Foundation data show that the costs of Medicaid, listed on page 11 of her handout, are rising more slowly than health care costs in the non-Medicaid arena. The committee asked Mr. Geisler to find out the per-person cost for Medicaid patients versus non-Medicaid patients in the state.

Groundbreaking for the Integrated Primary Care Clinic at Hidalgo Medical Services (HMS) and Tour

At the groundbreaking, Charlie Alfero, chief executive officer of HMS, distributed a brochure describing the new HMS facilities. Mr. Alfero and other members of the HMS staff and community, including legislators and representatives from Congress, spoke at the groundbreaking.

HMS: Community Health Teams and Community Health Workers

Mr. Alfero distributed handouts and spoke about the populations that HMS serves. He contrasted the current vertical system of health care with the new model he advocates, which will be horizontal and will improve health outcomes and reduce costs. In one example of a vertical system of health care, he found 62% savings over a typical horizontal health care system.

Mr. Alfero stated that HMS's system of health care delivery includes the provision of behavioral health, dental health and health-related services, including nutrition and diet, to focus on the delivery of care and meaningful health outcomes. Mr. Alfero stated that at HMS, community health workers work one-on-one with patients to improve health outcomes. HMS budgets two to two-and-a-half patients per hour.

Carmen Maynes, director of community organization development at HMS, said that HMS's community health workers work with patients and their families, often in their homes, and help with the process of obtaining medication, food stamps and Human Services Department (HSD) services. Ms. Maynes illustrated the necessity of providing such services with the example that patients will not address their diabetes conditions if they cannot afford electric or gas utilities.

Mr. Alfero stated that community health workers advocate for their patients' improved health outcomes by helping them receive, to the extent possible, education about health and healthy food, housing and job search assistance and family support. He said that HMS has experienced statistically significant drops in blood sugar levels of diabetics who are seen by just one community health worker.

Ms. Maynes stated that staff at HMS know of one patient who went to the emergency room of the hospital 40 times in one year because that patient was homeless and needed food and a place to sleep. Mr. Alfero said that this individual inappropriately used the health care system to get a bed and food. Ms. Maynes stated that an HMS community health care worker found a bed at a residential facility while Molina provided transportation to the facility for the patient. Committee members asked why the emergency room staff did not flag this individual before the number of visits reached 40. Ms. Maynes responded that now that HMS has contracted with Molina, HMS hopes that such inappropriate use of emergency room services will not occur.

Mr. Alfero emphasized the importance of community self-determination. Mr. Alfero believes that state agencies and state-funded agencies and organizations have a duty to work with HMS and the HMS model to improve community health outcomes and to work on more demonstration projects to create a more credible health care delivery system. As an example, he stated that HMS engages in community outreach by working with teen moms. He said that HMS was able to help 90% of teen moms in the HMS program graduate from high school, a much higher rate of graduation than the overall 60% graduation rate in the state. Mr. Alfero stated that one of the greatest indicators of future health and use of Medicaid is high school graduation. Mr. Alfero asserted that when high school graduation rates increase, there will be health care savings from improved health and reduced enrollment in Medicaid.

Committee members asked whether some of the data Mr. Alfero presented will be reported in a formal study. Mr. Alfero said it will come out in the Annals of Managed Care, which staff was asked to provide to the committee.

Mr. Alfero said that the standardization of private medical practice is good to a certain point, but the ability of providers to make independent decisions is also important. Mr. Alfero stated that current care is based on following the dollars and driven by volume and concentration of siloed care. He stated that currently, providers do not track an individual's treatment by other medical providers, resulting in both the possible duplication of and inadequate provision of medical services.

Mr. Alfero believes that spending a set amount per Medicaid patient to manage the patient's care will save thousands or hundreds of thousands of dollars. Committee members asked if the HMS model can be scaled to different environments, both urban and more rural. Mr. Alfero answered in the affirmative. Committee members pointed out that HMS provides all services under one roof and wanted to know if HMS's model could be utilized successfully and cost-effectively by a currently operating, spread-out facility in a place like Albuquerque. Mr. Alfero said that there is Commonwealth Foundation data and HMS internal data showing that immediate cost savings will result from implementing the medical home model in just about any community. A committee member stated that just because the federal government said that the medical home model will work does not guarantee cost savings or avoidance of another huge bureaucracy. Ms. Maynes said that HMS has implemented four community health centers in other communities and that the model is scalable. According to Ms. Maynes and Mr. Alfero, the initial up-front investment will turn into long-term savings. Mr. Alfero said that if financial incentives are put into outcomes and overall health care costs are lowered, then that is what people will do.

Committee members stated that the role of state government is to provide services to people with needs. Committee members said that it appears that HMS starts with the patient, then looks at the providers who can be coordinated to serve the patient. Committee members suggested that the DOH, the HSD, and the Public Education Department try, in a similar vein, to coordinate the provision of services by starting with an assessment of the stakeholder's needs, then coordinating services to increase efficiency and effectiveness and reduce duplication.

Mr. Alfero and Ms. Maynes said that HMS helps its patients coordinate applications for services from various state agencies. Such help navigating the state system is necessary, as each patient could be required to fill out 33 different applications for such services as food stamps, housing, Head Start and Medicaid enrollment, according to Mr. Alfero and Ms. Maynes. Mr. Alfero stated that HMS uses a software program called Chassis to auto-fill such applications for patients and is trying to integrate such software with its medical records database.

In response to committee members' questions, Mr. Alfero stated that he has not supported the certification of community health workers because then they become fee-for-service community health workers.

Mr. Alfero stated that he supports bulk payments for outcomes. For example, he said, there is a model where providers get a bulk payment with an instruction that patients be kept out of nursing homes. He added that there is more than enough money being spent on health care to support an outcome-based health care model.

Forward New Mexico: Work Force Development

Darrick Nelson, M.D., chief medical officer at HMS, discussed provider supply and work force retention issues. He mentioned that House Memorial 2 (2011 regular session) created a task force to study work force development of health care providers, including not only physicians but also nurses, midwives and other health care providers. He stated that recently it

was determined that there is a need in this state for 168 physicians, 34 nurse practitioners, 16 physician assistants, 20 registered nurses, two licensed practical nurses, one certified nurse midwife, 46 dentists and seven dental hygienists, and that the greatest need is likely in rural areas.

Dr. Nelson said that promoting work force development should start within the state and must start in the primary schools. He stated that the University of New Mexico's (UNM's) BA-MD program searches for program candidates from the state's high schools.

Tamera Ahner, work force development coordinator at HMS, spoke about the current year work plan. By providing volunteer programs for high school students seeking immersion in health clinics, health career clubs for middle and high school students, mentoring and shadowing opportunities and communication through online social media and more traditional means, HMS gives students opportunities to discover which health fields they may be interested in joining. She added that HMS wants to increase the number of students coming into New Mexico to study and to join the health care field.

Committee members asked how to get more health care professionals in the areas where they are needed. Dr. Nelson firmly believes that it starts in the primary school level. There are curricula that can be offered in schools, and school counselors can be educated on how to inform students about their options pursuing health care careers.

Dr. Nelson stated that half of the students from the state who are in the UNM BA-MD program are from rural areas. Mr. Alfero said that students from rural areas are more likely to become primary care providers and more likely to practice medicine close to home.

Brian Bentley, chief executive officer of the Gila Regional Medical Center, discussed an impediment to physician recruitment in the state. He said that he had to pay the salary of a physician who agreed to work for the center yet could not start his job and practice in the state for six months due to credentialing delays, and such delays cost the center \$100,000. Committee members asked how they could help. Dr. Nelson advised the committee to stay on the same course, continue to support loan repayment options and continue to be innovative about recruiting students to the state.

Panel Discussion: ACO Models

Mr. Hely distributed a handout and gave an overview of ACOs. Mr. Hely stated that initial presentations about ACOs were based on the Academy of Health version, but now there are numerous possible versions of ACOs. Mr. Hely stated that the National Conference of State Legislatures describes ACOs as a structure that combines new medical service delivery forms with new forms of provider payments and that is designed to save costs. Under the ACO model, the payer negotiates risks and cost savings with providers and apportions payments accordingly. Mr. Hely added that the idea of care coordination and information sharing through information technology is critical to ACOs. Many ACOs are based on capitated systems (per member, per

month), such as those systems used by managed care organizations. In contrast, some use partial capitation, so that part of care may be carved out. The Academy of Health model requires all payers to discuss how the cost of care and payment for care will be apportioned between providers, according to Mr. Hely. Moreover, ACOs can be established for Medicaid, Medicare or in the private insurance realm. The federal Patient Protection and Affordable Care Act of 2010 (ACA) provides for the establishment of Medicare ACOs.

Lisa Farrell, vice president of integrated care solutions at Presbyterian Healthcare Services, elaborated on the establishment of Medicare ACOs. She reported that her office would be filing its ACO application in two days. She informed the committee that Kaiser Medical in California has been operating an ACO for a long time. She stated that the ACO model requires accountability, responsibility to patients and management of costs. There is a significant amount of care management necessary in an ACO, according to Ms. Farrell. She stated that the proper infrastructure must be built and care must be given to patients in their homes through telemonitoring and home visits by case managers in order to prevent readmission to hospitals. The challenge in the current system is that such follow-up and preventative care is not paid for. The ACO model provides for higher simultaneous profit-sharing and risk-sharing based on an actuarial model. Ms. Farrell stated that her organization has a lot of experience in the risk-based reimbursement capitation model.

Mr. Alfero reminded the committee of House Bill 35, which the legislature passed during the 2011 regular session. It would have created an ACO task force in Hidalgo County, but Governor Martinez vetoed the bill. Mr. Alfero stated that he knows of no current plans to create an ACO model in Hidalgo or Grant County and that HMS has no plans to apply to be a Medicare ACO.

Public Comment

Reza Ghadimi, P.A., taught a physician assistant's course at UNM that was popular but it was cut due to budget constraints. He emphasized the need for physician assistants in the state and the need to preserve programs to produce them.

Recess

The meeting recessed at 5:31 p.m.

Thursday, August 18

The meeting reconvened at 9:15 a.m.

Update and Panel Discussion on Medicaid Redesign

Julie Weinberg, director of the Medical Assistance Division of the HSD, distributed a handout about Medicaid redesign, which she said will focus on administrative streamlining, payment reforms, aligning incentives across the program, better quality health care and improved health outcomes. She stated that one of the benefits of obtaining a "1115 waiver" from the

federal Centers for Medicare and Medicaid Services (CMS) will be to give the HSD time to redesign Medicaid to provide better quality for less money. Listed on pages 5 and 6 of her handout are the key concerns expressed at the eight public meetings that the HSD held in July and August of 2011 to solicit public input on Medicaid modernization.

Ms. Weinberg reported that the HSD solicited input about Medicaid modernization from tribal leaders at the single tribal consultation, as listed on page 7 of her handout. Ms. Weinberg said that she expects there to be more tribal consultations on Medicaid redesign.

She also reported that the HSD met with smaller stakeholder groups such as the New Mexico Hospital Association, Salud!, the Coordination of Long-Term Services Program, the New Mexico Health Care Association, the New Mexico Association for Home and Hospice Care, representatives from advocacy groups for women, children, the physically and developmentally disabled and the poor, the New Mexico Primary Care Association and the Medicaid Coalition.

Ms. Weinberg thinks that the HSD can provide better health care and contain costs under its Medicaid modernization. The HSD's four principles of Medicaid modernization, according to Ms. Weinberg, are to: (1) develop and implement a comprehensive, coordinated service delivery system (explained more fully on page 16 of her handout); (2) pay for performance and require provider and health plan responsibility (explained more fully on page 15 of her handout); (3) require personal responsibility on the part of patients (explained more fully on page 14 of her handout); and (4) gain administrative simplicity (explained more fully on page 13 of her handout). The HSD has not decided yet whether to include the developmental disability waiver in the 1115 waiver and whether to carve in or carve out behavioral health.

Ms. Weinberg said that the development of health information technology is critical to Medicaid modernization.

Ms. Weinberg stated that Medicaid currently takes up 16% of the state budget, and that the CMS projects a 5.8% per year increase in health costs, which is faster than the economy is projected to grow.

Gwen Cassel, program director for the Department of Allied Health at WNMU, brought her first-year occupational assistants class to observe the meeting. Committee members suggested that copies of Ms. Weinberg's handout be distributed to these students.

Alicia Smith, president of Alicia Smith and Associates, contributed to Ms. Weinberg's handout and was present during Ms. Weinberg's presentation.

Mr. Bentley said that the center worked with four different Medicaid managed-care Salud! contractors, one of which arbitrarily stopped paying on the contract. He believes that the non-paying Salud! contractor owes the center \$1 million. Mr. Bentley agrees with the concept of personal responsibility for an individual's health. He also believes that pay for performance is

already happening in the health industry and that his center can demonstrate it. Mr. Bentley said that the center's expenses have increased, yet its revenues have not increased. He believes that the 40 or so additional performance measures to be imposed by Medicare will require the incursion of additional costs, as the center will have to hire employees to review and submit the proper documentation to comply with the additional performance measures. Mr. Bentley indicated that administrative rule simplification and flexibility to allow the center to provide care inexpensively would be ideal. He said that in contrast to HMS, private doctors receive no payment to provide longer visits and follow-up care. Mr. Bentley anticipates a huge increase in enrollment in Medicaid. Mr. Bentley urged the committee to support and encourage health care provider educational programs at state higher educational institutions to reduce the constant recruitment from other states.

Karen Carson, M.D., president of the New Mexico Pediatric Society and chief of pediatrics at BCA Medical Associates, distributed handouts and testified as a private physician in Roswell. She supports the concept of requiring personal responsibility and co-payments from Medicaid patients. In her observation, 25% to 30% of the Medicaid patients at her office do not need medical services. For example, she stated, runny noses can be taken care of by a grandmother or an aunt. In another example, she stated that patients will use an office visit to obtain a prescription for over-the-counter medications such as analgesics so that Medicaid will cover the cost because Medicaid will not cover the same medication as a non-prescription drug.

On the issue of co-payments, Dr. Carson believes that Medicaid patients should be charged for sick visits, visits to the emergency room and missed appointments but not for well visits. She also believes that there should be a sliding scale, since for the truly destitute, a \$1.00 co-payment means no milk for the day. However, for those at 200% of the federal poverty level, a \$1.00, \$2.00 or even a \$5.00 dollar co-payment is reasonable, she believes. She reported that people at the top of the Medicaid income level come in to her office with their nails done, drive beautiful cars and play on Nintendo Game Boys.

Dr. Carson indicated that reimbursement for Medicaid can be problematic. She lamented that when the Salud! contractors delay or wrongfully deny Medicaid reimbursement, they do not have to pay interest. Because one of the Salud! contractors failed to update immunization codes in January, as it should have, \$4,000 worth of immunizations administered in the spring went unpaid until just before this committee meeting. She reported to the committee that a physician in Las Cruces had to take out a loan to pay for office operating expenses and go unpaid for a couple of months when a Salud! contractor delayed reimbursements. Committee members suggested that Ms. Weinberg and the HSD should investigate the Salud! contractors' lack of accountability.

Dr. Carson agrees with pay-for-performance measures for providers. However, she does not want to see a reduction in the amounts of Medicaid reimbursements, which she believes would result in a reduction in the number of providers willing to see Medicaid patients.

Quela Robinson, staff attorney for the New Mexico Center on Law and Poverty, distributed a handout and said that her center represents low-income people in the state. She said that her center is glad that the HSD solicited public comment and has refrained from committing to charging Medicaid patients co-payments and integrating the developmental disabilities waiver into the global waiver. Ms. Robinson reported that 25% of the population, which amounts to 550,000 people, in the state are on Medicaid. She clarified that to qualify for Medicaid, patients must be not only impoverished but also, in most cases, disabled, elderly, pregnant or a minor child. Sixty percent of Medicaid enrollees are children, she stated. She added that the next largest group of Medicaid recipients is seniors. She asserted that Medicaid is not a charity.

Ms. Robinson stated that the HSD's Medicaid redesign should start with the concerns repetitively expressed at the public hearings by stakeholders, instead of with the HSD's four principles of Medicaid redesign.

Ms. Robinson disagreed with charging Medicaid recipients co-payments, as 20% of New Mexicans cannot pay for food. In addition, she said that for the vast majority of people, it is in their best interests to see medical providers and that missed appointments are often the result of unreliable transportation or the inability to get time off from an hourly wage job. Moreover, she asserted that fees and co-payments will not save money for the state because when people cannot afford co-payments, they will avoid seeking medical care until the crisis stage. This ultimately would result in greater costs, she stated.

Ms. Robinson suggested that before the state seeks to expand the managed care system, the system should be scrutinized to determine how and whether it is working. Ms. Robinson stated that the Center on Law and Poverty is concerned that an expansion of managed care would result in difficulties receiving services, as has occurred in Florida and Tennessee.

As for the HSD's proposed pay-for-performance measure, Ms. Robinson stated that she has seen no evidence that pay for performance would result in the improvement of health outcomes rather than just an increase in administrative costs for oversight and monitoring.

Ms. Robinson reported that her center is concerned about a global waiver that would include home, community and developmental disability waivers. She stated that the 1115 waiver sought by the HSD would give the state the discretion to waive any aspects of Medicaid.

Bill Jordan, policy director of New Mexico Voices for Children, distributed two handouts, one titled "The Economic Benefits of Health Care Reform in New Mexico" and the second describing the tax revenue impact of the ACA. He expressed appreciation for the HSD's and Ms. Smith's engagement of the advocates in the Medicaid redesign process. A redesign that does not result in a reduction of eligibility, benefits or access to care would be great, he said. However, Mr. Jordan warned, the last time Medicaid was described as "unsustainable", during the early part of the Richardson administration, 30,000 children lost their Medicaid coverage. The state has the second highest rate of uninsured kids in the nation, and many children who are eligible

for Medicaid are not enrolled. This is due to a lack of political will to ensure coverage for eligible children, according to Mr. Jordan. He believes that the ACA could help remedy that situation.

Mr. Jordan directed the committee to his first handout, "The Economic Benefits of Health Care Reform in New Mexico", which contains projections for Medicaid enrollment for 2012 and 2014 and projections for the amount of federal dollars that could flow to the state under the ACA. According to this handout, between 2014 and 2020, the state should receive between \$10.5 billion and \$13.3 billion, by a "very conservative estimate". Furthermore, Medicaid expansion will bring in a great deal of money that will offset any expense the state can expect to incur.

In response to committee concerns, Ms. Weinberg said that even if the developmental disability waiver is incorporated into the 1115 waiver, the state cannot do whatever it wants; a change in Medicaid benefits would require a formal request to the federal government and solicitation of public input. Committee members advised Ms. Weinberg that the HSD should demonstrate that a 1115 waiver would save money rather than cause the state to lose out on federal funding. Committee members suggested that, rather than making cuts to Medicaid, the state should raise taxes or agree to the ACA.

As for whether behavioral health care should be included or carved out of a global waiver, Ms. Weinberg stated that she has always been opposed to "silo"-ing mental health from physical health care, as the brain is part of the body.

Committee members asked the HSD what role the legislature will have in this process. Ms. Weinberg agreed to give committee members a copy of the 1115 waiver application with an attached summary. Ms. Weinberg asserted that there is no guarantee that the HSD will solicit the committee's input before submitting the 1115 waiver application. However, there will be a long process of dialogue with the federal government during the 1115 approval process, she said. Committee members suggested that the HSD give them an outline of the proposed application sooner rather than later. Committee members mentioned that staff will have to get started on any legislation that may need to be prepared for the 2012 regular session to implement a 1115 waiver. Ms. Weinberg agreed to present the committee with a concept paper before the application is completed.

Mr. Hely stated that Cindy Mann, director of the Center for Medicaid and State Operations at CMS, said that states that have zero cost sharing would have their federal match payment — known as the federal matching assistance percentage (FMAP) — increased by 1%. Ms. Weinberg had not heard of that, nor had Ms. Smith, although she did not deny that could be true. The committee chair expressed the expectation that the HSD would verify that information and report back.

Minutes Approved

The minutes from the July 2011 committee meeting were approved.

Public Comment

Kathleen Hunt, the executive director of Border Area Mental Health Services, stated that her clinic serves people from a broad, rural, frontier area, regardless of their ability to pay and on a sliding-scale or no-fee basis. She described co-payments as a collection nightmare and an unbearable administrative burden. Her clinic supports the carving out of mental health services from the global waiver to avoid a dilution of services.

Sylvia Sapien, director of the promotora program at Dona Ana County's La Clinica de Familia, stated that her program focuses on parenting. La Clinica de Familia, Ms. Sapien explained, is one of the first clinics of its type in the state. She stated that there are a few adult patients on Medicaid in her clinic who drive fancy new cars (in response to Dr. Carson's comment), but there are many more who have to wash their dishes with bar soap because they lack the money for dishwashing liquid.

Doris Husted of the Arc of New Mexico said that promotoras are critical in New Mexico, since there many families lack the ability to negotiate the medical system. Ms. Husted asked that incentives such as Medicaid debit cards not be used to discriminate against people with developmental disabilities; that practitioners not be punished under a pay-for-performance system; and that practitioners not be given incentives to select only those patients who can get better quickly. She stated that the most severely mentally ill are long-term patients who will not improve quickly.

Jim Jackson, executive director of Disability Rights New Mexico, stated that he will join with other members of the disability coalition to meet with the HSD to discuss the impact that co-payments will have on individuals with developmental disabilities. Mr. Jackson asked that the HSD focus on how to improve health services to Medicaid recipients and not drive the system based on the fear that it will go broke. Mr. Jackson added that his group believes there is room for cost savings in the developmental disability waiver program without cutting services to those in the program. Cost-saving measures would allow people to be added to the developmental disability waiver program from the wait list.

Barbara Webber of Health Action New Mexico stated that the redesign of Medicaid and Medicare presents an opportunity to change the health care system to a preventative care model. She pointed out that in all other industrialized countries, the proportion of doctors is 70% primary care doctors to 30% specialists. In the U.S., it is the reverse, she said.

Evangeline Zamora of Life Quest, Inc., asked that the Medicaid redesign spare emergency room services, the family, infant, toddler program and the developmental disability waiver from cost-cutting measures.

Anna Otero Hatanaka of the Association of Developmental Disabilities Community Providers said that there already are changes happening now to the developmental disability waiver that she hopes will produce benefits for the medically fragile and most disabled.

Sandra Adondakis, New Mexico government relations director of the American Cancer Society Action Network, spoke about the hardship that co-payments would impose on cancer patients, who go through periods when they see doctors numerous times each week. Even a small co-payment such as \$4.00 per provider over the course of a month could render treatments unaffordable, she said. She stated that patients who forgo medical care due to financial impediments could delay seeking treatment, resulting in later stage diagnosis and treatment and ultimately higher health care costs.

New Mexico Health Policy Commission: Health Care Work Force Data Collection

Jerry Harrison, Ph.D., acting director of the New Mexico Health Policy Commission (HPC) and executive director of New Mexico Health Resources, distributed a handout about HPC data records. As the HPC is unfunded, Dr. Harrison asked the committee to resuscitate the provisions of a 2009 bill so that all functions of the HPC may be transferred to the DOH, to which Secretary of Health Catherine Torres agrees. Specifically, Dr. Harrison recommends that:

1. the HPC functions be transferred to the DOH;
2. the DOH continue to have access to the hospital inpatient discharge data system, which is at least 30 years old;
3. the UNM Health Sciences Center and the DOH work around the geographic access data system;
4. the legislature fund the HPC for the period when such functions are transferred; and
5. there be a public advisory committee to oversee the data records formerly maintained by the HPC.

In addition, Dr. Harrison lamented the lack of analysis since the defunding of the analyst position in 2009 of the hospital inpatient discharge data system data submitted under statutory mandate by hospitals and the Regulation and Licensing Department. The committee chair agreed to take on the legislation suggested by Dr. Harrison and wondered about whether it could be put on the governor's proclamation for the upcoming special session.

Status of DOH Program Contracts; Disabled Children Services; Prenatal Services; Immunizations; Tuberculosis Treatment; and Buprenorphine Treatment for Incarcerated Individuals

Secretary Torres distributed handouts titled "Status of Prenatal Care", "Brain Development in Children", "Health Care Work Force Data Collection" and a handout outlining DOH contract processes and record-keeping processes.

Secretary Torres also distributed handouts showing fiscal year 2011 tribal memoranda of understanding, fiscal year 2012 tribal professional service contracts and fiscal year 2012 tribal provider agreements.

The committee chair asked Secretary Torres to ask the governor about the process of transferring all of the HPC data to the DOH, which initially will require a bill. The committee chair suggested that such a bill be placed on the proclamation for the special session.

Secretary Torres referred the committee to the handout containing updates on DOH contract processes and record-keeping processes. That handout included a flow chart showing the state's use of the procurement process; the professional service contract provider agreement process; contracts funded in fiscal year 2011 and contracts not funded in fiscal year 2012; discussion of the federal Family Educational Rights and Privacy Act of 1974; discussion of the federal Health Insurance Portability and Accountability Act of 1996; a list of goals for the provision of children's medical services and children's medical services provider agreements; a list of immunization programs and contracts and tuberculosis programs and contracts; and a discussion of the suboxone (buprenorphine) treatment program with a list of contracts and agreements. Secretary Torres contrasted the daily \$12.00 per-patient cost of suboxone treatment, which adds up to \$10,920 per year, with the \$30,000 annual cost of incarceration.

Jim Green, deputy secretary of the Department of Finance and Administration, spoke about the New Mexico Abilities process. For more information about New Mexico Abilities, a central nonprofit agency that provides comprehensive statewide support to foster development of contracts for New Mexico people with disabilities, community rehabilitation programs and public bodies, see www.newmexicoabilities.org.

Gayle Kenny, bureau chief of the Infectious Disease Bureau of the DOH, referred to the DOH's handout and discussed the DOH's actions in treating hepatitis in the state.

Secretary Torres informed the committee that Dr. Dan Derksen was appointed as the director of the executive's Office of Health Care Reform and started working in that capacity two weeks ago. Prior to the committee meeting, Dr. Derksen reported to the committee chair that he would work on applying for an ACA grant for the health insurance exchange. The committee chair wants Dr. Derksen to speak at the committee meeting in October.

Committee members asked whether the DOH has a general counsel. Secretary Torres said that she is still searching for a general counsel, but that the DOH employs six attorneys, including Ramona Schmidt, who reviews all DOH contracts. By July 29, 2011, Secretary Torres had signed at least 1,000 provider contracts, most involving CMS, thus meeting the retro-payment requirement.

Committee members were concerned that people released from jail would not have access to suboxone opioid addiction therapy due to lack of payment means. Dr. Maggi Gallaher, medical director of the Family Health Bureau of the DOH, discussed vendor issues that affected the suboxone program. She stated that those issues apparently have been addressed and resolved.

Committee members inquired about school-based health center contracts. Secretary Torres stated that the contracts allow the provision of health care services on September 1. Committee members were concerned about the gap in services, given that this school year started on August 15, 2011 in most districts.

In response to a committee member's inquiry about the DOH's most important unfunded or inadequately funded need, Secretary Torres responded that school-based health clinics and the protection of minors are her biggest concerns, in addition to the continued provision of hepatitis, tuberculosis and addiction treatment services.

Committee members inquired whether the director position at the Fort Bayard treatment facility is being filled. Secretary Torres responded that Fort Bayard has the most difficult director position to fill due to the location and the requirement that the director be hospital-certified. A handout about the Fort Bayard treatment facility was distributed by a member of the public who did not submit her name.

Cathy Stevenson, deputy director of the Developmental Disabilities Supports Division of the DOH, spoke about the developmental disabilities waiver. Committee members asked whether the DOH spoke to the HSD about not compromising the current waiver programs. Secretary Torres stated that the DOH is using its assessment tools to get to the point where people can be taken off the waiting list.

ACA: Federal Fund and Grant Opportunities

Ms. Esquibel distributed two handouts prepared by the Federal Funds Information for States (FFIS) and State Policy Reports: "Health Care Reform Grant Allocations Per State" and "Status of Funding Opportunities in Health Care Reform Law". Ms. Esquibel reported that New Mexico received the first \$1 million for planning the health insurance exchange and may apply for two subsequent tiers of funding for implementation. The amounts of subsequent funding will depend on the application, including how the scope of work is described.

Ms. Esquibel stated that the state should be strategic in how it applies for and uses federal funds. She said that the federal congressional "super committee" could decide on funding cuts to state programs but that ACA funds could replace the state funds that are cut.

Ms. Esquibel explained that some of the grants for which the state could apply include exchange innovation grants, which have been awarded to seven other states in the amount of \$50 million; grants for professional health care recruitment, some of which UNM has sought. Some grants have deadlines and other grants provide rolling opportunities for application, according to Ms. Esquibel.

Committee members asked whether grants are available to fund capital outlay for community health centers. Ms. Esquibel stated that she believes that there are grants to fund the operational budgets of, but not the capital outlay for, community health centers. Committee members asked whether community health centers have received information about grant opportunities under the ACA. Ms. Esquibel suggested that the question be submitted to Dr. Derksen now that he has become the director of the Office of Health Care Reform.

Committee members also asked Ms. Esquibel how many ACA funds were applied for by this administration as opposed to the last administration. Ms. Esquibel did not know the answer to

that but said that the DOH under Secretary Torres is applying for a community transformation grant under the ACA. The DOH seeks community transformation grants to create spaces based on Las Cruces revitalization areas that feature schools, walkable spaces, nutritional programs, gardens and community health centers, according to Mr. Hely. Ms. Esquibel added that the community transformation grants are not capped and the amount will depend on how the application is structured.

Ms. Esquibel promised to provide LCS staff with FFIS updates on ACA grant opportunities as they are posted every three months.

The meeting adjourned at 2:15 p.m.