

MINUTES
of the
THIRD MEETING
of the
TOBACCO SETTLEMENT REVENUE OVERSIGHT COMMITTEE
August 28, 2009
Health Sciences Pete Domenici Center
North Campus, University of New Mexico
Albuquerque

The third meeting of the Tobacco Settlement Revenue Oversight Committee (TSROC) for the 2009 interim was called to order as a subcommittee by Representative Gail Chasey, co-chair, on Friday, August 28, 2009, at 10:20 a.m. at the University of New Mexico Health Sciences Pete Domenici Center in Albuquerque.

Present

Rep. Gail Chasey, Co-Chair
Sen. Mary Jane M. Garcia, Co-Chair
Sen. Dede Feldman
Rep. Danice Picraux
Sen. John C. Ryan

Absent

Rep. Gloria C. Vaughn

Advisory Members

Sen. Rod Adair
Sen. Sue Wilson Beffort
Rep. Ray Begaye
Rep. Karen E. Giannini
Sen. Linda M. Lopez

Sen. Mary Kay Papen

Staff

Sandy Mitchell, Staff Attorney, Legislative Council Service (LCS)
Michael Hely, Staff Attorney, LCS
Roxanne Knight, Researcher, LCS

Guests

The guest list is in the meeting file.

Copies of all handouts and written testimony are in the meeting file.

Committee Business

Representative Chasey welcomed committee members. Committee members and staff introduced themselves. Dr. Paul Roth, vice president of the University of New Mexico's (UNM) Health Sciences Center (HSC), and Dr. Richard S. Larson, vice president for translational research at UNM HSC, welcomed the committee.

Federal Tobacco Legislation Update

At 10:23 a.m., Nathan Bush, vice president of government relations for the American Cancer Society (ACS), gave a presentation regarding the new federal Family Smoking Prevention Tobacco Control Act (FSPTCA). Mr. Bush informed the TSROC that the FSPTCA grants the federal Food and Drug Administration (FDA) authority to regulate tobacco products. The bill had been before Congress for over a decade. Cigarettes' harm is well-established. Section 904 of FSPTCA requires disclosure of: all ingredients of cigarettes; industry research regarding health effects; and notification to the FDA of any changes to a product. Section 907 of the act holds that the FDA does not have authority to ban all cigarettes, smokeless tobacco or nicotine in tobacco products. There is federal preemption regarding limits on sales, marketing and promotions. New regulations may go as far as the free speech limit of the U.S. Constitution. The time, place and matter, though not content, of that speech may be regulated. The ACS has cautioned states about moving quickly on regulating commercial speech because, as yet, this is untested.

Mr. Bush offered to get experts in touch with legislators interested in consulting with the ACS on this subject.

Section 102 of the act concerns point-of-sale advertising. It limits the text to black and white and limits tobacco advertising in publications with "significant teen readership". There is debate as to the definition of "significant teen readership".

Section 906 of the act states that the federal secretary of health and human services may impose additional restrictions by regulation. Currently, the FDA is taking public comment on the implementation of regulations pursuant to the FSPTCA.

The old federal statute on cigarette regulation, which gave rise to mandatory warning labels on tobacco products, has been amended to provide for much more explicit warning labels. Fifty percent of cigarette packages will have a graphic warning label on the top half of the package.

Mr. Bush discussed the options state lawmakers have in regulating tobacco in this climate of preemption. The ACS suggests that legislators may:

- increase tobacco taxes and use the revenues to fund programs on tobacco use; and
- restrict sales at certain locations not already set forth in the FSPTCA.

Questions and comments included the following:

- *Are organizations commenting on FDA regulations pursuant to the FSPTCA?* Yes. The ACS wants to comment after public input has been made.

- *How can the public give input on FDA regulations pursuant to the FSPTCA?* Mail or email.

- *Does the ACS foresee any Commerce Clause problems with restricting the time, place and manner of tobacco marketing by the states?* Mr. Bush informed the committee that he would investigate this matter with ACS counsel.
- *What are "modified risk" tobacco products?* These products go back to 1970s to 1990s-era big class-action lawsuits. These are products labeled "light" or "low tar" cigarettes and now include smokeless tobacco. There are also breath-mint-like lozenges and smokeless tobacco that may be used without spitting.
- *What about electronic cigarettes?* Electronic cigarettes are vaporized nicotine inhalers without any tobacco. The FDA just issued a statement. Due to the FDA's oversight, much of state regulation on tobacco is not applicable. The FDA issued a statement saying these inhalers are NOT safe; chemicals in inhalants are harmful.
- *What are "adulterated or misbranded" tobacco products?* Counterfeit cigarettes ("knock-offs") belong in this category (e.g., a product sold as "Marlboros" that is not made by Phillip Morris). Phillip Morris would be a good authority on this.
- *Are the electronic cigarettes lit at the very tip?* Mr. Bush informed the TSROC that he has never seen these. These might be new cigarettes that claim to heat but not smoke the tobacco; they are heated but not lit. Mr. Bush suggested that, if any legislation were introduced to regulate this product, drafters might want to include this phrase. He explained that lower temperatures may be more dangerous because of smaller particles entering the system faster.
- *There was a request to see popular brand names for some of these products.* Mr. Bush is going to be presenting in Madison, Wisconsin, soon and may make all of these definitions clear.
- *Comment: demonstrations of these products would be helpful; e.g., it was helpful when attorneys general provided charts. (Then-State-)Senator Tsosie brought in look-alikes for alcohol products.* Mr. Bush pointed out that New Mexico is not usually a test market for new products, so residents see them later than other states do.
- *With regard to the slide on page 4:*
 - A. *Does "more than 15 percent or two million" mean the greater of the two?*
 - B. *Referring to the advertising restrictions in the FSPTCA, what is a "teen readership"? How is this reported? If a family subscribes to a magazine, how does the family isolate teens' access?* Mr. Bush will investigate this matter. This is likely a regulation that is being developed by a federal executive agency. What has not been fleshed out is who will enforce the advertising rule. The FDA has a history of contracting with state departments of health and other enforcers. The committee will be informed.

- *Candy cigarettes: they are obviously set up to induce smoking among children. Is there any legislation about this?* Mr. Bush informed the committee that he believes a lawsuit is currently pending in Oregon, but that he knows of no legislation banning candy cigarettes in the United States.
- *Members exchanged ideas about where this candy is banned; some conjectured that Canada has a ban, and that North Dakota has a ban.*
- *What about on page 4 of the handout, giveaways and coupons? (Bullet 2, slide 1 on p. 4)* Mr. Bush alluded to coupons (Camel Cash, etc.) for smoking. Promotional products were addressed in part by the Master Settlement Agreement (MSA). New Mexico Attorney General Gary King filed a complaint against National Tobacco for having given away some promotional items.
- *Regarding page 3 of the handout, if states may regulate advertising outside of content, what are the legal views of the ACS for any Commerce Clause problems? When the MSA was being negotiated, the state was trying not to disadvantage its one local manufacturer, but the state was not allowed to favor an in-state manufacturer versus an out-of-state manufacturer.*
- *Page 8 of the handout reports that states are allowed to restrict tobacco sales. New Mexico does this already. Are locked cases in stores not a retail decision, or is it required?* The legislation was for a clerk-assisted sale — not for locked cases, but likely this is due to shoplifting concerns.
- *Regarding page 9 of the handout and Commerce Clause (of the U.S. Constitution) issues: states' attorneys general have developed model legislation based on the MSA. Attorneys general should develop model legislation pursuant to the FSTPCA. Mr. Bush agreed.*
- *If states tax too much, revenues will actually decline. Do the data support a raise in the tobacco tax? Only a \$.50 to \$1.00 increase in the tobacco tax has been studied. Revenues from these taxes have always been a net gain. There is always the concern about where people will try to buy cigarettes alternatively. Since 2003's increase from \$.21 to \$.91, Mr. Bush saw that revenues increased substantially to \$59 million to \$60 million in state excise taxes, and numbers have held steady. States saw a big decrease when the Centers for Disease Control and Prevention (CDC) chartered a smoking survey that showed that people are smoking fewer cigarettes. Mr. Bush told the TSROC that he would send members data indicating a \$40 million a year increase in revenue for the state from the latest tobacco tax increase.*

New Mexico did not increase smokeless tobacco taxes, but revenues from smokeless tobacco increased from \$3 million-\$4 million to \$5 million-\$6 million, which Mr. Bush attributes to increased usage.

- *Do you follow lung-cancer statistics? As smoking rates are reduced, does this translate into less lung cancer?* Mr. Bush will supply CDC data showing that an increase in tobacco taxes correlates with fewer people smoking cigarettes. Mr. Bush told the TSROC that he did not know the lag time between a decrease in smoking and a decrease in the incidence in lung cancer, but heart disease numbers may indicate good things for cancer statistics.
- *Comment: early detection advances may contribute to reductions in tobacco-related illness.* Mr. Bush informed the TSROC that the Taxation and Revenue Department has legislation to track tax-free cigarettes. The department has linear tracking as to how many tax-free cigarettes are sold by tribes.
- *Regarding the \$59 million-\$60 million net from tobacco tax revenue — is this earmarked or going to the state's general fund?* Mr. Bush suggested that staff should investigate this matter.

With the arrival of several committee members, a quorum was achieved at 10:45 a.m.

The University of New Mexico Health Sciences Center Performance Report

At 11:15 a.m., the UNM HSC Executive Vice President for Health Sciences and Dean of UNM's School of Medicine, Dr. Roth, gave an HSC performance report.

Dr. Roth praised the legislature's move to use tobacco settlement funds to fund a great deal of clinical, instruction and general programs at UNM. He began by discussing UNM HSC's participation in the Area Health Education Centers (AHEC) program, which he characterized as a popular program that receives federal funding. Usually, AHEC representatives appear at schools of medicine, though they support allied health professional students. The AHEC promotes health care work force pipeline programs and provides middle and high school students with health career information. There is a northern AHEC, southern AHEC and a UNM HSC AHEC.

Next, Dr. Roth gave an overview of UNM HSC's Center for Telemedicine, whose director, Dale Alverson, has been active in building telehealth and telemedicine programs.

The Los Pasos program uses state dollars, which have supplanted lost federal dollars, to work with high-risk families in order to prevent child abandonment, abuse and neglect. It is a home-based program that monitors the development of children and supports parents in eliminating substance addiction.

UNM HSC's Poison Control Center serves New Mexico and nearby communities in neighboring states. The major impact is that it allows people to get advice over the phone and avoid emergency room visits. The center reduces morbidity and mortality because it offers timely information. The TSROC helped address salary issues with the 16.5 full-time employees (FTEs).

UNM HSC's pediatric oncology program is the only one in the state. It employs roughly 14 FTEs, who are supported through state funds. The program is trying to raise more money through its development program.

The Specialty Education Pediatric Trauma Center has unfortunately seen business increasing in recent months. The TSROC funds are responsible in part for the center being able to bring in more trauma surgeons and to train future surgeons. The center needs to bring in more faculty for this program. Funding for medical school is not done through the funding formula.

Questions and comments included the following:

- *Regarding Casa Esperanza, the home where individuals with cancer from outside Albuquerque and their families stay during treatment in Albuquerque, is it only charity-supported? Are any state funds used by Casa Esperanza? It's free to families, right?* Dr. Roth does not know the details of Casa Esperanza's funding. This is highly dependent on private donations. Casa Esperanza is designed to accommodate families who have children with cancer.

Staff from UNM's pediatric oncology program go throughout the state to help families manage care in local communities. UNM HSC develops relationships with local providers and general internists who may be able to pick up treatment. Periodically, they return to Albuquerque for testing, etc.

- *How are Los Pasos sites selected? How is money used?* Dr. Roth does not have detailed information on this. Historically, it began in southeast Albuquerque and the south valley of Albuquerque, and the program expanded gradually. The details of the treatment plan are not known, but Dr. Roth can get this information to the committee. As the years went on, the federal government reduced and eliminated funding, so state funds replaced the federal money lost.
- *Regarding UNM's pediatric oncology program, how are children brought in from other areas of the state?* When children are referred by providers throughout the state, they are brought to Albuquerque for an initial evaluation and they begin their initial treatment in Albuquerque. They return to their local communities for continued treatment.
- *Is the incidence of cancer growing among children?* Dr. Larson says the rate is flat, but grows with the population.
- *On page 6 of your handout, you list the distribution of TSROC funds. How does UNM HSC distribute the money?* UNM receives this funding like any other state funding: it receives it as a single bonus at the beginning of the fiscal year (July 1).
- *Providers do not see funds for a long time after funds are allocated. The Department of Finance and Administration (DFA) says it can only go back a month. If a contract*

is signed in August, the month of July is lost. This problem is being experienced by the Indian Affairs Department. Is it happening here? It is different with contracts than with appropriations. There are about \$18 million in funds through contract services with the Department of Health (DOH). The contract piece has been very difficult. There were delays in signing the contract. Dr. Roth pointed out that appropriations to UNM do not revert under most circumstances, but when it initially receives new funding, there is reversion language.

- *Who is the fiscal agent for appropriations? UNM?* The state will appropriate to various agencies, who will then contract with UNM. Funds should flow as described earlier between the state and agency, but the processing of individual contracts goes through the agencies. UNM expends a "huge amount" of effort making sure contracts are signed with the DFA.
- *Regarding Los Pasos: are there any policies or regulations on the funding? Are these nonprofits or UNM?* It is a UNM-funded organization, not an outside organization. Money allocated for Los Pasos must go only to this program.
- *What happened to the Milagro program?* Dr. Roth informed the committee that Milagro and Los Pasos were very similar programs. Milagro treated drug-dependent pregnant women; Los Pasos treats mothers and children after birth. Much of Milagro's functions have been subsumed in the UNM Obstetrics and Gynecology Department. Dr. Roth told the committee that he would follow up and provide the staff with further information.
- *Please tell us about UNM's Center on Telemedicine organization.* Dr. Roth informed the committee that the center creates the infrastructure — hardware connectivity — the highways on which individual programs travel.
- *UNM is a member of the AHEC; is this a good way to initially spot students for health career programs?* AHECs have historically been based around nursing. There are recruiters that go out to all New Mexico high schools. There is also BA/MD program promotion.
- *Is AHEC a physical center? Is patient care delivered?* It is a physical site — in Las Cruces (NMSU) and in Las Vegas. It is education provided to high school and college students. The AHEC serves as a great entry into those communities to arrange for housing and other services.

Biomedical Research at UNM

Dr. Larson testified to the committee regarding UNM HSC's success over the last several years in getting federal dollars. It is viewed as a model biomedical research program for how to promote health care and act as a local economic engine.

UNM HSC's fund strategy has been to "build a state highway on which to move federal monies into the state". The TSROC has appropriated funds to pilot funding and core facility support.

UNM HSC is having great successes in technology development; *e.g.*, scientists at UNM have invented a hand-held device to diagnosis lung disease or infection, which is adapted to diagnose H1N1 flu. This technology is more advanced than Biomoda's. This is all the result of investing \$50,000 in 2003 in pilot funds.

Clinical trials at UNM HSC provide over 100 therapies otherwise unavailable in New Mexico, including a new oral drug to help stop smoking.

- *What percentage of people on trials survive?* Dr. Larson informed the committee that the answer depends on what the disease is.

The TSROC funded a few jobs directly (around 62) in 2009, but a lot of jobs indirectly (1,219 in 2009). Within the last five years, 758 new jobs in private industry have been developed as the result of new technologies (see page 22, handout).

The Clinical and Translational Science Center (CTSC) is a name mandated by the federal government, which has contributed greatly to the CTSC. It allows UNM HSC to move new therapies from the lab into practice much more quickly. What the cancer center has done for cancer, UNM wants to do with all other diseases.

UNM has increased federal, private foundation and private industry funding for biomedical research in New Mexico to \$137.5 million, an increase of \$ 3.5 million from 2008.

Questions and comments included the following:

- *Referring to page 24 of your handout, is this what UNM has to do to get the designation as a CTSC?* The federal government requires an investment over a period of years. UNM has not requested additional state funds for the CTSC because of the use of federal and other funding. However, existing TSROC funds are crucial.
- *Are tobacco settlement funds designated by law to biomedical research? Is there any other biomedical research competing for MSA funding?* TSROC funds are a single allocation; UNM does not compete on an annual basis.
- *It is quite imperative that the legislature fund this program because of all of the federal leveraging, is it not?* Yes.
- *Biomoda: the TSROC has supported Biomoda. What do you think about its work?* Dr. Larson pointed out that even though there are competing technologies, these technologies should be developed alongside each other so that the best technology results. Biomoda's

work is for screening, not diagnosis. Diagnosing flu is exact, whereas cancer is screened, not diagnosed, with this type of technology.

- *Please discuss UNM's work in genomics.* UNM can put all 54,000 genes in a human body on a chip; the facility can analyze all of these in a matter of moments. UNM uses that to figure out what genes predict breast cancer, for example. UNM scientists discovered that they could predict a small percentage of children who would not respond to chemotherapy if they have leukemia. This helps save children and families from the tribulation of going through chemotherapy before learning that it would not work.
- *What does bioinformatics mean?* It means the application of information technology to medicine, in this case. It is used to look at data, for instance, to see when physicians order too many or too few tests.
- *What does epidemiology mean?* It is study of what happens in a population to try to understand what exposures there are, etc.
- *Have you heard reports that the best therapy for diabetes is nopal?* Some drug therapies are more directed at unusual situations. They are trying some very unusual substances for snake bites. There are some trials using nutraceuticals such as nopal.
- *Comment: Remedios are known to our communities; Hispanics use them regularly.*
- *Has there been much focus on early detection?* UNM's overall research mission emphasizes prevention; hence the prevention research center at UNM. Some are drug-based; others intervention-based. Project CHILE is changing behaviors among fourth graders by showing the risk of obesity and reversing that. There are school interventions throughout the state.

There is a program working with adults at the Pueblo of Zuni, which looks at changes in young adult behavior to prevent renal diseases.

TSROC funds support prevention research.

- *What about screening versus prevention — when disease occurs despite prevention efforts?* Screening technologies are generally failed diagnostic technologies; they screen because they are not precise enough to diagnose.
- *Does UNM HSC disseminate to the technical community needs for certain technologies; e.g, the syringe invented at UNM HSC, which is usable one-handed?* Dr. Larson answered that UNM HSC facilitates this dissemination, but does not itself disseminate this information.

- *Comment: regarding page 21 of the handout, which discusses small cuts to state government being unwise when so many jobs are created through state funding. The legislature is trying to avoid job loss and it is good for the Legislative Finance Committee (LFC) to know this. Page 21 demonstrates this. Drs. Larsen and Roth agreed it is a good idea to present this information to the LFC.*
- *Will you provide the details regarding site selection, funding sources and types of treatment plans devised for families in the Los Pasos program? Dr. Roth agreed to provide this information to committee staff.*

Approval of June and July 2009 Minutes

Upon a member's motion, seconded by another member, the minutes from the June and July 2009 TSROC meetings were adopted unanimously.

Lovelace Respiratory Research Institute (LRRI) Performance Report

At 12:45 p.m., Robert W. Rubin, Ph.D., president and chief executive officer of LRRI, made a performance report to the TSROC. According to Dr. Rubin, there are 100 Ph.D.-level scientists doing lung research at LRRI. It is turning down research requests because it cannot even keep up with demand. Clients include federal national institutes for health and over 200 pharmaceutical and trade associations for respiratory disease biotechnology.

TSROC funds are the only funds received from New Mexico sources.

The LRRI has done research that will likely reduce the push for "reduced-harm cigarettes". It will not likely be able to show any benefit from using these products.

The LRRI is interested in developing new therapies for people with lung disease and creating technical jobs in New Mexico by leveraging state money for federal funding. It wants to prevent chronic obstructive pulmonary disease (COPD) and lung cancer.

Every year smoking is implicated in more diseases, reported Dr. Rubin.

The LRRI is currently testing 130 new therapies for COPD and emphysema.

Questions and comments included the following:

- *Now that the LRRI has examined genetic susceptibility to disease, can people start getting diagnosed? The LRRI has licensed to biotech companies technologies for kits for self-diagnosis; these are already being used in Europe and undergoing review in the U.S. One can take a cheek sample and mail the swab to a biotech company in California, and for \$100, screen for susceptibility.*
- *Regarding the handout, on page 13: the LRRI is transferring technology to biotech and pharmaceutical companies. Will there be any companies in New Mexico receiving this technology? Dr. Rubin answered that there would not be any companies in New Mexico*

receiving this technology because biotech in New Mexico is "tiny". New Mexico is superior in engineering technology, and biotechnology may not be developed.

Dr. Tesfaigzi of the LRRRI testified about a study of smokers that focused on quitting, diet and lung function. The study established two things, which were unexpected results: Hispanics in general have less susceptibility than other ethnic populations to developing COPD. Yet, Puerto Ricans showed a higher risk of developing COPD. New Mexico offers interesting opportunities because of the high percentage of Hispanics in this area. It is a population unique in the world, affording an opportunity to compare Hispanics and non-Hispanic whites. This study opened a new study regarding genetic differences. The findings also showed that burning wood in the home does not predict COPD, and that leafy-green vegetables may help reduce risk of lung disease.

- *Have remedios been studied?* Dr. Tesfaigzi answered that in order to study the efficacy of these folk remedies (*remedios*), one has to study whether any correlations exist first. Then one conceivably has to do experiments, though it will cost too much to do an experiment. A researcher can give the remedy to people or to animals. If there is an effect and a correlation, there is proof. Also, it is difficult to do a study of folk remedies in a small population.

The LRRRI's focus has been on early detection: looking at people susceptible to developing a disease and investigating which genes make people susceptible to disease. The LRRRI's focus has come to the stage when it is looking at genetic associations.

- *Is there a 10:1 ratio above base funding required? Is the funding ratio kept at 10:1 in order to avoid losing independence from private companies?* Dr. Rubin did not think the LRRRI is in danger of losing any independence if it retains a wide diversity of clients; LRRRI's clients are often in competition with one another. The LRRRI does try to keep it at about 50:50 public-private ratio for reasons of stability.
- *Now that information will be available about ingredients in cigarettes as a result of the new tobacco legislation, are you looking at what ingredients are in the products used by your subjects?* It is difficult to have enough assurance that a particular effect is trackable in a population of 2,100 people. However, if a product chemistry is changed, the LRRRI can ask its subjects to report this change, and the LRRRI can test for changes in blood chemistry. It is very complicated. If a reduced-harm product comes out, the LRRRI will definitely start identifying users to see if there is a change in their physiological status.
- *Does loyalty to a particular brand show differences?* Dr. Rubin explained that the LRRRI does not know what the differences between brands are, but he guessed that scientists would need a larger sample of smokers in order to demonstrate differences.

Breast and Cervical Cancer Program

Julie Weinberg, deputy director of the Medical Assistance Division (MAD) at the Human Services Department (HSD), and Virginia Alcon, staff manager of the MAD breast and cervical cancer (BCC) program at HSD, gave a presentation on the BCC program. The HSD oversees BCC eligibility, while DOH implements the clinical aspects.

The BCC program was implemented on July 1, 2002, after the BCC Prevention and Treatment Act was passed by Congress to allow Medicaid coverage for BCC, as it is an optional coverage under federal regulations. All 50 states opted in. Every program has to follow a state plan amendment to make it an entitlement.

The DOH starts by screening women who meet the CDC program financial eligibility criteria; they must be screened and diagnosed by a DOH-contracted provider. Otherwise, a patient is not eligible for the BCC program.

- *Can someone get a non-DOH screening and then be rescreened by the DOH?* If diagnosed by a non-DOH provider, a person is not eligible for the Medicaid program. Based on data, the program is funded to serve 15% of eligible women in New Mexico. Of the 15% diagnosed, 21% are found not eligible for Medicaid for other reasons. It is assumed that approximately 62 women will be diagnosed; 85 will be diagnosed in the program but 12 to 19 women will not be eligible for Medicaid. While 350 women might be diagnosed; approximately 60 will not be eligible for Medicaid.

Here is a summary of the eligibility criteria for inclusion in the BCC program.

- The patient must have been diagnosed by a DOH provider and by no other.
- The patient must be uninsured; Native American women are included, because Indian Health Service is not "insurance".
- The patient must be under 65 years old.
- The patient must have an income below 250% of the federal poverty level (FPL).
- The patient must be a citizen of the United States.
- When the DOH determines Medicaid eligibility, the patient may be enrolled using a presumptive eligibility process for access to services as quickly as possible.
- There is no assets test; only an earned income test at 250% of the FPL with a 12-month certification.
- Patients receive the full Medicaid benefits package, not just cancer benefits.
- *Why do some counties with only small percentage of New Mexico's population show an incidence of breast cancer that is so much higher than the county's population?* These numbers reflect the fact that this a poverty program and those are high-poverty areas. The rates of diagnosis might also be higher in the BCC screening program than the average population because the program is building awareness in providers to look for uninsured women and emphasizing that these private providers should not diagnose their patients who may qualify for the BCC program, but send them to the DOH providers who can diagnose BCC.

- *Do these numbers reflect the total number of diagnoses and referrals to the BCC program? Yes.*
- *Out of all the people diagnosed in New Mexico with BCC, what percentage is diagnosed by a DOH-contracted provider? The DOH will later provide this information to the TSROC.*
- *How many women screened in Bernalillo County reported to the BCC program? How many were diagnosed? Why do the FY 2007 numbers in the handout not add up to 92%? The DOH or the HSD will look into these matters and follow up with information.*
- *At what FPL would non-pregnant women be qualified for Medicaid? Family planning services are the only category for single non-pregnant women. The income limit for pregnant women and children is 133% of the FPL.*
- *The BCC waiver was supposed to increase eligibility. Women who qualify for regular Medicaid do not need the BCC program because these women are already insured. The BCC program is for higher-income women who do not qualify for Medicaid; i.e., women whose income is as high as 250% of the FPL.*
- *When is treatment considered to be "concluded" in the BCC program? What about relapses; do they require re-enrollment? It would be based on the doctor's determination as to when the cancer is considered to be in remission. When the cancer does not return, the patient is considered treated and the treatment is concluded. Dr. Cameron at the DOH is knowledgeable on this subject and does recertifications. If a woman has a relapse and is still eligible, she can come back so long as a physician states that she needs surveillance.*
- *Is the federal match (FMAP) high for this program? The panel informed the committee that, yes, the FMAP is higher than for regular Medicaid. The BCC program receives an "enhanced" FMAP of just under 80%.*
- *A TSROC member requested the panel to provide figures to the TSROC regarding the diagnoses of breast and cervical cancer by county.*

Adjournment and Tour of the UNM Cancer Research and Treatment Center

At approximately 3:00 p.m., the committee adjourned. Some members of the committee toured the new UNM Cancer Research and Treatment Center, led by Donald Whitehead, clinical services administrator, UNM Cancer Center.