

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

**October 5-6, 2011
South Valley Health Commons
Albuquerque**

The fourth meeting of the Legislative Health and Human Services Committee (LHHS) was called to order by Senator Dede Feldman, chair, on October 5, 2011 at 9:36 a.m. at the South Valley Health Commons in Albuquerque.

Present

Sen. Dede Feldman, Chair
Rep. Danice Picraux, Vice Chair
Rep. Dennis J. Kintigh
Sen. Linda M. Lopez
Rep. Antonio Lujan

Absent

Rep. Nora Espinoza
Sen. Gay G. Kernan
Sen. Gerald Ortiz y Pino

Advisory Members

Sen. Sue Wilson Beffort (10/5)
Rep. Ray Begaye (10/5)
Rep. Eleanor Chavez
Sen. Stephen H. Fischmann
Rep. Miguel P. Garcia
Rep. James Roger Madalena (10/5)
Sen. Cisco McSorley
Rep. Bill B. O'Neill
Sen. Mary Kay Papen (10/5)
Sen. Nancy Rodriguez (10/5)
Sen. Sander Rue

Sen. Rod Adair
Sen. John C. Ryan
Sen. Bernadette M. Sanchez
Rep. James E. Smith
Rep. Mimi Stewart

(Attendance dates are noted for 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
Ruby Ann Esquibel, Principal Analyst, Legislative Finance Committee (LFC)

Wednesday, October 5

Welcome to South Valley Family Health Commons

Robert DeFelice, chief executive officer, and Paul Luna, president of the board of directors, First Choice Community Healthcare, welcomed the committee to the facility, located at the South Valley Health Commons. Mr. DeFelice thanked the committee for its good work promoting health care in the state. Senator Feldman informed the committee that First Choice Community Healthcare is a model that other health care facilities could emulate. At the end of the meeting, she thanked the staff at First Choice Community Healthcare, especially Michelle Melendez, patient services director, for hosting the committee and helping the meeting run smoothly.

Update from the New Mexico Office of Health Care Reform; Options for a State Health Insurance Exchange

Daniel Derksen, M.D., appointed in August as the director of the New Mexico Office of Health Care Reform in the Human Services Department (HSD), along with Priscilla Caverly and Jonnie Lus, represented the New Mexico Office of Health Care Reform before the committee. Dr. Derksen distributed a handout setting forth:

- (1) the priorities of his office (slide 2 of the handout);
- (2) an overview of the payer sources of health insurance in the state (slide 3 of the handout);
- (3) a projection of New Mexicans who will gain health insurance coverage starting in 2014, then in 2020 (slide 4 of the handout);
- (4) a chart showing current New Mexico health insurance coverage numbers in 2011 versus 2014 health care insurance coverage projections, which chart was used to apply for federal grants (slide 5 of the handout);
- (5) a list of future New Mexico health insurance exchange (HIX) time lines, which shows very tight time lines (slide 6 of the handout);
- (6) a summary of the federal Patient Protection and Affordable Care Act of 2010 (ACA) HIX requirements (slide 7 of the handout), which require the state to create its own exchange, which Dr. Derksen's office would prefer; in the event of the state's failure to do so, the state is required to use a federal government-established HIX;
- (7) a description of the need to integrate the screening, eligibility and enrollment of New Mexicans in one of the following coverage programs (slide 8 of the handout):
 - (a) Medicaid's Children's Health Insurance Program;
 - (b) the state basic health plan;
 - (c) an individual HIX on either a subsidized or unsubsidized basis; or
 - (d) a Small Business Health Options Program exchange;
- (8) a description of some of the information technology (IT) interfaces for a future HIX, Medicaid and federal data hub (slide 9 of the handout), including:
 - (a) eligibility screening, including income data;
 - (b) eligibility determination;
 - (c) eligibility results;
 - (d) plan selection; and

(e) enrollment confirmation;

(9) an illustration of the Integrated Service Delivery System 2 Replacement (ISD2R) Project and HIX parallel track approach, including a plan to submit a level 1 and a level 2 grant on a tight schedule (slide 10 of the handout);

(10) a chart showing the HIX business functions (slide 11 of the handout) that had to be described for the grant application, as referred to in the previous numbered paragraph;

(11) a list of the state's primary care shortage numbers and distribution problems (slide 12 of the handout), including a determination that the state currently lacks 400 primary care physicians (anticipated to expand to 500 when more residents are covered by a HIX or Medicaid);

(12) a description of SB 14 (Laws 2011, Chapter 152), sponsored by Senator Feldman, about maintenance of health care data and signed by the governor on April 8, 2011 (slide 13 of the handout);

(13) a mention of HB 710, sponsored by Representative Picraux during the 2009 regular session, for the promotion of patient-centered medical homes (slide 14 of the handout);

(14) a chart showing a comprehensive primary care initiative that the federal Centers for Medicaid and Medicare Services (CMS) released, which presents an opportunity to taper off from a fee-for-service system to a payment system to keep people healthy and to team-manage chronic conditions such as diabetes (slide 15 of the handout);

(15) a brief description of ACA funding sources for 2014 (slide 16 of the handout);

(16) a *Wall Street Journal* headline about a lawsuit filed by the U.S. Department of Justice in the U.S. Supreme Court to review the health care overhaul (slide 17 of the handout); and

(17) Dr. Derksen's contact information (slide 18 of the handout).

Dr. Derksen asserted that the HIX must mesh seamlessly with the Medicaid program.

The committee members expressed concern about confidentiality of medical conditions and data security with regard to the IT interfaces for a future HIX, Medicaid and federal data hub. Dr. Derksen directed the committee to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which provides protections. Senator Feldman pointed out the hefty civil penalties that could be imposed for HIPAA violations.

Dr. Derksen commended the committee for endorsing legislation several years ago requiring a call center, which has given the state a jump on this federal requirement for the HIX.

Dr. Derksen said that there are many New Mexicans who are eligible for Medicaid but are not enrolled. With the ACA and HIX requirements, many more residents will have insurance coverage either through Medicaid or the HIX. In addition, there are special provisions in the ACA that allow Native Americans a number of options for setting up their own HIXs.

In response to a committee member's query, Dr. Derksen stated that his office would be happy to provide the number of Native Americans covered by Medicaid. Committee members asked Dr. Derksen to repeat his presentation to the five Sandoval County pueblos.

In response to committee member concerns, Dr. Derkson stated that, even with the institution of the HIX, there will still be an estimated 100,000 to 250,000 uninsured individuals in 2020. It is anticipated that there will be a number of individuals who will opt out and accept the tax penalty or who will move from program to program and be exposed to potential gaps in coverage.

In response to a committee member pointing out that behavioral health was omitted from his presentation, Dr. Derksen stated that it is currently unknown whether behavioral health will be carved into or carved out of Medicaid. The state has the ability to include behavioral health treatment in the HIX plans. Dr. Derksen mentioned that there is a work force shortage in the field of behavioral health care, which means limitations on access to care. However, a committee member pointed out that the state does allow treatment to be provided by psychiatric nurses.

Committee members discussed with Dr. Derksen the problem with health care work force shortages in the state. The primary health care worker shortage and the multi-hour wait for emergency room services and infrastructure deficiencies are a problem, Dr. Derksen said.

Dr. Derksen asserted that the state needs to make sure work force needs are met to fully effectuate coverage under the HIX. Committee members noted that it will take longer to train workers to fill the current need than it will take to implement the ACA. Committee members also suggested that instituting a team-based approach to care, such as that provided by First Choice Community Healthcare, could be part of the solution. Dr. Derksen added that it is also necessary to change the way payments for health care services are structured, regardless of whether a recipient is insured under the HIX or Medicaid. Moreover, he asserted, the HIX must mesh seamlessly with the Medicaid program.

Dr. Derksen discussed the 70-page grant application, titled "New Mexico Level 1 Health Insurance Exchange Establishment Grant", which was submitted by his office on September 29, 2011 and has been posted on its web site. He did not provide the committee with a copy of the application. He reported that the application requested \$33.4 million, an amount in line with other states' requests. Of that amount, 60% to 70% was requested for IT purposes. Dr. Derksen hopes that his office will receive the level 1 grant in November. He anticipates submitting a level 2 grant application in March 2012.

A committee member suggested that Dr. Derksen explore the possibility of postponing a HIX in the state until after 2014 so that the state can observe how well other states' HIXs and the federal data hub work. A committee member also expressed concern that the state not become insolvent by adding people to Medicaid if the federal government becomes unable to adequately fund Medicaid. A committee member also asked whether undocumented non-citizens will be part of the HIX.

Committee members also inquired about the HIX plans for children, which is a concern because there are 60,000 uninsured children in the state.

Dr. Derksen distributed a second handout, titled "NM's Health Extension (HERO) Program: Enhancing Community Infrastructure, Supporting Health Reform". Dr. Derksen was asked by the committee members whether he was asked for his input regarding a Medicaid redesign, to which he replied that he expects to be asked. A committee member said he would be more inclined to support the HSD's Medicaid redesign if Dr. Derksen were part of it.

Senator Feldman asked what Dr. Derksen envisioned would be the legislature's role, if any, in a HIX. Dr. Derksen said he hesitates to ask for a legislative fix when the federal rules are still in a proposed state. He believes that the final federal rules will look different from the proposed rules currently posted online. He believes that an award of federal grant money could allow his office to consult with legislatively authorized work groups, including representatives from the Insurance Division of the Public Regulation Commission, to discuss policy. Senator Feldman indicated that the legislature has a constitutional obligation to be partners with his office.

Senator Feldman also asked about the State Coverage Insurance (SCI) program, whose participants want to know whether they will continue to receive insurance through SCI or the HIX. Dr. Derksen responded that it would depend on their eligibility factors. Some individuals who are up to 138% of the federal poverty level may be newly eligible for Medicaid, while others may be covered by a basic health plan established pursuant to the ACA or by private insurance with a tax subsidy.

Senator Feldman also asked about payment aggregation and risk adjustment plans, to be answered by Dr. Derksen in the future.

Minutes

The minutes from the LHHS meeting in August were approved.

Proposed Federal Rules and Developments on the HIX

Marge Petty, regional director, Region VI, U.S. Department of Health and Human Services (HHS), introduced Jay Angoff, senior advisor to U.S. Secretary of Health and Human Services Kathleen Sebelius. Mr. Angoff stated that insurance is a dysfunctional market because there is no industry competition based on price and quality. Instead, consumers compete based on industry assessments of their risk factors. However, because not everybody is insured, the risk cannot be spread across all populations of patients. After the implementation of the ACA in 2014, insurance companies no longer will be able to exclude or disproportionately charge people with preexisting conditions. The insurance industry agreed to this requirement of the ACA because it will have many more insureds and will be able to spread the risk and insure people at a standard rate. There also must be a risk adjustment system to take risks away from companies with low-risk consumers and spread it to companies with more high-risk consumers.

Mr. Angoff stated that the most meaningful part of the HIX is a web site on which consumers can compare programs by services, price and quality, which may spur competition in the market. The insurer also benefits by cutting sales and advertising costs, as more consumers

than ever before can have access to information about the insurance policies through the HIX web site.

Mr. Angoff stated that the federal government hub would be interconnected with various agencies that could verify the input data that HIX applicants enter. He stated that the functions of the HIX should include:

- (1) certifying, decertifying and recertifying plans;
- (2) establishing ratings based on relative quality and price;
- (3) providing consumer information in a standard format;
- (4) providing electronic calculations of performance indicators after input of income data;
- (5) comparative information viewed on the web site;
- (6) determining eligibility for the HIX and facilitating enrollment;
- (7) establishing exemptions and granting approvals based on exemptions; and
- (8) establishing a navigator program.

Mr. Angoff listed the multiple areas in which the federal government has indicated that states have the flexibility to tailor the HIX to their needs, such as:

- (1) where the information is housed and whether the HIX will be a nonprofit entity, an independent agency or housed within an existing state entity;
- (2) what the exchange's jurisdiction is: most states will opt for a single state exchange, but the states with large populations may have regional exchanges;
- (3) what type of conflict-of-interest standards will the HIX adhere to: in the proposed rule, parties with an economic interest, such as insurers, can be on the board of the exchange;
- (4) how active or weak will the HIX be: how much bargaining power on behalf of consumers should the state exercise through the HIX;
- (5) network adequacy standards: how many providers will compete in a market and how near must the providers be to the insureds;
- (6) marketing standards: by what consumer protection laws must insurers abide;
- (7) risk adjustment: balancing risk among qualified health plans;
- (8) small business participation in the HIX: whether the ceiling should be 50 employees or 100 employees; whether the employer or each employee should choose the plan; and whether a small business exchange should merge with the individual exchange;
- (9) discretion over whether the state will run the HIX or allow the federal government to run the HIX or whether the state will run the exchange in partnership with the federal government;
- (10) whether to use a single application the HIX develops or to use one developed by the federal government; and
- (11) if states can decide whether to use the navigator program.

Mr. Angoff stated that there are five primary functions of a HIX:

- (1) consumer assistance;

- (2) plan management;
- (3) eligibility determination;
- (4) enrollment; and
- (5) financial management.

Mr. Angoff asserted that the HHS supports states by:

- (1) providing exchange grants;
- (2) managing a data services hub on behalf of the state; and
- (3) providing financial management assistance services (including running risk-adjustment and risk-carvers programs).

Mr. Angoff listed a number of HHS resources, particularly for IT support, including that:

- (1) New Mexico applied for and received a planning grant;
- (2) the HHS offers an establishment grant; and
- (3) the HHS offers an innovator grant.

In a federal-state partnership model, the HHS would primarily be responsible and accountable for establishing the HIX, while the state would be responsible for running the HIX. The federal government so far has identified the following partnership model options:

- (1) the state will engage in plan management through plan selection by rating and doing quality analysis of each insurer's plan and providing data management;
- (2) the state will provide consumer assistance, including in-person assistance, navigator management, outreach and education; and/or
- (3) the federal government will manage the remaining functions.

Mr. Angoff reminded the committee that if the state HIX were certified under the ACA, federal grant funding would be available on January 1, 2013 and January 1, 2014 for all functions. If the state is performing limited functions to effectuate the HIX, then grant funding would be available for the functions actually performed. If the state decides not to participate, no additional funding would be available in 2013 or 2014.

Mr. Angoff commended the committee for being "visionary" in introducing insurance exchange bills and a patient protection bill before the ACA was passed.

Committee members asked how the HIX would be implemented in the state, given that the state has multiple areas with no broadband and populations with no computers. Ms. Petty remembered that Dr. Derksen said that 30% of the state's residents lack web access, and he emphasized the utility for the state to be involved in establishing the HIX to accommodate the populations without internet access. Also, Ms. Petty stated that the New Mexico State University agricultural extensions serve as models for community access and outreach.

Mr. Angoff stated that the small business tax credit under the ACA will give small businesses through 2014 an estimated \$40 billion in benefits. Committee members mentioned the small business help option and were concerned about seasonal and temporary employees and their impact on small business administration of a highly fluctuating employee pool. Mr. Angoff stated that there is no requirement for small businesses with fewer than 25 workers to buy insurance for their workers. In response to committee concerns, Mr. Angoff stated that the rules concerning businesses located in multiple states have not yet been written. In response to committee questions about nonprofit businesses, Mr. Angoff stated that they also would be entitled to a tax credit, although the credit would be smaller than what other small businesses would receive.

Committee members asked if there is any way to postpone the January 1, 2014 deadline, to which Mr. Angoff answered no, unless the ACA is amended. In contrast, the January 1, 2013 certification deadline in the regulations is flexible.

Committee members asked if the federal match for Medicaid is "in concrete" such that, as the state experiences higher Medicaid enrollment, it will be reimbursed at 100%. Mr. Angoff stated that Senator Feldman and Mr. Hely would know and that it is in regulations, not in statute. For the federal pool, patients must have been uninsured for six months to qualify, unlike in New Mexico. Mr. Angoff stated that the young and healthy could be covered at lower risk and less expense under catastrophic policies. Ms. Petty stated that premiums are scaled by age, even if they have preexisting conditions. Committee members added that there is a need for personal responsibility and personal habits that are voluntary, and there is a desire for private industry to flourish. Committee members asked whether the state may take advantage of the federal HHS data hub yet opt out of establishing a HIX pursuant to the ACA, to which Mr. Angoff answered in the affirmative.

Committee members made several inquiries, to which Mr. Angoff responded by promising to follow up with staff with answers to the following:

- Can a state hold money that is granted in, e.g., 2012, for use to implement at a date beyond the January 1, 2013 readiness review — say, in 2014 or 2015?
- What happens if a state receives implementation grant money and later decides not to implement the exchange?
- The final rule on the exchange is not yet out, but is any further definition available for what is meant by a federal exchange or a state-federal partnership for exchange operation and financing?

Colorado Health Benefit Exchange Development

Shawn Raintree, operations manager of the Colorado Health Benefit Exchange (COHBE), has been working for six months on the exchange with Joan Henneberry, the planning director. Mr. Raintree distributed a handout titled "Colorado Health Benefit Exchange Overview, October, 2011". He described Colorado's exchange development, which started with a statewide dialogue in 2010 followed by: a planning grant to the Colorado Health Institute; broad-based work groups; support from foundations; dialogue with technology and service firms;

bipartisan legislation last spring; the appointment of an unpaid board of directors; and the submission of a level 1 grant application. Mr. Raintree stated that the core principle is consumer engagement, but having a healthy insurance market is also important.

Mr. Raintree informed the committee that no state general funds have been used for establishing the COHBE. Committee members asked how the COHBE will pay for operating funds after the federal grant money is gone, to which Mr. Raintree responded that it would be funded by insurers as a cost of their participation in the exchange. In response to a committee question about why insurers would willingly do that, Mr. Raintree responded that the insurers would be motivated by the size of the marketplace that would be opened to them by the exchange. Mr. Raintree stated that from a business point of view, anyone should be able to make an exchange work and that the proposed federal regulations offer an extraordinary degree of flexibility. When asked by the committee whether he saw any problems in the proposed federal regulations, Mr. Raintree said not really, although the procedures in the proposed regulations could have been simpler. For example, giving tax credits involves complications. Mr. Raintree reported that in Colorado, the view is that even a conservative role is to just jump into the ACA — there is no downside. As Mr. Angoff said, the state can pull out at any time.

Public Comment

Gail Evans, legal director of the New Mexico Center on Law and Poverty, reviewed the 70-page grant application, titled "New Mexico Level 1 Health Insurance Exchange Establishment Grant", recently submitted by the New Mexico Office of Health Care Reform. Ms. Evans discussed several problems with proposals in the application, including the following:

- (1) the HIX will be "housed" at the New Mexico Health Insurance Alliance, which includes up to nine governor appointees, as well as insurance industry appointees;
- (2) there was no notice to ACA supporters that the HIX would be housed in the alliance;
- (3) no advocate input was solicited; and
- (4) the board of the alliance will become the board of the HIX.

Ms. Evans informed the committee that the center would inform the federal government that it opposes the HIX as described in the level 1 grant application, and she asked the committee to send a similar letter. Ms. Evans asked the committee to allow the New Mexico Center on Law and Poverty to make a presentation to the committee about its concerns after the committee has a chance to review the grant application.

Dick Mason of Health Action New Mexico said he agrees with Ms. Evans' analysis and opinions.

Tour of South Valley Health Commons

Melissa Manlove, chief operations officer for First Choice Community Healthcare, and William Burns, D.D.S., dental director for First Choice Community Healthcare, gave a tour of the facility.

Thursday, October 6

The meeting reconvened at 9:18 a.m.

Early Childhood Services Data

Peter Winograd, Ph.D., director of the Center for Education Policy Research at the University of New Mexico (UNM) College of Education, distributed a handout titled "Early Childhood Services: How Data Can Help Us Understand What We Have and What We Need", which covers:

- (1) the importance of a common agenda for collective impact;
- (2) the present need for effective data systems;
- (3) the goal that every child be prepared for school;
- (4) gathering, organizing and presenting data to enable the exploration of fundamental policy issues affecting children in the health and human services and education realms; and
- (5) 22 pages of data and graphics illustrating the measures of risks for children and the existence of and the need for additional early childhood programs in the state.

Dr. Winograd congratulated the legislature on passing SB 120 (Laws 2011, Chapter 123) and advised the committee to prioritize legislation based on where children are most at risk, where existing early childhood programs are, where the gaps are and how such gaps might be filled.

Mimi Aledo-Sandoval, senior fiscal analyst for the LFC, agreed that SB 120 demonstrates the legislature's commitment to a robust early childhood system. She distributed a handout titled "Early Childhood Services CYFD, DOH, PED". Ms. Sandoval stated that 80% of brain development occurs before a child reaches three years of age, and there is a 10% return of investment for early childhood programs. According to Ms. Sandoval, the LFC supports the alignment of service delivery programs delivered by the Children, Youth and Families Department (CYFD), Department of Health and Public Education Department (PED), which does not occur currently. Consequently, there may be both overlap and gaps in services.

Committee members inquired about data on babies born to unwed mothers and noted that it was not in Dr. Winograd's handout. Dr. Winograd said he has that data, but he could not include everything in his handout. A committee member suggested focusing on the individual families posing the greatest risk to their own children. Dr. Winograd noted that the CYFD does a great job at trying to make appropriate choices in the best interests of children on a case-by-case basis.

Committee members discussed data indicating that Head Start's benefits fade by third grade. Dr. Winograd countered by saying that there is tremendously well-documented evidence on how the return on investment in early childhood programs provides benefits to the children that last well into adulthood.

Committee members suggested that the data presented in Dr. Winograd's handout could have been manipulated by programs seeking funding and could ignore the family support systems that help babies and children in their communities. Dr. Winograd said that it can be challenging to develop an early childhood program that respects families and communities and to pinpoint where there is good family support and where there is not. Dr. Winograd said he agrees with the need to respect traditional values and the strength of traditional New Mexico families.

Committee members suggested that there could be a problem with using percentages rather than absolute numbers because the percentages of children who cannot read are higher in rural, low-population-density counties than in Bernalillo County, yet there would be a higher absolute number of children who cannot read in Bernalillo County than in more rural counties, as the population is much higher in Bernalillo County. Dr. Winograd said that the maps he presented are rough guides and would have to be accompanied by tables showing total numbers of children (not percentages) and discussions by experts to present as much information as possible to support policy discussions.

In response to committee members' queries, Diana Martinez Gonzales, division director, Early Childhood Services, CYFD, said that the pre-kindergarten program is in the sixth year. An external evaluator from UNM examined the effectiveness of program, and the results showed that children who come to pre-kindergarten straight out of the home require more assistance than those who come from a quality preschool experience. Ms. Gonzales hoped that the federal Race To The Top funding and implementation of SB 120 would allow the CYFD to collect longitudinal data on the effectiveness of the pre-kindergarten program.

Dr. Winograd stated that the PED has the data on children who entered pre-kindergarten six years ago and are now in third grade and he hopes that the PED starts analyzing that data.

Committee members asked how PED-taught pre-kindergarten and CYFD-contracted private pre-kindergarten results differ. Ms. Gonzales responded that the results appear identical.

Committee members looked at the LFC's data and asked whether there are early childhood care and education needs that have yet to be met. Ms. Gonzales stated that some charts may show areas of unmet needs due to a lack of community infrastructure to provide early childhood services, and in those cases, there are no programs to fund. Committee members also asked whether there is any failure to apply for all possible federal matching funds for early childhood care and education. In response to committee members' queries, Ms. Gonzales stated that all funding for pre-kindergarten programs comes from the state's general fund, while all funding for early childhood home visits comes from federal funding. Committee members asked about whether there are unmet early childhood care and education needs and how much more general fund dollars would be needed to cover the early childhood care and education needs of children whose households live at 150% of the poverty line and 200% of poverty line. Dr. Winograd stated that he would provide those figures by the 2012 regular session.

Child Protective Services Investigation and Report; Formal Action Plan

Michael Weinberg, program evaluation manager with the LFC, distributed a handout titled "Report to the Legislative Finance Committee" and reported on the LFC's evaluation of the Protective Services Division of the CYFD. Mr. Weinberg stated that over the last five years, the legislature has minimized fund reductions to the CYFD in recognition of the incredibly important services that the CYFD renders. Pages 12 through 15 of Mr. Weinberg's handout list the findings and recommendations showing performance data for the CYFD, areas of progress and opportunities for improvement in safety outcomes for children.

Mr. Weinberg stated that one of the challenges that the CYFD has faced is high caseloads. Jared Rounsville, director of the Protective Services Division, CYFD, stated that when the economy tanked, the CYFD saw more instances of abuse. He assumes that greater unemployment creates more stress on families, which sometimes results in increased instances of substance abuse, which in turn creates the circumstances for higher rates of abuse.

Mr. Weinberg added that the executive hiring freeze reduced the number of caseworkers available to handle a greater number of cases. In addition, an 18% employee turnover rate contributed to inefficiencies, according to Mr. Weinberg. Such systemic turnover cost the CYFD \$1 million to \$2 million to train new people and get them up to speed.

Mr. Weinberg described some of the LFC's recommendations listed in his report, including: (1) training caseworkers to use technology to reduce the amount of paperwork they need to do; (2) increasing the caseworker-to-supervisor ratio; (3) differentiating between the amount of training new employees receive based on their experience, education and qualifications; (4) differentiating between investigations based on levels of risk presented after an initial assessment of risk; (5) placing children in foster care only as a last resort; (6) reallocating appropriations for back-end services, such as foster care, to front-end services, such as home services, to teach families appropriate care; and (7) maximizing federal dollars.

Mr. Rounsville stated that his division agrees with many of the LFC's recommendations, such as maximizing federal dollars, which the division will be better able to do since it had an audit in July containing helpful suggestions. However, Mr. Rounsville said that his office disagrees with increasing the caseworker-to-supervisor ratio. He stated that the CYFD currently has one supervisor for every 3.8 caseworkers, and if the CYFD were fully staffed, it would have one supervisor for every 4.5 caseworkers, which is close to the standard recommended by the National Association of Social Workers, which the CYFD prefers to follow. Mr. Rounsville's division also disagrees with shifting funding from back-end services to front-end services because there is still a dire need for back-end services.

Mr. Rounsville's division also disagreed with the LFC's suggestion of a differentiated response and investigation system because the state has the lowest rating for service array, according to federal data, which means that there would not be the infrastructure to deliver a differentiated response.

Mr. Rounsville disputed the LFC's characterization of a significant waiting list for in-home services. As a result of a recent federal audit, the CYFD continues to improve the in-home services program, according to Mr. Rounsville. The in-home services program helps to prevent the removal of children from their homes by providing instruction so that parents can safely care for their children. As a result, there has been a dramatic reduction in the number of children in foster care.

A committee member expressed concern about the information that Mr. Weinberg provided indicating that, nationally, the incidence of child-on-child violence is four times higher in foster homes than in the general community. In addition, a committee member asked about the CYFD's data on treatment foster care in the state compared to the nation, which Mr. Rounsville said he could provide.

In response to a committee member's query, Mr. Rounsville said that there are multiple programs that provide some funds for former foster children once they are age-ineligible for foster home services. Such funds may provide financial assistance for utilities, furniture, post-secondary education and training.

Committee members asked whether the CYFD collaborates with law enforcement to increase agency efficiency and reduce costs. Yolanda Berumen-Deines, secretary of children, youth and families, responded that such collaboration is done to the extent possible, but the CYFD still needs caseworkers in the numbers presented.

CYFD: Update on Programs and Priorities

Secretary Berumen-Deines, Edna Reyes-Wilson, deputy secretary of children, youth and families, and Bob Tafoya, chief of staff, CYFD, addressed the committee and distributed a handout. They spoke about the CYFD's:

- (1) strategic focus;
- (2) early childhood services initiatives;
- (3) child protective services initiatives;
- (4) juvenile justice services initiatives;
- (5) behavioral health services initiatives;
- (6) department-wide initiatives; and
- (7) performance measures.

A committee member expressed concerns about a policy of favoring family reunification, even in some cases of serious abuse and when reunification may not be in the child's best interests. The committee member opposed the tendency to preserve the family instead of preserving the child. The committee member also requested data on how many reunified children were subsequently abused in their family households.

Family-Friendly Workplace Task Force (HM 1 — Regular Session, 2011)

Giovanna Rossi Pressley, president of Collective Action Strategies, LLC, Jessica Aranda, program director of Southwest Creations Collaborative, and Lee Reynis, Ph.D., director of the

Bureau of Business and Economic Research at UNM and chair of the HM 1 task force, were joined by Representative Picraux in addressing the committee. They distributed a handout titled "Taskforce on Work-Life Balance". Ms. Rossi Pressley reported that the task force has been studying the economic security of working mothers. Dr. Reynis stated that 60% of children under six had both parents in the work force, yet employers generally have not been accommodating. The only federal law that supports workers with families, the federal Family and Medical Leave Act of 1993, allows unpaid leave for no more than 12 weeks to be taken when a baby is about to be born or after the baby is born.

The presenters asserted that there can be a net bottom-line benefit to employers from passing family-friendly policies.

A committee member suggested that men and members of the business community be asked to collaborate with the task force.

Casa de Salud — Justice, Access, Support and Solutions for Health

Zane Maroney, clinic administrator of Casa de Salud, appeared with Andru Zeller, M.D. and Jesse Barnes, M.D. They reported that Casa de Salud was founded in 2004 in the South Valley of Albuquerque by clinicians who wanted to provide high-quality, low-hassle health care services delivered through traditional and alternative methods. They serve Albuquerque's uninsured, underinsured and immigrant populations. They stated that the goals of the clinic are to deliver: (1) same-day services, including evening and weekend hours; and (2) value-based and holistic health care, while the clinicians enjoy the freedom to focus on diagnosing the patient based on the whole person.

Mr. Maroney reported that Casa de Salud employs four physicians, two nurse practitioners, two physicians assistants, a doctor of oriental medicine, a licensed massage therapist and a technician who specializes in the removal of tattoos, scars and hair. Casa de Salud is planning an expansion to double the current 2,400-square-foot facility.

Casa de Salud saw 11,000 visits during the preceding year, of which 85% to 95% were uninsured. Though the majority of clients have low incomes, 90% pay the \$30.00 per-visit fees. The average cost is \$39.00 per patient, per visit. Casa de Salud has no on-call system. The clinic sees patients for extended hours and on weekends. Patients are referred to Presbyterian hospitals if needing hospitalization, thus lessening some of the burden on the UNM system. Not taking insurance decreases much of the administrative burden. However, next year, Dr. Zeller explained, the clinic will pilot a project to accept reimbursement from one insurer.

Dr. Zeller explained that Casa de Salud uses pre-med, pre-nursing and other students planning to enter medical training programs to do a lot of the medical assistant work. They are an affordable work force that learns cultural competence in a number of areas at the clinic, including the culture of health care delivery, working with clinicians, etc. Many of these individuals are from the local community and are bilingual in Spanish and English.

Mr. Maroney drew the committee's attention to JAZZ for Health's legislative proposal (see handout) to average at least three insurers' rates to set a maximum rate that providers may charge uninsured individuals. JAZZ for Health administrators have put together a patient-friendly billing project that should lead to fair pricing and billing policies. Representative Chavez stated her wish to reintroduce this legislation, informing the committee that other states have passed this legislation. New Jersey and California, she reported, base their maximum rates on those rates that Medicaid pays providers. Though the ACA contains such a provision, it applies only to nonprofit hospitals. This bill would "level the playing field; she said."

Upon a motion to endorse a duplicate of the 2011 regular legislative session's House Bill 223 (Representative Chavez), the committee voted to endorse it.

Nandini Pillai Kuehn, Ph.D., M.H.A., president of the board of directors of New Mexico Health Connections, a nonprofit 501(c)(29) corporation, and Rick Thaler, a member of the board of directors of New Mexico Health Connections, gave a presentation. Mr. Thaler owns a woodworking company, OGB Architectural Millwork, that employs 80 people. He provides his employees with health insurance. He said that having a work force whose health needs are taken care of well means a good work force. However, since his health care insurance costs have risen 14% to 18% each year, that jeopardizes his ability to provide health insurance. He and other members of New Mexico Health Connections founded the organization as a nonprofit health insurance cooperative that will make insurance plans available at a reasonable rate for small businesses and individuals. New Mexico Health Connections is considering developing its own network across the state, contracting with community clinics and becoming its own insurance company. Milton Sanchez, BlueCross BlueShield of New Mexico, stated that his company is a member-owned, not-for-profit insurance company.

Public Comment

Dick Mason said he opposes appointments of insurance company representatives to the New Mexico Health Insurance Alliance. He said he comes out of the corporate world, and, in his years of corporate work, has never encountered putting a distributor on an oversight committee. Mr. Mason distributed a one-page handout titled "Testimony to the Legislative Health and Human Services Committee", dated October 6, 2011, summarizing his viewpoints on the exchange.

Shari Gonzales, a private citizen who grew up in the South Valley, testified that not only is the care at Casa de Salud far superior to other facilities' health care services, but it is also delivered at a very reasonable rate. She feels that because of her connection to the health care workers at Casa de Salud, the compassionate way in which she is treated there and the reasonable prices, she is compelled to volunteer there. By giving her time to Casa de Salud, she helps the clinic extend care to others.

Adjournment

Senator Feldman thanked the South Valley Health Commons and Ms. Melendez, who helped ensure that the meeting ran smoothly. There being no further business before the committee, the fourth meeting of the LHHS for the 2011 interim adjourned at 4:05 p.m.